Board of Directors (Public)
The Rotherham NHS Foundation Trust

Schedule	Friday 8 November 2024, 9:00 AM — 12:30 PM GMT
Venue	Boardroom, Level D
Organiser	Angela Wendzicha

Agenda

9:00 AM	PROCEDURAL ITEMS

P153/24. Chairman's welcome and apologies for absence
For Information - Presented by Dr Mike Richmond

P154/24. Quoracy Check
For Assurance - Presented by Dr Mike Richmond

P155/24. Declaration of interest
For Assurance - Presented by Dr Mike Richmond

P156/24. Minutes of the previous meeting held on 6 September 2024
For Approval - Presented by Dr Mike Richmond

P157/24. Matters arising from the previous minutes (not covered elsewhere in the agenda)
For Assurance - Presented by Dr Mike Richmond

P158/24. Action Log
For Decision - Presented by Dr Mike Richmond

9:15 AM	OVERVIEW AND CONTEXT

P159/24. Board Committees Chairs Reports - Committee Chairs
i. Quality Committee - Chair's Log - Julia Burrows
ii. People & Culture Committee Chair's Log - Rumit Shah
iii. Finance & Performance Committee - Chair's Log - Martin Temple
iv. Audit & Risk Committee - Chair's Log - Kamran Malik
For Information

P160/24. TRFT Strategic Risk Appetite Review 2024/25
For Approval - Presented by Angela Wendzicha

P161/24. Board Assurance Framework
For Decision - Presented by Angela Wendzicha

P162/24. Corporate Risk Register Report
For Information - Presented by Angela Wendzicha

P163/24. Report from the Chairman - Verbal
For Information - Presented by Dr Mike Richmond

P164/24. Report from the Chief Executive
For Information - Presented by Dr Richard Jenkins

10:05 AM CULTURE

P165/24. Patient Story - Oncology - Presentation by Jenni Webb
For Information - Presented by Helen Dobson

P166/24. Integrated Equality, Diversity and Inclusion Plan - Hashim Din
For Approval - Presented by Daniel Hartley

P167/24. Progress on Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) - Hashim Dim
For Approval - Presented by Daniel Hartley

	P168/24.	Sexual Safety For Approval - Presented by Helen Dobson and Daniel Hartley
	P169/24.	Freedom to Speak Up Quarterly Report For Assurance - Presented by Helen Dobson
10:50 AM	SYSTEM WORKING	
	P170/24.	National, Integrated Care Board and Rotherham Place Update For Information - Presented by Michael Wright
10:55 AM	STRATEGY & PLANNING	
	P171/24.	Five Year Strategy Six Month Review For Assurance - Presented by Michael Wright
	P172/24.	Operational Plan Six Month Review For Assurance - Presented by Michael Wright
	P173/24.	Winter Plan For Approval - Presented by Jodie Roberts
	P174/24.	Digital Strategy For Approval - Presented by James Rawlinson
	P175/24.	Quality Improvement Strategy For Approval - Presented by Helen Dobson
11:40 AM	BREAK	
	PERFORMANCE	

	P176/24.	Finance Report For Assurance - Presented by Steve Hackett
	P177/24.	Integrated Performance Report For Assurance - Presented by Michael Wright
11:45 AM	ASSURANCE	
	P178/24.	Maternity and Neonatal Safety Report For Assurance - Presented by Helen Dobson
	P179/24.	Quality Assurance Quarterly Report For Assurance - Presented by Helen Dobson
	REGULATORY AND STATUTORY REPORTING	
	P180/24.	Learning from Deaths & Mortality Quarterly Report For Information - Presented by Jo Beahan
	P181/24.	NHSE Self-Assessment for Placement Providers 2024 For Approval - Presented by Jo Beahan
12:00 PM	BOARD GOVERNANCE	
	P182/24.	Review of Standing Financial Instructions For Approval - Presented by Steve Hackett
	P183/24.	Review of Standing Orders For Approval - Presented by Angela Wendzicha
	P184/24.	Reservation of Powers to the Board and Delegation For Approval - Presented by Angela Wendzicha
	P185/24.	Application of the Company Seal Report For Information - Presented by Angela Wendzicha

P186/24. Nominations and Remuneration Committee Terms of Reference
For Approval - Presented by Angela Wendzicha

P187/24. Audit and Risk Committee Terms of Reference
For Approval - Presented by Angela Wendzicha

P188/24. Escalations from Governors - No Esclations
For Discussion - Presented by Dr Mike Richmond

Board Annual plan
For Noting - Presented by Dr Mike Richmond

P189/24. Any Other Business
For Discussion - Presented by Dr Mike Richmond

P190/24. Questions from Members of the Public on the Business of the Meeting
For Discussion - Presented by Dr Mike Richmond

P191/24. Date of next meeting - 10th January 2025

CLOSE OF MEETING

Draft until approved at 8th November 2024 meeting

MINUTES OF THE BOARD OF DIRECTORS MEETING
Friday 06 September 2024, 09:00 – 12:30 pm
Boardroom, Level D, Rotherham Hospital

Present:
Dr M 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
Mr M Temple, Non-Executive Director
Dr R Shah, Non-Executive Director
Mr M Wright, Managing Director
Ms J Burrows, Non-Executive Director
Ms H Watson, Non-Executive Director

In attendance:
Ms A Wendzicha, Director of Corporate Affairs
Mrs L Martin, Director of Estates and Facilities
Mrs E Parkes, Director of Communications
Mr J Rawlinson, Director of Health Informatics
Ms C Rimmer, Corporate Governance & Risk Manager (minutes)
Mr J Brammer, Matron – for item P134/24
Ms L Price, Nurse Team Manager – for item P134/24
Mrs S Petty, Head of Midwifery - for item P140/24
Ms A Harris, Maternity and Neonatal Independent Senior Advocate – for item P140/24
Dr G Lynch, Guardian for Safe Working - for item P144/24

Observers:
Mr F Kler, Public Governor
Mr G Berry, Lead Governor and Public Governor
Mr M Ayub, Public Governor
Ms D Preston, Graduate Trainee

Apologies:
Mr D Hartley, Director of People
Mrs J Roberts, Director of Operations/Deputy COO
Mr A Wolfe, Deputy Director of Corporate Affairs

Item	Procedural Items	Action
P122/24	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE** The Chairman welcomed everyone to the meeting and noted apologies for absence.	
P123/24	**QUORACY CHECK**	

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	The meeting was confirmed to be quorate.	
P124/24	**<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. Mrs Parkes' interest in terms of her role as Director of Communications of both the Trust and Barnsley Hospital NHS Foundation Trust was noted.	
P125/24	**<u>MINUTES OF PREVIOUS MEETING HELD ON 5 JULY 2024</u>** The minutes of the meeting held on 05 July 2024 were agreed as a correct record following a minor amendment.	
P126/24	**<u>MATTERS ARISING</u>** There were no matters arising which were not covered by either the action log or agenda items.	
P127/24	**<u>ACTION LOG</u>** The action log was considered and log number 9, 10, 12 and 13 were agreed to be closed. Log no. 8 and 11 were agreed to remain open.	
	<u>OVERVIEW AND CONTEXT</u>	
P128/24	**<u>Board Committees Chairs Reports</u>** i. Quality Committee Ms Burrows was pleased to report that the escalations raised at the previous Board meeting had now been resolved. As the most recent Quality Committee meeting was only two days prior to the meeting, Ms Burrows gave a verbal update to the Board noting pleasing results in recent CQC surveys and commended the Chief Nurse on the work done on recruitment and engagement. Ms Burrows escalated to the Board two concerns from the committee: • The lack of continued funding for Smoking Cessation Midwives • The increased sickness rates, following the Safe Staffing and Quality Report received ii. Finance & Performance Committee	

	Mr Temple reported that CIP (Cost Improvement Programmes) remain a challenge for all, following presentations by Care Group 3 and Care Group 4; key challenges were identified, but there is still lots to be done. Mr Temple detailed the cyber security report received and the Data Security and Protection Toolkit (DSPT) for which the committee noted the issues and looked at the priorities, debating the risks. Dr Richmond highlighted a key concern regarding cyber-attacks is business continuity and the ability to function as a whole entity, and raised that reassurance is needed that this is an area of focus and monitoring. Executives explained the increased focus the EPRR team have on cyber and the effect on business and operations, and that they are working with procurement conducting table top exercises. Non-Executives questioned the organisation's preparedness, reflecting on recent national Covid reports and referring to the DSPT. Mrs Kilargiff explained the areas that are non-compliant, the level of evidence required and the changes to standards. Stress tests are also conducted to provide reassurance. Referring back to cyber security, Mrs Craven raised concerns over suppliers, specifically software development, and how to gain assurance that third party contributors have not created a weakness. Mrs Craven highlighted this to be considered with the new EPR system and the reassurance required. Mrs Kilgariff confirmed she would pick this up. Dr Richmond summarised that the Board must be keen to keep on top of this and revisit on a regular basis.	***SK***
P129/24	**Strategic Risk Appetite Review** Ms Wendzicha presented the report which was based on the results of the previous strategic Board session and the outstanding decisions to be made. Dr Jenkins suggested that the Quality risk appetite be named 'Quality of Care', and regarding the definitions, minimal is too risk adverse and cautious is a more accurate description. Mrs Dobson reflected on the refresh to the BAF aligned to Quality and agreed that cautious feels more appropriate. Mr Malik referred to the matrix, Trust values and objectives and noted that some categories have not been addressed, such as reputational and operational risk. Ms Watson suggested further review of the wording, particularly for People and Culture. Ms Burrows raised caution on reputational risk appetite, considering and reflecting on the appetite for other categories. Dr Richmond concluded there was a good directional of travel, aligning with the strategy refresh and that a further review is required to approve. Ms	

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	Wendzicha agreed that she would make the discussed amendments and circulate to the Board, summarising that it is a dynamic document for the Board to consider and amend accordingly.	***AW***
P130/24	**Board Assurance Framework** Ms Wendizcha introduced the BAF report, noting the individual meetings that have taken place, the presentations at Assurance committees and the recommendations for the Board. Ms Wendzicha explained that the discussions and decisions on the Strategic Risk Appetite review would flow through to this framework. Dr Richmond was pleased that the discussions and suggestions at the previous Board meeting had been actioned and that the BAF is now a more dynamic document that is regularly revisited by the Board.	
P131/24	**Corporate Risk Register Report** Ms Wendzicha presented the report and highlighted the recent deep dive and outcomes in relation to the risk register and detailed the monthly scrutiny of risks in conjunction with the BAF. Dr Richmond queried the engagement with Care groups and owning their risks and mitigations. Ms Wendzicha detailed the positive engagement at Risk Management Committee (RMC), cross-Care Group interaction and support from her team. There is increasing understanding on how risks are used and using risks in departmental meetings. Executives commended Ms Wendzicha and her team on the work to drive forward risk management and engagement, allowing Executives to put in extra challenge to risk owners and review static risks; the next step would be to see Care Groups with better ownership of risks. Mr Temple reflected on committee presentations and discussions from Care Groups, and the triangulation and orientation to risks, although some mitigation work varies.	
P132/24	**Report from the Chairman - Verbal** Dr Richmond reflected on the strategy refresh around the pursuit of excellence, which can only be achieved when the foundations are strong. Surveys show and seem to echo the terminology of being the best at getting better and there is a positive improvement trajectory. Dr Richmond emphasized the focus on funding and noted that there is considerable noise in the system regarding the financial situation. Dr Richmond referred to the Darzi review and hoped the report will be analytic and not reactive. The NHS has many challenges and although we are part of a macro system, we must also focus on our own system.	
P133/24	**Report from the Chief Executive**	

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Dr Jenkins reported that in terms of operational performance, there is no doubt that progress is being made, however, it is challenging due to rising demand and issues such as sickness. Although overall performance is improving, it is not progressing as quickly as desired. Dr Jenkins highlighted positive news in Cancer and Diagnostics, with some risk to achievement this month, yet plans are in place.

Dr Jenkins updated the Board on the high volume of meetings in the South Yorkshire space, due to the financial gap at SY ICB level.

Lastly, Dr Jenkins celebrated the recent listing for awards, with a strong presence in Nursing Awards.

A question from a member of the public was submitted prior to the meeting regarding the fire safety in the accommodation blocks and the Chief Executive gave a response at this point in the meeting.

Dr Jenkins explained that the Board had been made aware of fire safety risks and the options regarding the accommodation blocks. The fire risk had been validated by SY Fire and Rescue and the use of the accommodation blocks cannot continue into the new calendar year. There had been no reference to the risk in previous reports and Dr Jenkin noted that this highlighted work to do to understand and think about the consequence on the rest of the estate.

Dr Jenkins outlined the cost of circa £5million to remedy the issues and how this removes the level of choice for the organisation. Dr Jenkins acknowledged the effect on residents and detailed the engagement work to support tenants to find alternative arrangements.

The question submitted also referred to document requests and Dr Jenkins proposed that the Board respond directly.

Ms Burrows queried the mitigations put in place and Mrs Martin explained that the actions following a review last year have been completed and that the fire inspector was satisfied that the blocks could be evacuated successfully, in the event of a fire.

Ms Watson raised that the situation had drawn attention to whether there is a strategy in place for accommodation allocation and Dr Jenkins explained that there has not been a systematic policy in place, nor has there been a progressive approach to pricing. A policy is being worked on, with methodology, to move forward.

Furthermore, Dr Jenkins detailed that in regard to the rest of the estate, a review is in progress with the Fire Office and the Executive Team are addressing issues. They are also reflecting on additional assurance for the rest of the estate.

Referring to the awards, Mrs Craven suggested that a showcase of awards is installed in the reception area and would like to hear more about engagement with the public, on the positive achievements of the Trust. Dr

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	Richmond supported the positive momentum in marketing and Mrs Parkes would lead on this.	***EP***
	CULTURE	
P134/24	**Staff Story** The Board welcomed Ms Price and Mr Brammer to the meeting and Ms Price presented the Staff Story which looked at her journey through the RCN Leadership programme. Ms Price detailed the development of her QI project based on personal experience and patient care throughout her nursing career which started as a Health Care Assistant to a managerial role. Ms Price expanded on the patient experience that formed the QI project around Cancer and Pathways, with the idea of having pre-assessments on the same day as diagnosis. Challenges to the project included some reluctance to change and consideration of long waiters. Ms Price summarised that it was a fine balance of not losing activity but still providing this opportunity to patients. The results of the project were positive with some patients achieving 7 days from diagnosis to surgery. Some cases were more complex and the average was 2 weeks. Moving forward, Ms Price expressed her wish to expand the project beyond ENT, working with the CNS team. Non-Executive Directors (NEDs) queried patient choice here and the fast decision making, but Ms Price explained that it is patient led and if more time is needed, that it is given. She also reassured that the anaesthetics team are highly experienced and follow NICE guidelines to ensure they determine the appropriate plan and pathway, with the key point of keeping the patient fully informed. Mrs Kilgariff highlighted to the Board the positive Cancer performance for the Trust, shown in the IPR and triangulated the success with projects such as this. Ms Watson queried what support the Board could offer and Ms Price detailed the barriers to expand to other areas, such as, reluctance to change, and also some tangible items such as space and computers. Dr Richmond commended the positive work and the prospects for other colleagues to benefit from this leadership programme.	
P135/24	**Adoption of the North West BAME Assembly Anti-Racist Framework** Mr Ferrie presented the report, requesting support from the Board for the adoption of the framework. Mr Ferrie linked the framework with the new People and Culture Strategy and EDI plan 2024-2027, highlighting the aspirations to achieve gold attainment by 2027. Ms Watson queried the connection to actions already committed to in the WRES plan and looking at the landscape to ensure changes translate to	

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	real action and change. Mr Ferrie highlighted that a new Head of EDI has been appointed and that they are looking at practical examples for areas to add real value. Dr Shah shared that this is intended to be difficult and stretch organisations, so queried the goal to align with the strategy timeframe. Ms Burrows drew attention to the local population and commented on the system-wide approach with partners. The Board supported the adoption of the framework.	
	SYSTEM WORKING	
P136/24	**National, Integrated Care Board and Rotherham Place Update** Mr Wright introduced the report and highlighted key points including: • Agenda for Change pay uplift had been agreed and due in October's pay • The work supporting the RMBC Foster Caring Team • Place updates on Health Inequalities, noting that this area is due to come to a Strategic Board session to allow for more depth and discussion • Challenges currently faced such as the reduction in funding for the Smoking at the Time of Delivery Service • Work with South Yorkshire Police • Nominations for various awards Ms Burrows highlighted that the regular ICB communications lack news of the various award successes for Rotherham and Mr Wright confirmed that this had been brought to attention previously and will continue to push for spotlights. Mr Wright also drew attention to the circa £3.5m funding for South Yorkshire to help long-term sick and disabled people into work. Dr Jenkins discussed the work with partnership organisations and that it is an important issue for all places and requires large employers to be open about helping people back into work.	
P137/24	**Partnership Working** Mr Wright updated the Board on the strengthened governance arrangements, the joint roles and the joint meetings held. Mr Wright highlighted the service sustainability reviews pioneered by Barnsley and Rotherham for which the Acute Federation are now using and running workshops for specific areas. Mr Temple reflected on the positive Board to Board meeting and the achievements made from the partnership and Dr Richmond concurred on the positive meeting and beneficial alignment taking place.	
	PERFORMANCE	
P138/24	**Finance Report**	

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	Mr Hackett presented the report which covered the period up to the end of July and Month 4 position. Mr Hackett reminded the Board that July saw a period of Industrial Action and effects were felt in the weeks afterwards. Mr Hackett detailed that the Trust was off financial plan and referenced additional bed capacity; this experience has been shared across the vast majority of South Yorkshire. There has been significant activity across CEOs and Directors of Finance to discuss financial grip and control. In summary, Mr Hackett detailed that challenges remain due to various impacting factors, but aside from Industrial Action, these challenges had been previously identified. Mrs Craven queried the high expenditure on staffing and referenced the high sickness rates and asked how assured the Executives are that the work to address this will bear fruit. Mr Hackett detailed the challenge and scrutiny on these costs at Performance Meetings and Executive meetings but long term sickness is a challenge. Dr Shah queried how the Trust benchmarks in this aspect and Mr Ferrie explained that the recent IPR for SYIBC showed TRFT as middle of the pack. Health and Wellbeing work is being introduced and they are conducting a gap analysis and exploring collaboration with Barnsley. Mr Temple raised concerns over the ICB deficit and Dr Richmond confirmed that the Board must be resolute in its plan and delivery of the plan that has been submitted. Mr Malik drew attention to agency costs and the good work in the nursing profile, and pushed for this to be seen in other areas. Mr Hackett concurred that other options need to be explored with different models of workforce and discussed the deliberate and bolder decisions taken in UECC which are taking effect. Dr Richmond summarised that Board continues to share their concerns with the ICB, through the Chief Executive, and to protect the boundaries the Trust has set.	
P139/24	**<u>Integrated Performance Report</u>** Mr Wright presented the IPR report and drew attention to the positive quality metrics such as mortality, the improved C.Difficile rates and Friends and Family Test. On People metrics, Mr Wright highlighted that sickness is a challenge but retention metrics are positive. Ms Burrows queried the drop in appraisal performance and Mr Ferrie explained that the slower uptake may be due to the divisional restructure and the team are focusing on areas to support and that it is also brought to attention in performance meetings. On the Subtheme Cancer, Dr Shah questioned the mitigation for the risks outlined and Mrs Kilgariff highlighted that the Trust is achieving all three	

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	cancer standards but the key risks are workforce driven. There is lots of work in train on pathways and intense work around tracking to monitor. Dr Shah also drew attention to the productivity priorities and lack of achievements in that data set; Dr Jenkins confirmed that a Task and Finish Group has been set up involving Mr Wright and Mrs Kilgariff to focus on this and include utilisation of MEOC (Mexborough Elective Orthopaedic Centre of Excellence). Mrs Craven raised a point regarding the bed occupancy data which masked ring fenced capacity, to be picked up as part of the ongoing IPR development.	**Mr. Wright**
	ASSURANCE	
P140/24	**Maternity and Neonatal Safety Report** The Board welcomed Mrs Petty and Ms Harris to the meeting. Mrs Petty highlighted key points from the report including: • The SPC Charts show no new escalations to report • CNST is on track although there have been challenges in anaesthetic training as the requirement is now a full day training • Implementation of the RSV vaccination Ms Harris explained her role as the Maternity and Neonatal Independent Senior Advocate for South Yorkshire (SY). Ms Harris talked about working with families across SY and the themes emerging around communication and the experience for families. Mrs Kilgariff reflected on winter plans and the increase in C-sections to gain assurance that these are sighted or presented any concerns. Mrs Petty confirmed this is discussed with the Safety Champion and that they are working with theatre colleagues to manage the flow. HSJ (Health Service Journal) reports that rates increase safely however, Mrs Petty raised that capacity remains the same. Mr Wright drew attention to the Quality Committee escalation on Smoking Cessation and funding, discussing with Mrs Petty that this has been raised at ICB and a robust solution is not being seen; it is an important service provided and an element of the SBL (Saving Babies Lives) bundle. Mrs Petty summarised that it is a threat to maintain the Trust high standards and maternity schemes.	
P141/24	**Quality Assurance Quarterly Report** Mrs Dobson presented the report and highlighted the different format and structure for Quality Assurance. NEDs were pleased with the structure and for further development suggested more evidence-based triangulation, focus on outputs and linkages made through committees to ensure Board is fully assured.	

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	The Board supported the methodology moving forward.	
P142/24	**<u>Safeguarding Annual Report</u>** For the Safeguarding Annual Report, Mrs Dobson commended the journey and that the report details successes; all statutory duties have been met and there is a real continuous improvement mind-set. There were clear links to learning from incidents and there are challenges linked to mandatory training however, they are addressed proactively. Dr Richmond acknowledged the great work going into this area. Dr Jenkins drew attention to areas with poor ERS safeguarding compliance over a number of years and Dr Beahan provided re-assurance that this is being monitored and proactively addressed.	
	REGULATORY AND STATUTORY REPORTING	
P143/24	**<u>Responsible Officer Report – Q4 2023/24 and Annual Board Report & Statement of Compliance</u>** Dr Beahan presented the Annual Board Report and Statement of Compliance. Dr Beahan highlighted the external review of the appraisal system which gave positive feedback and updated the Board on the 96% appraisal completion rate. Dr Beahan raised that the appraisal budget is disproportionate across Care Groups and there is work to be done and taken through Executive Team meetings. The Board reviewed the content of the report and confirmed that the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).	
P144/24	**<u>Guardian of Safe Working Quarterly Report</u>** The Board welcome Dr Lynch to the meeting who outlined a number of key points from the report. Dr Beahan updated the Board that the GMC national training survey was satisfactory across the board but the Trust is striving to be positive outliers here. Dr Beahan aligned this with additional pressures and noted a few changes in regards to staff to look at.	
P145/24	**<u>Controlled Drugs Annual Report</u>** Dr Beahan presented the report, noting the statutory requirement. Mr Malik drew attention to the peak in May for 2022 and 2023 but no concerns were raised on this.	
	BOARD GOVERNANCE	
P146/24	**<u>Vice Chair and Senior Independent Director Appointment</u>** The Board supported Kamran Malik as Vice Chair for a further year, and supported Heather Craven as Senior Independent Director for the duration of her current term of office.	

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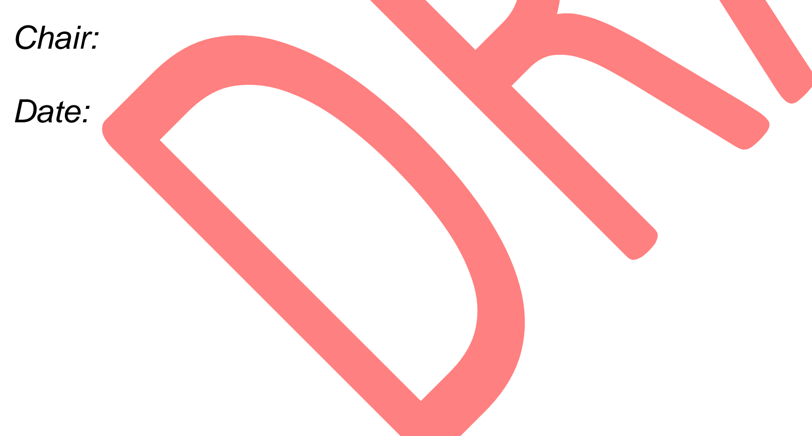
P147/24	**Fit and Proper Persons Report** As per the report, Dr Richmond declared that all Board members are deemed Fit and Proper Persons in accordance with the Framework as set out by NHS England. The Board noted the declaration.	
P148/24	**Annual Board Meeting Dates 2025** The Board noted the meeting dates for 2025.	
P150/24	**Annual Work Plan 2024-25** The Board noted the Annual work plan.	
P151/24	**Any other business** There were no other items of business.	
P152/24	**Questions from Members of the Public** The question received from member of the public was discussed in section P133/24 and a formal response will be sent by the Chief Executive.	
P153/24	**Date of next meeting** 8th November 2024	

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
2024								
8	03.05.24	Fire Safety Strategy	P73/24	Further clarity was required on whether it is an overarching document and would be carried forward in terms of a decision	LM	Sep-24	30.08.24 - Following discussion at ETM, it was agreed that the Fire Strategy needed to be considered at Finance & Performance Committee prior to approval at Board. 31/10/24 - was approved at September 2024 FPC	Recommend to Close
11	05.07.24	IPR	P111/25	Ensure targets for Quality metrics are included and generic wording is reviewed	MW	Sep-24	Targets have now all been added onto IPR. Required changes to Maternity dashboard have been agreed and will be enacted from next month. Virtual Ward metrics are reported through Care Group 4 IPR monthly. This includes numbers of patients, average length of stay, percentage of step up patients and readmissions. Medication incidents, pressure ulcers and complaints are also included but not separated out on the Care Group report to differentiate between Virtual Ward and other community patients	Recommend to Close
14	06.09.24	IPR	P139/24	As part of the ongoing IPR development, review bed occupancy data to ensure more clarity regarding ring fenced capacity.	MW	Nov-24	SK/MW have requested increased clarity in IPR, included on agenda. T	Recommend to Close
15	06.09.24	Finance & Performance Committee Chair's Log	P128/24	Assurance to be sought that there is assurance from third party suppliers on cyber security safeguards	SK	Nov-24	SK included in the Supply Chain Continuity and Supply Chain Resilience paper that was preseneted at the October 24 Finance & Performance Committee	Recommend to Close
16	06.09.24	Strategic Risk Appetite Review	P129/24	A further review of the wording for the People and Culture risk was required, amendments to be made and criculated to the Board	AW	Nov-24	Report included within Board agenda papers November 2024	Recommend to Close
17	06.09.24	Report from the Chief Executive	P133/24	Increased public awareness of positive achievements by the Trust and move towards positive momentum in marketing	EP	Dec-24	Due in December 2024	Open

Open
Recommend to Close
Complete

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: 30 October 2024**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Reporting on Quality Compliance - Care Group 1 (UECC & Medicine) Learning from Deaths Quarterly Report	The Committee agreed to alert the Board of the current position relating to the risk posed by sustained increased pressure of demand, currently c17% up from the previous year on services. The recent Trust wide communication about the impact of long waits in UECC on mortality was raised. The Committee wish to alert the Board, noting it is a risk for the whole Trust and the wider system.	Board of Directors
2	Board Assurance Framework	The Committee received the report and agreed for the rating to remain at 8.	Board of Directors
3	Health & Safety Committee Annual Report Infection, Prevention and Control Quarterly Report	The Committee received the report and agreed to alert the Board to the continuing position of the Trust being the only NHS Trust in South Yorkshire that does not have a scheduled proactive deep clean programme. Although noted that this is not a regulatory requirement of the Trust the Committee agreed that a planned and scheduled deep clean programme should be conducted annually, especially in light of the recent increase in C Difficile (Clostridioides difficile) infections as highlighted in the Infection, Prevention and Control Q1 Report also presented to the Committee. In view of the Trust's outlier position in rates of C.Diff, the importance of improving antibiotic stewardship and hand hygiene training is also emphasised. There is concern about the uptake of hand hygiene MAST training by medical staff, although some recent initiatives were reported that are anticipated will improve the position.	Board of Directors
4	Patient Safety Incident Response Plan	The Committee received the report and noted that it is an annual requirement for the report to be approved by a Board level committee. It was agreed that progress updates against the plan would be reported to	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		Quality Committee quarterly as part of the Patient Safety Report. The Committee approved the plan under delegated authority.	
5	Safe Staffing and Quality	The Committee agreed to advise the Board and also the People & Culture Committee of the current additional demand for capacity, which as well as being a risk to patients, is a risk to Trust staff, with this additional activity not always able to be staffed appropriately. The Committee also wanted to alert the Board regarding the position of the department who provide the data for the Assurance Committee reports with data not being available due to the only members of staff able to produce the data not being in work. The Committee is aware that this will be resolved in November, however point out that there should not be such single points of failure in a Trust the size of TRFT.	Board of Directors People and Culture Committee

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 and Culture Committee	**Date: 25 October 2024**	**Chair: Mrs Hannah Watson**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Key Issues	The Committee wanted to raise awareness and recognition to the Board of Directors of the large amount of awards that colleagues have been nominated for in recent months. This included nominations to the Nursing Times awards due this October and November.	Board of Directors
2	Corporate Risks Aligned to the People & Culture Committee	The Committee noted the increased number of risks that align to the Committee a number of which are dependent on decisions outside the Trust itself and with organisations such as NHSE and the ICB. The Committee advise the Board of Directors that going forward this is an area which will require cross Assurance Committee oversight as the risks relate to funding, delivery, people and quality.	Board of Directors
3	Progress on WRES and WDES	The Committee noted the progress made and challenges that remain and recommended that the paper should be taken to Board for approval.	Board of Directors
5	Any Other Business	The Committee wished to advise the Board of Directors that Mrs Sally Kilgariff, the Chief Operating Officer will from November 2024 attend the Committee, this was due to the overlap between people and delivery.	Board of Directors

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

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

Committee / Group: Finance & Performance Committee	**Date:** 30 October 2024	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Care Group 1 - (UECC & Medicine)	The Committee agreed to alert the Board of Directors to the current position relating to the risk posed by sustained increased pressure of demand, currently 8.6% above plan year to date. The Committee agreed that following discussions from the Care Group the current model for service provision does not fit the current demand and a review of how to deliver the increased demand which effects the entire Trust is required. The Committee also wanted to advise the Board of Directors of the really strong stories behind the data and the hard work of the Care Group staff for which they should be commended for.	Board of Directors
2	2024-2028 - Digital Strategy	The Committee agreed that it was assured with the work highlighted in the report the Strategy was recommended for presentation to the Board of Directors.	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: 25 October 2024**	**Chair: Kamran Malik**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Risk Management Report	The Committee recognise the increased focus and work being done in completing actions and mitigating risks but then the risk ratings not moving. The Committee also agreed to advise on the new increased focus in the report of the "so what", which they agreed was a positive next step and direction forward.	Board of Directors
2	Board Assurance Framework	The Committee noted the relationship between risk appetite and the target risks which was a good example of the developing maturity and understanding of our risks.	Board of Directors
3	Standards of Business Conduct:	The Committee agreed to alert the Board of the continuing poor compliance of staff with the annual declaration of conflicts of interest. The Committee noted the staff issues within the team who provide the data for this item and the single point of failure which is being looked into by the Director of People. The Committee also agreed to alert the Board of Directors of the previously agreed position of medical staff completing their declaration of interest at their appraisals, this is not being followed with the declarations not taking place. This is being picked up by the Director of Corporate Affairs and the Medical Director.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
4	Internal Audit Progress Report	The Committee agreed to advise the Board of Directors of the audit opinion of Limited Assurance for the CIP 360 audit with relation to the weaknesses in design and/or inconsistent application of the framework. It also noted the requirement for a multi-year focus on the CIP going forward as well as the need for greater links across the region of South Yorkshire, hand in hand with the direction of travel to achieve back to balance. The Committee also agreed to advise the Board of Directors of the Limited Assurance opinion for Medicines Management with a need to improve the governance and the importance of having Quality Committee oversight of this and it being a route to the Board of Directors.	Board of Directors
5	Annual Review of Standing Orders	These had been updated to reflect the new NHSE guidance, the Committee recommended the paper for approval pending minor amendments.	Board of Directors
6	Annual Review of Standing Financial Instructions (SFI) and Scheme of Delegation	The Committee noted the minor amendments in the paper to reflect items such as the new Care Group structure and the Managing Director's role, the Committee recommended the paper for approval pending minor amendments.	Board of Directors

Board of Directors’ Meeting
8 November 2024

Agenda item	P161/24
Report	**Update to the Strategic Risk Appetite Review 2024/25**
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	Links with all Trust Values
Purpose	**For decision** ☒ **For assurance** ☒ **For information** ☐
Executive Summary	The Board approved a number of risk appetite categories at the meeting held in September 2024 with the exception of the risk appetite relating to People, Culture and Estates. Following further discussion, the following report recommends the risk appetite for the aforementioned categories as People – Cautious Culture – Seek Estates - Cautious
Due Diligence	The paper is an update following the Risk Appetite paper agreed at the Board in September 2024.
Board powers to make this decision	Matters reserved to the Board
Who, What and When	Subject to approval, the risk appetite will be added to the current Risk Management Policy and communicated to the wider organisation.
Recommendations	It is recommended that the Trust Board: ➢ Approve the risk appetite for People, Culture and Estates.
Appendices	Appendix 1 Risk Appetite aligned to the Trust objectives Appendix 2 Applying the Risk Appetite Matrix

Strategic Risk Appetite Review 2024/25

1. Introduction

1.1 Risk appetite is defined as 'the amount and type of risk that an organisation is prepared to pursue, retain of take'[1] in order to meet its Strategic Ambitions/Objectives. Risk appetite represents a balance between the potential benefits of innovation and the threats that change inevitably brings. It provides a framework which enables the Trust to make informed management decisions. The benefits of adopting a risk appetite include:

- Supporting informed decision-making;
- Reduces uncertainty;
- Improves consistency across governance mechanisms and decision-making;
- Supports performance improvement;
- Enables focus on priority areas within the Trust; and
- Informs spending and resource prioritisation.

1.2 The Board of Directors reviewed the Trust Risk Appetite categories at the Strategic Board session in June 2024, the outputs of which were approved at the Board meeting on 6 September 2024 with the exception of the risk appetite relating to People and Culture and Estates.

1.3 The following paper provides a reminder of the Board approved risk appetite now included in the Board Assurance Framework in addition to recommendations relating to the risk appetite for People, Culture and Estates.

2. Review of the Risk Appetite

2.1 The Board, at the meeting in September, approved the following risk appetite categories all of which have been aligned to our strategic objectives and Appendix 1:

a. Clinical Innovation – Open

b. Commercial – Open

c. Compliance/Regulatory – Minimal

[1] ISO 31000 – Risk Management

d. Financial/Value for Money – Cautious
e. Partnerships – Seek
f. Reputation – Cautious
g. Quality of Care – Cautious
h. Environment – Cautious

People and Culture

2.2 The Board survey resulted in a direct spilt between ‘cautious’ and ‘seek’. Following discussion at the People and Culture Committee on 25 October 2024, consensus was reached that the definitions within the Good Governance Institute matrix did not fully suffice (Appendix 2). Further discussions have taken place with the recommendation that the risk appetite relevant to this category is split into two separate categories; People/Workforce to reflect our employment models and Culture with the recommended risk appetite as follows:

People/Workforce Risk Appetite

Cautious: We are willing to take limited risks with regards our workforce. Where attempting to innovate, we would seek to understand where similar actions have been successful elsewhere before taking a decision.

Culture Risk Appetite

Seek: We are willing to take greater risks and choose options that will develop a positive, inclusive culture for the benefit of our patients, carers and staff.

Estates

2.3 The survey carried out at the strategic session resulted in a split between Open and Seek for the category of Estates. Following further discussion and deliberation with the Director of Finance with the recommended risk appetite as follows:

Estates Risk Appetite

Cautious: We have a preference for safe delivery options relating to our estate that have a low degree of residual risk.

Recommendations

The Board is asked to:

- Approve the risk appetite for People and Culture and Estates

Appendix 1: Risk Appetite aligned to the Strategic Objectives and Ambitions.

Objective	Key Element	Ambition	Risk Appetite
Deliver care that is consistent with CQC 'Good' by the end of 2024/25	QUALITY OF CARE	Focus on providing high quality care & improving the experience of our patients	Cautious
Ensure significant improvement in National Inpatient and UECC Patient Experience Surveys			Cautious
Deliver 4 hour performance of 80% before March 2025	OPERATIONAL DELIVERY	Focus on our operational delivery and improving access to care	Minimal
Eliminate long waiters and go beyond the national ambition in long-waiters and RTT performance			Minimal
Consistently deliver the Cancer Faster Diagnostic Standard			Minimal
Achieve a top quartile engagement measure in the 2024/25 staff survey	PEOPLE & CULTURE	Focus on engaging with our people & improving the organisational culture	Seek
Improve attendance by reducing sickness absence by 1%			Seek
Ensure that we deliver inclusion by closing the gap between the experience of our people with different protected characteristics			Seek
Deliver the financial plan for 2024/25 and deliver year 1 of the plan to return the Trust to a break even position for 2026/27	FINANCIAL SUTAINABILITY	Focus on becoming a financially sustainable & productive organisation	Cautious
Ensure significant improvement across the full range of system productivity metrics			Cautious
Electronic Patient Record (EPR)	EPR TRANSITION	Focus on the transition to a new EPR system before our current system requires changing in 2026	Minimal

Applying risk appetite matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

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BOARD OF DIRECTOR'S MEETING
08 November 2024

Agenda item	
Report	**Board Assurance Framework**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Links with 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 therefore supports all three core values, Ambitious, Caring and Together.
Purpose	**For decision** ☒ **For assurance** ☒ **For information** ☐
Executive Summary	The development of the new Board Assurance Framework has continued on a monthly basis. The People Committee, Quality Committee and Finance and Performance Committee have each reviewed the Strategic Board Assurance Risks aligned to them as follows: **People & Culture Committee:** Discussed and approved the position in relation to Strategic Risk U4 at the October 2024 Committee. In addition the Committee discussed the outstanding matter relating to the risk appetite with further work carried out outside the meeting for approval at Board. **Finance and Performance Committee:** Discussed and approved the position in relation Strategic Risk D5 and D8 relating to future financial risk at the September and October 2024 meetings. **Quality Committee:** Discussed and approved the position in relation to Strategic Risk P1 at the September and October 2024 meetings. The Board will continue to review and approve the recommended scores for Strategic Risks R2 and O3 which have been reviewed in October by the Managing Director and Director of Corporate Affairs. The attached report illustrates the position in relation to the Board Assurance Framework for Quarter 2 and the first month of Quarter 3 2024/25.

Due Diligence	Since presentation at the last Board in September 2024, the relevant sections of the Board Assurance Framework has been discussed at the relevant Board Committees during September and October 2024.
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 of Directors: • Discuss and note the progress made in the Board Assurance Framework; ➢ The rating for BAF Risk P1 to remain at 8; ➢ 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 16; and ➢ The rating for BAF Risk D8 to remain at 20.
Appendices	Board Assurance Framework for Quarter 2 and the first month of Quarter 3 2024/25

1. Introduction

1.1 The development of the new Board Assurance Framework (BAF) to align with the 5 Year Strategy was commenced during Quarter 1 2022/23 when the Board approved a total of five Strategic Board Assurance Risks that would be monitored via the relevant Board Assurance Committees on the monthly basis with final approval by Trust Board on a quarterly basis. The BAF was reviewed as a result of the Strategy refresh in July 2024.

1.2 The BAF has now entered its third year in 2024/25 and continues to be monitored on a monthly basis at the Board Committees and at every full Board held in public.

1.3 The following report illustrates the discussion and decisions taken by the relevant Board Assurance Committees and the Executives during Quarter 2 and the first month of Quarter 3 2024/25.

1.4 The Risk Appetite levels previously agreed at the Board have been included, agreed levels for People and Culture and Estates are outstanding and a separate paper addresses these matters at the Board meeting.

1.5 In terms of target scores, the Board will note that the following risks are currently at target score:

- P1: Quality of Care currently at the target score of 8
- R2: Leadership within the system currently at the target score of 8
- O3: Collaboration with our partners currently at the target score of 8

1.6 As per usual practice and for ease of reference, the corresponding BAF report contains all updates in red font, and where an action or gap is partially completed this appears in blue font.

2. Outcome of the Reviews carried out in Quarter 2 and the first month Quarter 3.

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

Risk aligned to the Quality Committee

2.1 The Chief Nurse and the Medical Director are the Executive Director leads for Strategic Risk P1. As part of the continuing review of the BAF, monthly discussions take place with the Chief Nurse, Medical Director and Deputy Director of Corporate Affairs. There is also linkage with the BAF and the current Risk Register.

Updates to the Controls, Mitigations and Gaps

2.2 Following the review additional commentary has been added to the controls and assurance section of the BAF Risk as follows:

2.3 Controls C1 to C7 remain relevant and up to date. No additional gaps in controls have been identified that would adversely impact on the likelihood of the risk materialising and the current identified gaps have been strengthened.

Review of the Risk Score relating to P1

2.4 The initial score agreed for Quarter 1 2022/23 was a score of 16 whereby the consequence was graded as a 4 (Major), defined in accordance with the 2008 Risk Matrix for Risk Managers as 'noncompliance with national standards with significant risk to patients if unresolved, low performance rating, critical report'. It is proposed the consequence score remains the same at 4 (Major).

2.5 The initial likelihood score agreed for Quarter 1 2022/23 was 4 (Likely) defined in accordance with the aforementioned matrix as 'will probably happen/recur but is not a persisting issue. This likelihood score was reduced in May 2023 to 3 (Possible) following the lifting of the CQC conditions in 2023.

2.6 It was agreed at the July 2024 Board of Directors that the likelihood should be reduced further to 2 and the risk rating for BAF P1 should be decreased from 12 to 8 due to the controls in place and the number of audit reports giving moderate and significant assurance, there have also been improvements in Mortality Rates. Following consideration, the scoring is recommended to remain at 8.

2.7 Taking the above into consideration, it was recommended the risk score remains at **8** at the beginning of Quarter 3**.**

3 Risk aligned to the Board

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 health inequalities.

Updates to the Controls and Mitigations

3.1 The only change to the controls or gaps was the establishment of a working group to complete actions related to Gap G1, the Managing Director continues to attend the various PLACE Commissions, Groups and Boards listed on the BAF report.

Review of the Risk Score relating to R2

3.2 It is recommended that the score remains at **8**.

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.

Update to the Controls and Mitigations

3.3 An update was received in relation to the Gap G1 and the actions being taken to mitigate the gap, this is mainly related to the introduction and establishment of the new governance structure for the Network following the commencement in post of the Head of Nursing (Governance & Quality).

Review of the Risk Score relating to O3

3.4 It is recommended that the score remains at **8**.

4 Risk aligned to People & Culture Committee (P&CC).

U4: There is a risk that we do not create and maintain a compassionate and inclusive culture which leads to an inability to retain and recruit staff and deliver excellent healthcare for patients.

4.1 The new form of wording seen above for U4 was agreed at the June 2024 P&CC and Board in July 2024.

4.2 The Director of People is the Executive Director lead for the current BAF Risk U4. As part of the review process, the Deputy Director of Corporate Affairs met with the Director of People throughout Quarter 2 on a monthly basis with the last review being in September 2024.

Update to the Controls and Mitigations

4.3 There were a number of updates relating to the Controls, Mitigations and Gaps during the quarter, these can be found in the BAF report highlighted in red.

Review of the Risk Score relating to U4

4.4 The BAF Risk U4 was initially graded with a consequence of 4, which in accordance with the aforementioned risk matrix relates to uncertain delivery of key objectives/service due to lack of staff, unsafe staffing levels or competence (>5 days), very low staff morale and no staff attending mandatory/key training. The likelihood target score is rated at 2 which is 'unlikely, do not expect it to happen/recur but it is possible it may do so'. The likelihood current score was deemed to be a score of 3 which is 'possible, might happen or recur occasionally.'

4.5 Following further discussions at the People & Culture Committee in September 2024 it is recommended that BAF Risk U4 remains at **12.**

4.6 The Committee will note that despite the risk score, the risk remains within the current approved risk appetite with a continuing acceptance of a greater degree of inherent risk in pursuing workforce innovation with the caveat that we could potentially improve the skills and capabilities of our workforce.

5. Risk aligned to Finance and Performance Committee

D5: There is a risk we will not deliver our performance priorities (Urgent Care, Elective Recovery and Cancer) because of insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.

5.1 The Director of Finance and the Chief Operating Officer are the Executive Director leads for Strategic Risk D5. The Deputy Director of Corporate Affairs met with the Director of Finance and Chief Operating Officer monthly during Quarter 2.

Update to the Controls and Mitigations

5.1 The wording of D5 was amended to refer specifically to the key areas of delivery, Urgent Care, Elective Recovery and Cancer, the link to workforce resource was also removed as it was felt that this was covered in BAF Risk U4. The Controls, Mitigations and Gaps are all themed by the key areas noted above in addition to the theme of 'Winter'.

Review of the Risk Score relating to D5

5.2 The risk had been graded initially at **15** and following further discussion at December 2023 Board it was agreed that the rating should be increased to **20** due to pressures of industrial action. A recommendation for a reduction of the risk rating was taken to the April 2024 Finance & Performance Committee for discussion and approval. Following the discussion it was agreed that the risk rating should remain at **20**.

5.3 A further recommendation for a reduction of the risk rating to 16 was then taken to the July 2024 Finance & Performance Committee for discussion and approval. Following the discussion it was agreed that the Likelihood should be reduced to 4 and the risk rating should decrease to **16**; the risk will continue to be reviewed on a monthly basis.

D8: 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 2024-25 leading to further financial instability.

6 BAF Risk D8 covers the financial situation for the Trust, 2024/25, this risk is an annual risk covering the financial year only.

Update to the Controls and Mitigations

6.1 Controls **C1, C2, C3, C4, C5, C6, C7, C9, C10, C11** and **C14** have been updated with date of latest assurance received and additional forms of assurance confirmation.

Updates to Gaps in Assurances

6.2 There were no changes to the gaps, the Director of Finance continues to monitor these gaps and will be reviewed again at the July meeting.

Review of the Risk Score relating to D8

6.3 The risk had been graded at **20** and will continue to be monitored on a monthly basis.

Recommendations

The Board of Directors is asked to:

- Discuss and note the outcomes following review of the BAF Risks with the individual Executive Leads and

- Approve the recommendations from the Assurance Committees in relation to the risk scores Quarter 2 2024/25.

Alan Wolfe

Deputy Director of Corporate Affairs

October 2024

Ambition	Strategic Risk: There is a Risk that….	Because…..	Leading to…..	Original Score LxC	Score Q1	Score Q2	Score Q3	Score Q4	Target Risk Score	Movement	Risk Appetite
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**	8 ↓	8 ↔		~~3(L)x4(C) =12~~ 2(L)x4(C)= 8	↔	CAUTIOUS
Rotherham: ***We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve.***	**R2:we will not establish ourselves as leaders in improving the lives of the population we serve**	**..of insufficient influence at PLACE**	**..increased ill health and increased health inequalities**	2(L)x4(C)=8	**8**	8 ↔	8 ↔		2(L)x4(C) =8	↔	SEEK
Our Partners: ***We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care.***	**OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system**	**..of lack of appetite for developing strong working relationships and mature governance processes**	**..poor patient outcomes**	3(L)x4(C)=12	**8**	8 ↔	8 ↔		2(L)x4(C) =8	↔	SEEK
Us: ***We will be proud to work in a compassionate and inclusive organisation that delivers excellent healthcare for patients***	**U4: that we do not create and maintain a compassionate and inclusive culture**	**..**	**.. we do not create and maintain a compassionat e and inclusive culture**	3(L)x4(C)=12	**12**	12 ↔	12 ↔		2(L)x4(C) =8	↔	TO BE CONFIR MED
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 our performance priorities (Urgent Care, Elective Recovery and Cancer)**	**.. of insufficient resource and increased demand**	**.. an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.**	4 (L)x3(C) = 12	**20**	16 ↓	12 ↓		~~5(L)x4(C)=20~~ 2(L)X3(C) =6	↓	MINIMAL
	D8: we will not be able to sustain services in line with national and system requirements	**... of a potential deficit in 2024/25**	**... further financial instability.**	5(L)x4(C)= 20	**20**	20 ↔	20 ↔		1(L)x4(c)= 4	↔	CAUTIOUS

Applying risk appetite matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our Resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had beensuccessful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

Strategic Theme: Patients	Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2024-25				
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)~~ 8 2(L)x4(C)	~~3(L)x4(C) =12~~ 8 2(L)X4(C)	~~Very Low (1-5)~~ CAUTIOUS	15, 10, 5, 0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar risk score target risk	Previous Score Q4 2023-24	Q1	Q2	Q3	Q4
Link to the Operational Plan: P1: Deliver care that is consistent with CQC 'Good' by the end of 2024/25.Ensure improved performance of at least one quartile in the National Inpatient and UECC CQC Patient Experience Surveys.							12	12	8	8	

BAF Risk Description	Linked Risks on the Risk Register & BAF Risks:	Assurance Committee & Lead Executive Director
	RISK6623, RISK5761, RISK6809, RISK6800, RISK6630, RISK6762, RISK6627, RISK6886, RISK6284, RISK5238, RISK6723, RISK6958, RISK6857, RISK6801, RISK6888, RISK6718 and RISK6421	
P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.		**Quality Committee Chief Nurse and Medical Director**

Controls and Mitigations *(what have we in place to assist in securing delivery of our ambition)*		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational Level 2 = Internal Level 3 - Independent*	
C1	Implementation of agreed Quality Strategy to provide quality assurance to the Board and external regulators	Quarterly report on Quality Assurance to Quality Committee and Board of Directors to provide update on all aspects of Quality Management System including process management, monitoring, measurement and continuous improvement	October 2024 Board November 2024	QC	L1	Chief Nurse
		Range of tools utilised to measure quality achievements including Tendable Audit programme and Power Bi Quality Dashboards with outcomes reviewed at monthly Care group Performance meetings. From October 24 added in subject matter expert and senior nurse review to tenderable audits	October 2024	QC	L1	Chief Nurse
		Exemplar Accreditation Programme established for adult inpatient areas	October 2024	QC		Chief Nurse

		Meeting structure established to provide quality assurance both within Care Groups and corporately through Quality Governance and Assurance Group monthly to quarterly Patient Safety Committee	October 2024	QGAG PSC					Chief Nurse
C2	Ongoing monitoring of Patient Safety and PSIRF implementation through a variety of sources to ensure we keep patients safe and optimise patient outcomes	Ongoing use of Datix incident reporting system to report all adverse incidents or near misses. All incidents rated as moderate or above reviewed at Incident Review panel by CN / MD three times a week. Incidents identified as requiring a PSII or AAR and associated themes and actions reported to Patient Safety Committee and Quality Committee quarterly. Harm Free Panel reviews TVN and IPC incidents monthly. Summary of key findings included in report to Patient Safety Committee and Quality Committee quarterly. Completed PSIIs reviewed in Executive led monthly sign off panel with representation from ICB. Summary of key findings included in report to Patient Safety Committee and Quality Committee quarterly. Actions from PSIIs and AARs monitored to ensure completion within agreed timescales. Monthly report sent to Care Groups and summary included in report to Patient Safety Committee and Quality Committee quarterly. All National Patient Safety Alerts and information received by the Central Alerting System Liaison Officer are shared quarterly through the Patient Safety Committee with completion of action plans monitored by the Quality Governance and Assurance Team. Operation plan PSIP updated for coming year to go to Patient Safety Committee October 24	October 2024	PSC QC ETM					Chief Nurse
C3	Mortality and Learning from Deaths	All actions in the 360 Learning from Deaths Audit have been completed. Work continues to further improve the program and to ensure there is no slippage for implemented improvements. Reports detailing the completion rates and timeliness of SJRs		CEC QC Board					Medical Director

		remain as a standing agenda item at the Bi-Monthly Trust Mortality Group (TMG). All SJRs with a Poor Care or judged to have been preventable are logged as incidents on Datix. Following closure the Lessons Lean and Actions are discussed at the TMG. All completed SJRs are sent to the Care Group Mortality Leads, those with learning points together with those Datix'd should be discussed at the respective CSU Clinical Governance Meeting. Compliance for this is being reviewed twice yearly. The SHMI continues to be monitored through the TMG. The response to any Diagnosis Groups Alerts, continue to be managed this Group. The reporting of the above is included in the quarterly Learning from Death report, which is reviewed at the Patient safety Committee, Quality Committee and Board.	October 2024 October 2024 October 2024 October 2024						
C4	Ongoing monitoring of the effectiveness of the newly implemented Clinical Effectiveness Strategy by the Clinical Effectiveness Committee.	The Care Groups report details of their Clinical Audits, Getting it Right First Time Programme (GIRFT), National Clinical Audits - Quality Accounts (NCAPOP & Other) relevant NICE guidance, National Confidential Enquiries into Patient Outcomes and Deaths studies (NCEPOD) and Commissioning for Quality & Innovation Scheme Topics (CQUINs) to the Clinical Effectiveness Committee. There is a Clinical Effectiveness Committee Report at the Quality Committee on a quarterly basis	September 2024	CEC QC					Medical Director
C5	Ongoing monitoring of Patient Experience through a variety of sources to ensure we are on track to improve performance in national inpatient and UECC surveys	Monthly text surveys to a proportion of discharged patients asking questions related to lowest scores on most recent national survey. Results and actions will be presented to Quality Committee in quarterly Patient Experience Report	September 2024	QC					Chief Nurse
		Friends and Family Test offered to all patients. Results shared with Care Groups on a monthly basis and reported at Patient Experience Committee and Quality Committee quarterly	May 2024	QC	L1				Chief Nurse

		Report on Complaints including volume, themes and learning reported at Patient Experience Committee and Quality Committee quarterly	October 2024	PSC QC	L1				Chief Nurse
		Introduction of PALs with monitoring of Key Performance Indicators through Patient Experience Committee and Quality Committee quarterly Results of 4 national surveys (inpatients, UECC, maternity and CYPS) published by CQC. Improvement plans developed and progress monitored quarterly through Patient Experience Committee and Quality Committee	Formal launch November 2024 September 2024	PEC QC PEC QC	L1				Chief Nurse
C6	Three Quality Priorities have been agreed for 2024/25	Rolling monthly update report to Quality Committee resulting in an update being received for each priority quarterly. Template provides data in SPC format, supported by Qi, Effectiveness and Data Analysis teams	October 2024	QC	L1				Chief Nurse
C7	Seek External Assurance to triangulate with internal assurance data	Quarterly reports on progress against self-assessment by Care Groups to Quality Governance & Assurance Group reported through Patient Safety Committee and Quality Committee quarterly	October 2024	QGAG PSC QC	L2				Chief Nurse
		External body reports such as from NHSE or inspections reported to Quality Committee via the appropriate sub group on quarterly basis	October 2024	SC QC	L3				Chief Nurse
		Quarterly Safety, Experience or Effectiveness reports to Quality Committee to provide updates on any partnership working with BDGH and details of associated actions	Sept 24	QC	L2				Chief Nurse
		Annual audit reports commissioned within the Quality domain following agreement of Audit & Risk Committee received at both ARC and Quality Committee with action plans monitored to completion. Audits include Internal Audit of Clinical Audit and Nice Implementation, Safeguarding and Medication Safety. Safeguarding and Medication 360 audits completed	June 24 October 2024	QC	L3				Chief Nurse

Gaps in Controls or Assurance Quarter 1 2023-24		Actions Required	Action Owner	Date Action Commenced	Date Action Due			Progress Update	
G1	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 Recruit additional palliative care consultant	Medical Director and Chief Nurse Medical Director	January 2023 September 2023 July 2024	~~May 2023~~ September 2023 May 2023 February 2025			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 NACEL to change to a rolling programme of audit All actions Completed - not archived as rolling programme The situation is ongoing and improving, awaiting a full year of improvement work and full report. Consultant Post recruited into, awaiting commencement into role.	
G2	Exemplar Accreditation programme needs to be expanded to all clinical areas beyond adult inpatient wards	Strategic planning session with Heads of Nursing	Chief Nurse	19/06/2023	December 2023 April 2025			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 A7, A5, B10 and Rockingham. Programme gone live and on track, this will now be an ongoing process across trust with inpatient adult wards completed. Criteria to be agreed for other departments and teams, Children's and Maternity in October 2024 and UECC in April 2025.	
G3	Challenges around sufficient workforce to support the recovery plans around staff absence in theatres and anaesthetics and industrial action now mitigated.	High level risks from Care Groups regarding workforce challenges monitored via P&CC. Industrial action whilst ongoing will be subject to regular industrial action meetings to mitigate impact.	Divisional Leads & FPC	**Ongoing**					
G4	Seek External Assurance to triangulate with internal assurance data	NHSE invited to undertake an appreciative inquiry into Adult Safeguarding. Report and any associated action plan will be presented to Safeguarding Committee and Quality Committee	Chief Nurse	**April 2024**	October 2024			Report complete to be presented at next Safeguarding Committee November 2024	
		Benchmarking Data will be reviewed to enable relevant services to compare quality and learn from exemplar organisations. Reporting will be through relevant subcommittee	Chief Nurse	**July 2024**	October 2024				

		and to Quality Committee quarterly. Reports to include increased comparison of data with external organisations and all associated actions.							
G5	Development of Trust Quality Strategy		Chief Nurse/Head of Quality Improvement		November 2024			To be presented to November 2024 Quality Committee with plan to include as agenda item at March 2025 Board	
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 2024-25			
Strategic Ambition: Rotherham: *We will be PROUD to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve.*	R2	2(L)x4(C)=8	8	2(L)x4(C) =8	~~Moderate (12-15)~~ SEEK	10 / 5 / 0; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; risk score; target risk	Previous score Q4 2023-24	Q1	Q2	Q3	Q4
Link to Operational Plan: R2: Ensure equal access to services							8	8	8	8	

BAF Risk Description				Linked Risks on the Risk Register & BAF Risks	Assurance Committee
R2: There is a risk that we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities				Risk	Trust Board Managing 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 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	**September 2024**	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 Public Health Consultant is 50/50 split with RMBC	**August 2024**		Level 1	**Control remains ongoing**
C3 Trust is a member of the Health and Wellbeing Board		**October 2024**		Level 1	**Control remains ongoing**
C4 Managing Director attends the Health Select Commission	Ran Workshop for Commission December 2023	**October 2024**	**Minutes**	Level 3	**Control remains ongoing**
C5 Meeting with PLACE colleagues to review IDT position.	Meet at least three times a week to review integrated discharge position.	**September 2024**		Level 1	**Control remains ongoing**
C6 PLACE Leadership Team meeting every Wednesday morning	Managing Director attends along with other Rotherham PLACE members	**Weekly**		Level 1	**Control remains ongoing**

Gaps in Controls or Assurance Quarter 1 2022-23		Actions Required	Action Owner	Date Action Commenced	Date Action Due			Progress Update	
G1	Ethnicity details not on all electronic systems	Public Health Consultant identifying and working on solution. A working group has been established including the Public Health Consultant and the Director of Health Informatics	Managing Director	Ongoing	~~End of Quarter 1~~ End Quarter 4			Work ongoing with Managing Director	
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 2024-25			
***Strategic Ambition:* Our Partners: *We will be PROUD to collaborate with local organisations to build strong and resilient partnerships* that deliver exceptional, seamless patient care.**	O3	2(L)x4(C) = 8	8	2(L)x4(C) =8	~~Moderate (12-15)~~ **SEEK**	10 / 5 / 0; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; risk score; target risk	**Previous score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: O3: Our Partners: Work together to succeed for our communities.							8	8 ↔	8 ↔	8 ↔	

BAF Risk Description				Linked Risks on the Risk Register & BAF Risks	Assurance Committee
O3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.				**Risk**	**Audit & Risk Committee and Trust Board** **Chief Executive & Managing 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 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	**September 24**		Level 1	
C2 Existing collaboration with Barnsley on some clinical services	Gastro service up and running, Haematology service in progress MEOC now opened.	**July 24**		Level 1	
C3 Board to Board, Joint Strategic Partnership and Joint Executive Delivery Group established for oversight and	Meetings of the Strategic Partnership every quarter, Monthly for Delivery Group.	**September 24**	**Reports to Boards on progress**	Level 1	**Additional Board to Board meeting with Barnsley scheduled for 11 February 2025**

	delivery of partnership plan								
Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	New Pathology Partnership model with new governance arrangements following TUPE. New arrangements will need to embed with assurance provided to TRFT	Identified colleague to lead on target operational model for TRFT, Managing Director to attend Governance meetings	Managing Director	Started 01/04/2024	End of Quarter 1 Head of Nursing (Governance & Quality) to be embedded in role and start receiving assurance from governance at Pathology Partnership			Head of Nursing & Governance Corporate Operations (HoN&GCO) in post and met with Partnership governance and senior management. HoN&GCO update: Monthly Pathology Governance Group with SYPB 20/08/24. Monthly meetings (catch up) with the SYPB Governance manager every month Attend the local Operational Management Team meetings with SYPB however, with the partner organisations with their Head of Pathology and Governance Manager, to take place from September onwards to discuss performance/finance/operational delivery & governance Attend the monthly SYPB Senior management meeting too which was last week. Attend the TRFT HTT as a representative for TRFT along with Consultant Haematologist, which although is related to TRFT and how we are using blood products/demand etc, still links into the SYPB.	
		Formal reporting to Board on the Pathology Partnership outputs to be established.	Managing Director	November 2024	End Quarter 3				
G2	Mexborough Elective Orthopaedic Centre (MEOC) - Not filling capacity leading to increased reputational and financial risk to TRFT	Director of Operations and COO meeting regularly with colleagues internally to increase fill rate	Managing Director	April 2024	~~July 2024~~ Ongoing until satisfactory capacity sustained.			Activity reviewed on weekly basis at ETM with full updated report.	
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

Board Assurance Framework People Committee: 2024/25 Quarter 3: Version 3.1

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 2024-25			
Strategic Ambition: ***Us: We will be proud to work in a compassionate and inclusive organisation that delivers excellent healthcare for patients.***	U4	3(L)x4(C)=12	3(L) x 4(C) = 12	2(L)x4(C) =8	~~Moderate (12-15)~~ **Decision to be confirmed**	15 10 5 0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar — risk score — target risk	**Previous score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: P3: Supporting our People P2: Improve engagement with our medical colleagues							**12**	**12** ⟺	**12** ⟺	**12** ⟺	

BAF Risk Description	Linked Risks on the Risk Register & BAF Risks:	Assurance Committee
	RISK6888, RISK6638, RISK6723 and RISK7210	
U4: there is a risk that we do not create and maintain a compassionate and inclusive culture which leads to an inability to retain and recruit staff and deliver excellent healthcare for patients		**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	New People & Culture Strategy	There will be a 6 month and 12 month review presented to the P&CC.	October 2024 and April 2025 P&CC		Level 1
C2	Integrated EDI (Equality Diversity Inclusion) Plan	Have current Board approved plan published and on website, will be refreshed for November Public Board 2024.	EDI Plan to P&CC in October 2024 and Board November 2024		Level 1
C3	Delivery of the People Promise – staff experience	Review progress against the Trust 'We said we did' plan and Care Groups to present progress on their 'We said we did plans'. NHS Staff survey outcomes and scores to be presented at People Committee and then the March 2025 Board of Directors. July 24 launched trust wide 'we said, we did' 2024/25.	October 2024 and March 2025 February 2025 P&CC At Care Group P&CC presentations		Level 1
C4	Health wellbeing and attendance work	Going to ETM w/c 15/07/24 and P&CC in October 2024.	End of Quarter 3 2024/25		Level 1 Level 2

		360 audit gave limited assurance, audit to be rerun early 2025/26	Quarter 1 2025/16		
C5	Development of the Trust Workforce Plan	Current Workforce Plan 2020-24 in place, new plan to be in place from April 2025.	April 2025 P&CC and May 2025 Board		Level 1
C6	Joint Leadership Programme	Delivery in train and on track	October 2024 P&CC		Level 1

Gaps in Controls or Assurance Quarter 1 2024-25		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**	**Progress Update**
G1	Challenges around sufficient workforce to support the recovery plan and mitigate industrial action.	High level risks from Care Groups regarding exceptional workforce challenges monitored via P&CC. Care Group 1 Care Group 2 Care Group3 Care Group4 Corporate Services Unexceptional workforce challenges are managed by the Care Group Management with risks escalated via Care Group Governance Committees and on to Risk Management Committee if rated 15 or above. Industrial action whilst ongoing will be subject to regular industrial action meetings to mitigate impact.	Divisional Leads & FPC	**Ongoing**		This Gap relates to four outstanding risks rated at 15 or above: Care Group 1 - Risk6638 - The division's ability to ensure sufficient numbers of suitably qualified, competent and experienced RN. Rated 20 Care Group 2 - Risk6723 - Anaesthetic Medical Staffing Availability. Both risks are covered by action plans which are due for completion by December 2024. Rated 15 Care Group 2 - Risk7210 - Reputational and financial risk related to medical trainee claim for back pay in Trauma and Orthopaedics - rated 12 Corporate Services - Risk6888 - Lack of clinical psychology support for all services for which it is required. Rated 15
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 2024-25				
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*** ***Link to Operational Plan:*** ***D5: To deliver 4 hour performance of 80% before March 2025, to go beyond the national ambition on long-waiters and RTT performance and consistently deliver the Cancer Faster Diagnosis Standard by Q4.***	D5	4(L)x3(C)=12	~~5(L)X4(C)=20~~ Dec23 Consequence increased due to more significant impact of IA ~~4(L)X4(C)=16~~ July24 Likelihood decreased as pressures eased. 4(L)X3(C))=12 Pay deal agreed, no further periods of IA for trust staff planned. Return to initial consequence.	2x3=6	~~Very low (1-5)~~ MINIMAL	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 2023-24 20	Q1 20	Q2 16	Q3 12	Q4
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 our performance priorities (*Urgent Care, Elective Recovery and Cancer*) because of insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.						~~Risk 5761, Risk 6569~~, RISK6800, RISK6627, RISK6762 ~~RISK6414~~, RISK6755, RISK6638, RISK6718, RISK6723, RISK6958, RISK6888, RISK6598 , 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	**PERFORMANCE:** Care Group Performance meetings chaired by the Deputy CEO.	Performance Meeting minutes and chairs logs Monthly reports within IPR to Finance and Performance Committee and Board Care Group Performance meetings with each CSU		Sept 2024 Sept 2024 IPR	Minutes Chair's Log	Level 1					Managing Director

	PERFORMANCE: Executive Team oversight via IPR	Weekly receipt of Performance IPR	**Sept 2024**	**ETM minutes Weekly** **ETM minutes Weekly**	Level 1				Weekly Executive Team Meeting Managing Director
C2	**URGENT CARE:** Monitoring waiting times of patients in UECC	Monthly TRFT Urgent Care Meeting 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 Weekly 4 hour performance emergency care target meeting chaired by COO. Waiting times have improved in UECC and monitored against trajectory	**Sept 2024**	**Minutes of F&P** **ETM minutes** **ETM minutes** **ETM minutes** **Action log** **Daily performance report**	Level 1				COO
	URGENT CARE: Monitoring right to reside and Length of Stay data	Monthly TRFT Urgent Care Meetings Monthly reports to Finance and Performance Committee and Board Weekly Length of Stay reviews including Care Group Director Improvement with regards to right to reside and IDT caseload Escalation meetings with external partners. 360 internal audit about to commence	**Sept 2024 IPR** **Sept 2024 IPR** **Sept 2024 IPR**	**Minutes of Urgent Care Meeting** **Weekly ETM minutes** **Weekly ETM minutes**	Level 1				COO
	URGENT CARE: Admission avoidance work remains ongoing	Acute Care Transformation Programme - monthly highlight report and minutes of meetings 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. Oversight through the Rotherham Place Urgent and Emergency Care Group (Previously the A&E Delivery Board)	**Sept 2024**	**Minutes of Urgent Care meeting**	Level 1				ACT Steering Group – emergency pathway workstream Medical Director Rotherham Urgent and Emergency Care Group COO
C3	**ELECTIVE:** Weekly access meetings with tracker for elective recovery schemes	Elective Delivery Group Weekly Access Meetings Care Group PTL Meetings To include financial allocation from ERF reserve.	**Sept 2024**	**Monthly** **Weekly** **Weekly** **Weekly**	**Level 1** **Level 3 - 360 Assurance audit report - July24**				COO Ass Director of Operations Ass Director of Operations

		New weekly PTL for Elective and Cancer week commenced 27/11/2023. Outpatient, Theatre & Endoscopy Transformation Programmes		**Monthly Highlight Report**					
C4	**CANCER:** Cancer PTL	Rotherham Cancer Strategy & Performance Meeting Cancer Services Quality, Governance & Business Meeting Cancer PTL Meetings. Cancer Improvement Programme	**Sept 2024**	**6 weekly** **Monthly** **Weekly** **Monthly Highlight Report** **FPC 1/4ly**					COO Ass Director of Operations Cancer Manager
C5	**WINTER:** **Winter planning**	Evaluation of 2023/24 Winter Plan Action log of Winter Planning Group Winter plan 24/25 which meets fortnightly	**ETM and FPC mins** **Commenced August 24** **24/25 plan went to September FPC, ETM and due to Nov Board**	**Evaluation – FPC mins May 2024**					COO Dir Ops

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Insufficient funding to support increased levels of non-elective demand – both attendances at UECC and emergency admissions	Discussions with commissioners re funding Additional capacity utilising winter funding but summer months at cost pressure ACT programme to support most effective use of bed base Admission avoidance work with partners	DoF COO					No growth funding in 24/25 contract Additional bed capacity open cost pressure identified in Care Group forecasts ACT programme in place led by Medical Director maximising use of existing capacity Admission avoidance work in conjunction with partners – joint post to support project management UECC attendances 7.5% above previous year. Unfunded escalation capacity remains open.	
G2	Lack of consistent SDEC model and trolley capacity across medical and surgical SDECs	ACT programme developing consistent models of care Relocation of medical SDEC to create ringfenced capacity Bed modelling and LoS to be reviewed to create capacity to ringfence trolleys in surgical and gynae SDEC	COO	Q1	Q3			Trolley capacity currently impacted by increased demand on inpatient beds – medicine relocated to B6. Surgery reviewing Los and bed requirements and ASU/SDEC requirements. Gynae dependent on reduction in surgical outliers. Gynae to review how SDEC delivered within existing footprint.	

								Further trust-wide bed modelling being undertaken to review current capacity vs demand on beds. Capital bid submitted to provide increase capacity Plans to utilise B6 for SDEC during winter. Revised Capital Bid submitted to regional team September 2024 - awaiting response from regional and national teams. New dashboard in place giving visibility of all SDECs. QI events held to further develop pathways.	
G3	Insufficient validation to support robust management of waiting lists	Review of validation capacity and resource required to support increased size of waiting list and maintain requirement to meet 90% validation Standardise validation processes and embed consistent ways of working Training of existing staff to support validation of waiting list Ensure oversight through regular audits and performance monitoring	Associate Director of Operations, Planning and Performance	Q2	Q4			360 Assure audit undertaken and actions agreed and in process of full implementation Text validation and admin validation in place Waiting list review meeting established to oversee and implement actions in relation to 360 audit Positive feedback received from 360 in relation to revised governance arrangements Further Deep Dive Validation Exercise undertaken Lead RTT Validation & Data Quality Officer in place and training and support commenced Review of capacity Increased validation being undertaken with Care Groups. Ongoing validation monitiored on a weekly basis via access meeting with each care group.	
G4	Challenges around sufficient workforce to support the recovery plan and mitigate industrial action.	High level risks from Care Groups regarding workforce challenges monitored via P&CC. Industrial action whilst ongoing will be subject to regular industrial action meetings to mitigate impact.	Care Group Leads & FPC					IA Planning undertaken and command and control in place through periods of IA. Pay offer accepted by consultants and junior doctors	

G5	Insufficient anaesthetic workforce to support elective recovery	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 care group	Chief Operating Officer Care Group 2 Leadership team					Initial review of capacity required and available workforce undertaken Job plans reviewed and completed Second phase of review to be undertaken. Specification developed, external review to be undertaken.	
G6	Financial investment/resources to support recovery of waiting lists	Financial allocation identified in plan for 2024/25 – risk in allocation of ERF given overall financial position	Chief Operating Officer DoF					Plan and process for agreeing additional sessions in place for recovery schemes and investment in line with ERF allocation in 2024/25 plan - now being implemented. Positive impact on both activity and waiting times. Continuation of ERF schemes Schemes being implemented.	
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 2024-25**			
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.	D8	5(L) X 4(C)=20	*5(L) X 4(C)=20*	*1(L)x4(C) =4*	~~*Low (6-10)*~~ ***CAUTIOUS***	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 2023-24, as D7**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: D8: To deliver the financial plan for 2024/25 and deliver year 1 of the plan to return the Trust to a break-even position for 2026/27, and to ensure significant improvement across the full range of system productivity metrics.							**20**	**20** ↔	**20** ↔	**20** ↔	

BAF Risk Description				**Linked Risks on the Risk Register & BAF Risks**	**Assurance Committee**
				RISK 7130, RISK6755 and RISK6801	
D8: 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 2024/25 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	**Sept 2024 Board**		Level 1
C2	CIP Track and Challenge in place		**Sept 2024 Board**		Level 1
C3	Contingency of £3m in place.		**Sept 2024 Board**		Level 1
C4	Winter funding allocated in reserves of £1.2m.		**Sept 2024 Board**		Level 1
C5	Elective recovery fund £6.0m		**Sept 2024 Board**		Level 1
C6	Financial plan submitted to NHSE by 08/05/2024	Submitted on time, still awaiting sign off by NHSE	**Sept 2024 Board**		
C7	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee	**Sept 2024 Board**		Level 1
C8	System wide delivery of Recovery	Director of Finance attends South Yorkshire DoF Group	**Sept 2024 Board**		Level 1

	On plan with mitigations in place to manage winter pressures.	Monthly Finance Report to CEO Delivery Group	**Sept 2024 Board**		Level 1
		South Yorkshire Financial Plan Delivery Group			Level 1
C9	Suitably qualified Finance Team in place	Team in place			Level 1
C10	Established Capital Monitoring Group	Capital and Revenue Plan signed off by Board	June 2024		
C11	Current Standing Financial Instructions in place	Reviewed and approved by Board			Level 1
C12	Internal Audit Reports	Internal Audit Financial Reports			Level 3
		Review of HFMA Improving NHS Financial Sustainability checklist			Level 3
		360 Assure Head of Audit opinion presented to Risk and Audit Committee initial indications show Significant Assurance overall			Level 3
C13	Monthly challenge on performance	Monthly Divisional Assurance meetings	June 2024		
C14	Clarity on Financial Forecast	Financial forecast will commence 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.			Level 1
C15	Deloittes review of South Yorkshire system including investigation and intervention work.	I&I report will be finalised and presented to Senior Leadership Executive for South Yorkshire highlighting areas for improvement	August 24		

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**
G1	Adherence to expenditure Run Rate as per financial plan	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			
G2	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.	Situation acceptable currently, future risk	Director of Finance					For Gaps G4-G7 awaiting further national guidance to fully assess the position. The Trust will run out of cash at some point during the second half of the financial year 2024/25.

G3	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 income risk	Director of Finance						
G4	Financial forecasts come to fruition	Monthly check and challenge with relevant Divisions and Corporate areas.	Director of Finance						
G5	Continuing industrial action leading to increased financial outlay in order to cover medical and clinical shifts. Also linked to challenges around sufficient workforce to support the recovery plan (including industrial action).	Regular industrial action meetings to mitigate impact. Finance team are currently working on a cost per day figure for future forecasting.	Director of Finance.	Reports to F&PC					
G6	Additional bed capacity as a result of increased non elective demand, which is non-funded due to block contract arrangements. Current risk £140K per month.	External support through Place to control demand on non-elective pathway.	Managing Director						
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

Board of Directors
8th November 2024

Agenda item	P162/24
Report	**Risk Register Report (including Corporate Risk Register)**
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 the Trust Value of 'Together'
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Summary (including reason for the report, background, key issues and risks)	This report provides an update to the Board for the review of all risks scoring 15 and above in addition to management information in relation to all open risks rated 8 and above. The key points arising from the report are: • As at 17th October 2024 there are 39 risks out of a total of 263 Trust-wide Approved risks that are out of review date. This shows a compliance rate of 85%. • An increased level of scrutiny has been applied to action plans for all approved risks rated 8 and above to address stagnation of risks and ensure reviews consider the work completed or still required (see Section 3) • A deep dive for risks rated 12 (opened before November 2022) has been presented to Risk Management Committee this quarter and a summary provided in this report. This review analyses the movement in risk scoring, responding to actions completed or changes in environment. • There are 7 issues identified on the Issues Register, previously all of these issues had been registered as risks on the Trust Risk Management database. • There were 2 areas of emerging risks identified that have now been inputted on to the Trust Risk Management database. 4 areas of emerging risks identified remain for information and horizon scanning that have not been registered on the Trust Risk Management database. • The Trust is in a strong position regarding its Risk Management Processes since the full review and introduction of the revised Risk Policy and Risk Management Processes in 2022. The additional

	scrutiny and challenge of the risk action plans, as reported below, will increase control of the Trust's risks and their management.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	All risks scoring 15 and above have been presented to and approved by the Risk Management Committee. The relevant risks are presented to the appropriate Board Assurance Committees, Executive Team Meeting and finally the Board of Directors.
Board powers to make this decision	Not Applicable
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 Board of Directors: • Note the content of the report; • Note the ongoing work carried out to further strengthen the risk register
Appendices	1. Corporate Risk Register - 15 and above risks 2. Issues Register

1. Introduction

1.1 The following report illustrates the evidence and progress the Care Groups are making in considering their risks, issues and emerging risks. The following information provides an update to the Board for the review of all risks scoring 15 and above in addition to management information in relation to all open risks rated 8 and above. The data analysed within this report was exported from Datix on 17th October 2024; any updates or changes subsequently within the database, will not be recorded in this report. Please note that whilst all of these risks have been approved at Care Group level not all have been considered or approved at the Risk Management Committee (RMC), this includes all risks rated at 12 or below which are discussed and approved at Care Group Governance meetings.

1.2 As at 17th October 2024 the Trust had a total of 263 Approved risks recorded on Datix, these are risks rated between 8 and 25, as follows:

High Risks: rated 15 - 25 and RMC Approved: = 21

Moderate Risks rated 8 - 12 and Care Group Approved = 242

1.3 This report does not contain any details to risks rated at 6 or below, these are Controlled/Managed Risks as follows:

Low Risks: Controlled/Managed Risks: rated 1 - 6 = 442

1.4 The following report illustrates the overview and analysis of the risks by review dates, action plans, Emerging Risks and the Issues Log.

2. Risk Review dates

2.1 In terms of compliance with risk review dates, the graph below shows all risks rated at 8 and above for all Care Groups. This graph is to provide the Board of Directors with

a view regarding the current Trust position for the management and review of risks. In accordance with the Risk Policy review dates are as follows:

- High Risks - Monthly review
- Moderate Risks - Three Month review
- Low Risks - Annual review

2.2 Trust-wide compliance with review dates remains in a slightly lower position at 85%; this is lower than achievements in June/July/August (≥91%). Care Group 2 have the lowest individual compliance at 74%, and Corporate Services the highest at 91%.

2.3 There was one risk that was out of date for review for between three and six months, there were also eleven risks overdue for between one and three months, further details regarding these risks and their risk ratings can be found below in section 2.4.

2.4 Care Group 1

Risk 6513, this is a risk that is between 3 and 6 months overdue for review. The risk relates to Divisional IT projects off target impacting on the progression of improvement work within the UECC department. The risk is rated at 8. The Risk Owner changed the risk to a Controlled/Managed risk, which in accordance with the current Risk Policy has a 12 month review date, however the risk rating is 8 so according to Policy is an Approved Risk with a 3 months review, the Risk Owner has been notified.

Risk 7056, this risk is between one and three months overdue and relates to Lack of Nebuliser Compressors in UECC. The risk is rated at 10.

Risk 6728, this risk is also between one and three months overdue and relates to Care Group 1's inability to provide adequate training for the nursing staff. This risk is rated at 12.

Care Group 2

There were no risks overdue three to six months, there were however five that were over one month overdue, all of these were rated between 8 and 12.

Risk 7068, this relates to Lack of Medwarm Patient Warming System. This risk is rated at 12.

Risk6939, this risk relates to the Emergency Nurse Call System for Theatres. The risk is rated at 8.

Risk 7097, this risk concerns the current sutures supplied into the Trust that might not be fit for purpose due to several incidents of snapping. This risk is rated at 8.

Risk 7134, this risk relates to Theatre Cleanliness and maintaining acceptable standards of cleanliness. This risk is rated at 12.

Risk 6942, this concerns Patient related outcome measure (PROMs) data not currently being captured & shared in CSU, risk to patient experience. This risk is rated at 12.

Care Group 3

No risks were out of date for review over one month.

Care Group 4

Risk 7031, this risk is between one and three months overdue for review and relates to the current Paediatric Audiology Service not being Accredited in Improving Quality In Physiological Services (IQIPS). This risk is rated at 9.

Corporate Services

Risk 5069, this risk is of lack of consultant job planning. The risk is rated at 9.

Risk 5791, the risk relates to outpatient orders created in Meditech by locum or rotating staff do not return to appropriate Attending Clinician, creating a risk that diagnosis or treatment is delayed causing patient harm. The risk is rated at 8.

2.3 All Care Group management teams are provided with a monthly data sheet which includes all Approved Risks which are the risks rated at 8 and above, highlighting risks that are overdue for review. There is the expectation that these risks are addressed and discussed at the Care Group Governance meetings. Corporate Services risks owners are contacted by the Corporate Affairs Team, as Corporate Services do not currently have overarching Governance meetings.

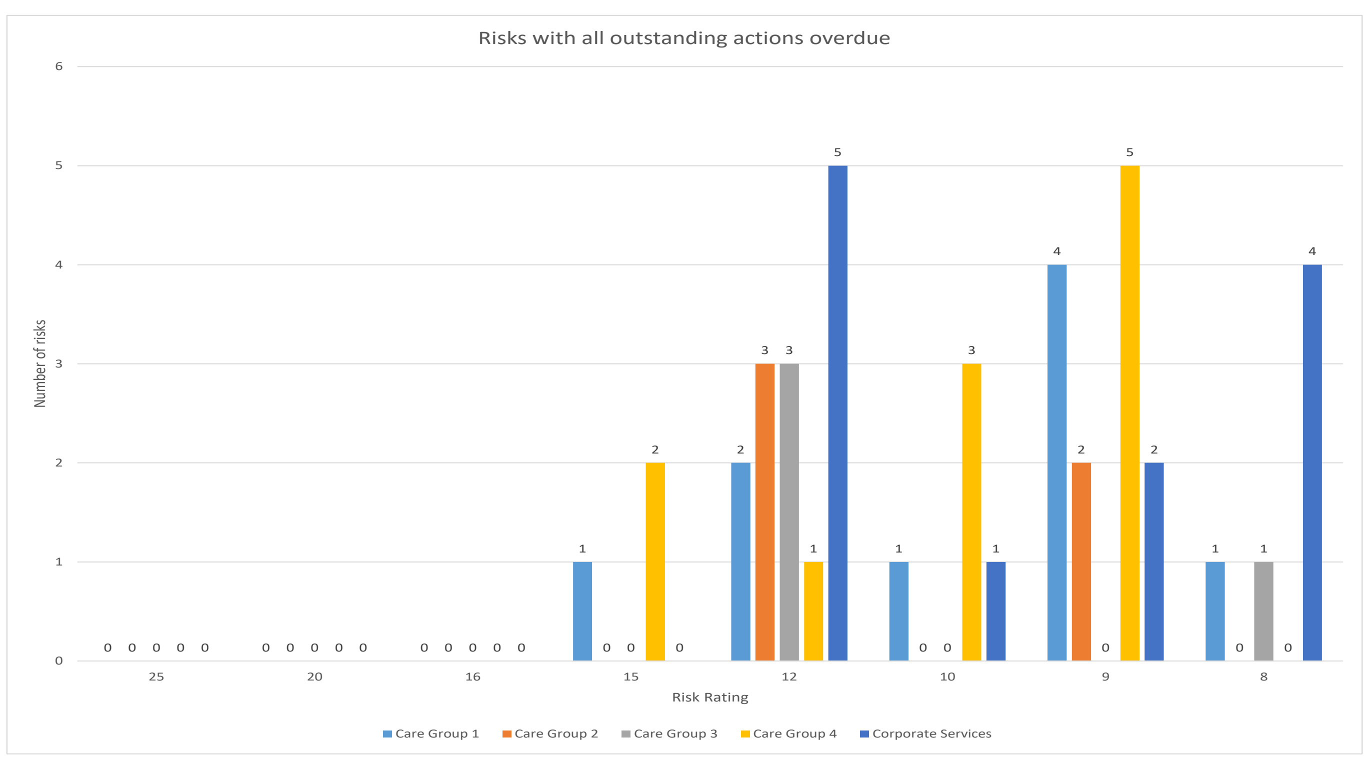
3 Risk Action Plans

3.1 The scrutiny of action plans now includes focus on action plans in place that have all actions marked as completed, action plans that are out of date, as well as risks with no action plan in place.

3.2 The Trust now has the highest number of risks with recorded action plans since the formal risk management process commenced in 2022. However areas where processes can be strengthened have been highlighted as follows:

- Individual actions within an action plan that are overdue of completion date with no recorded escalation.
- Risks with action plans that are recorded as complete, however there is no reduction of rating, closure of risk or a record of additional action to mitigate the risk

3.3 The graph below includes the data on risks with action plans only. All of these risks have action plans, however one or more individual action has been found to be out of date.



3.4 There is a total of 3 High Rated risks across the four Care Groups that have individual actions that are overdue for review as per policy, further details can be found below in section 3.5.

3.5 Care Group 1

Risk 7027, the risk relates to the inability to provide analgesia and other time critical medications in UECC in a timely manner. This risk is rated at 15. There are two actions which have a deadline of 30 August 2024 for completion. Both actions are long term, one investigating how IT can be used to highlight patients who require time critical medicines, and the other involving transformational work to improve patient flow, these are actions that require extended deadlines and an instruction has been sent to the Risk Owner.

Care Group 4

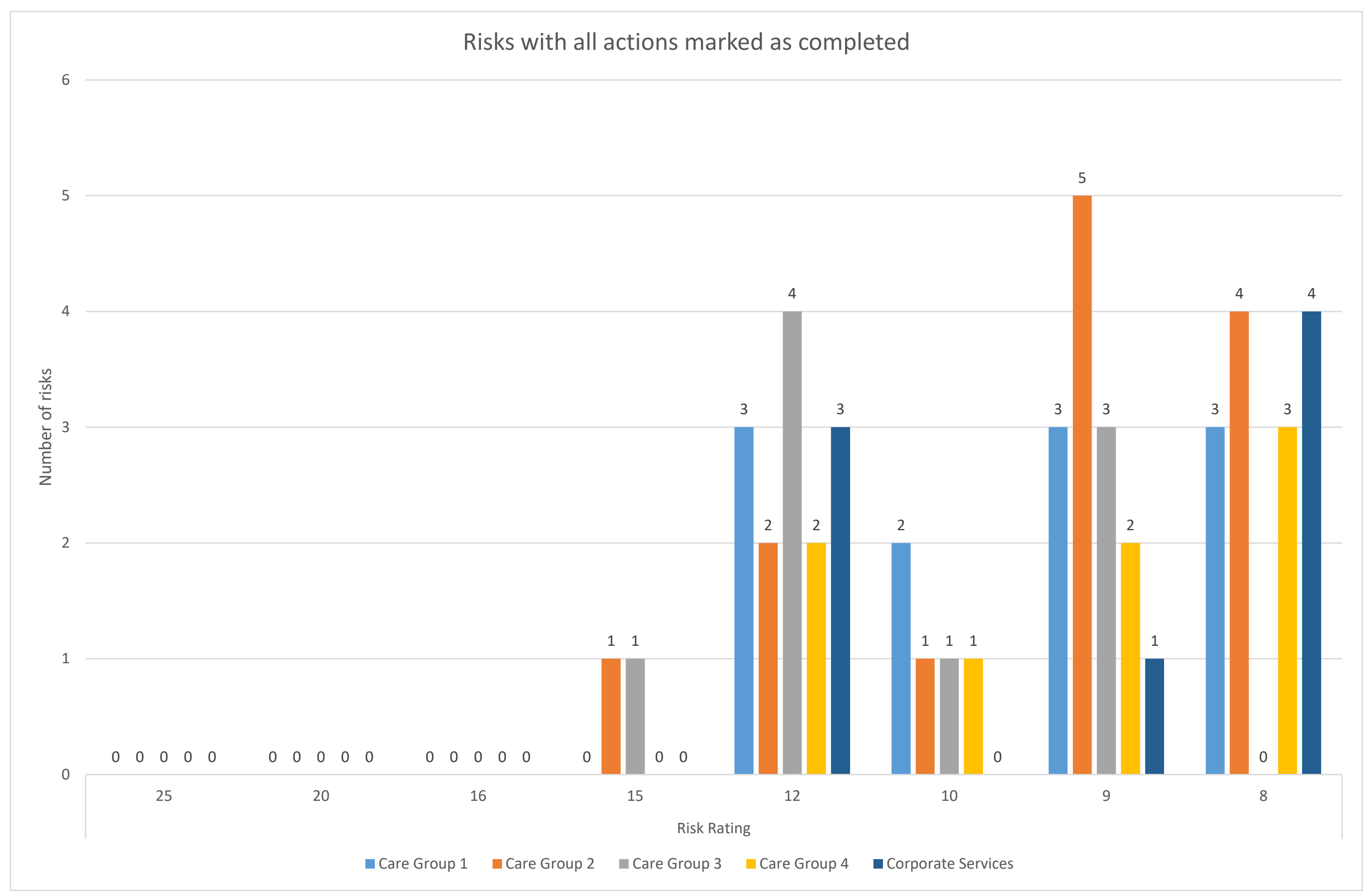
Risk 6284, this risk relates to the staffing levels for Cardiac Physiology. The risk is rated at 15. The action plan had an initial total of fourteen individual actions, these all have been completed apart form one, however there has been no reduction in rating. The outstanding action is also overdue for completion with no escalation recorded. An update was requested at the October RMC.

Risk 5599, the risk relates to the Community Cardiac Team capacity resulting in possible

clinical risk for heart failure patients. The risk is rated at 15. Of the nine original actions in the action plan one of the individual actions is out of date for completion of deadline by one month with no record of escalation, an update requested at the October RMC.

3.6 All actions closed

The graph below includes the data on risks with action plans only. All of these risks have action plans, however, all individual actions have been marked as complete with no subsequent reduction in rating or risk closure.



3.7 Care Group 2

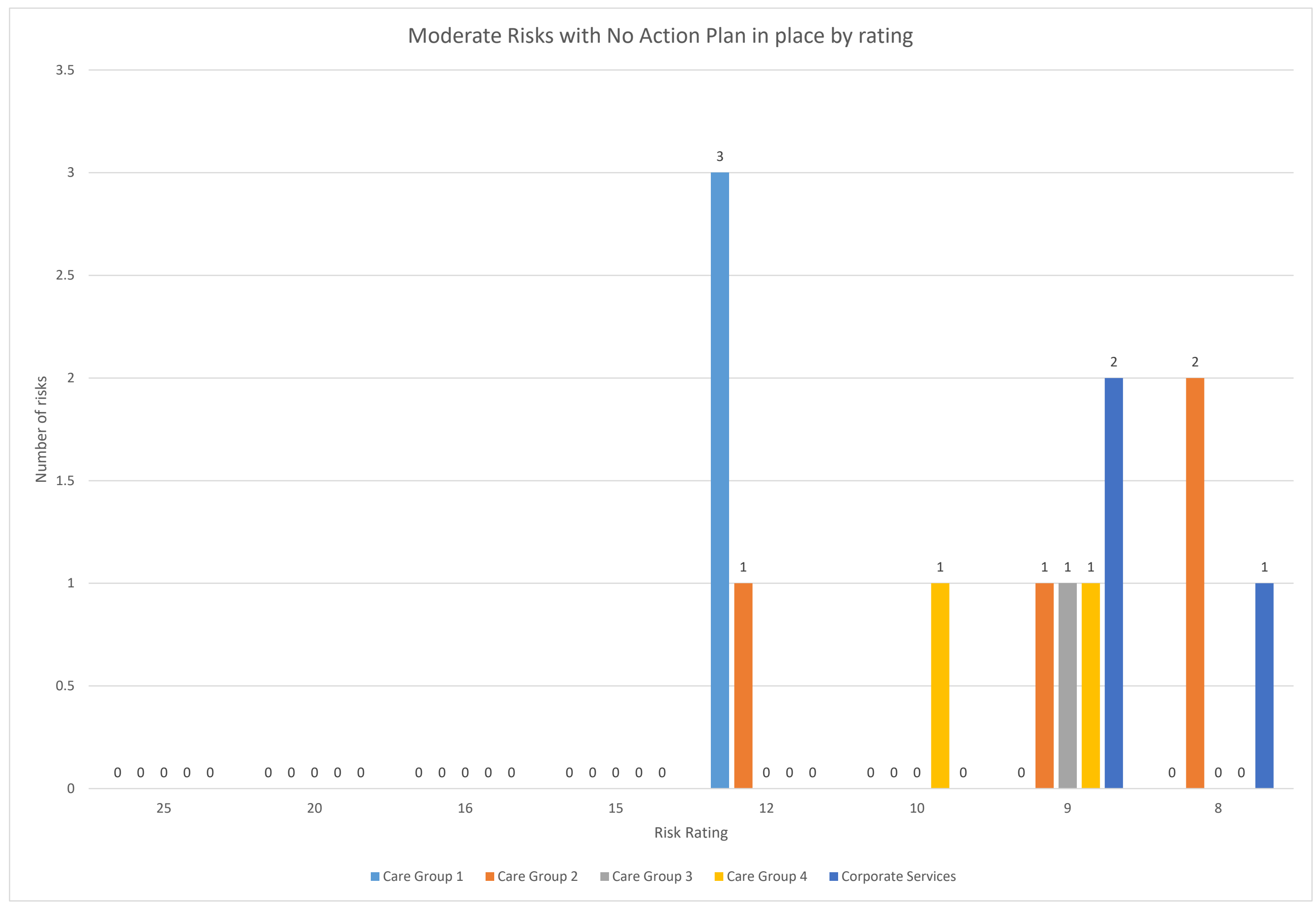
Risk 6630, this risk relates to the lack of Critical Care Follow up Clinic. The risk is rated at 15. There is only one action in the action plan and only one additional current control to mitigate a High Risk, there should be more actions and greater detail. Further details had been requested at the September and October RMC.

Care Group 3

Risk 6421 Backlog of children waiting to be seen for assessment Child Development

Centre (CDC), rated at 15 - all actions have been recorded as complete, however there has been no reduction in the rating, no additional actions and the risk remains open. This was raised at the October 2024 RMC with the request for review and additional actions if risk remains.

3.8 The graph below details the risks with No action plan from each Care Group and their rating:



3.9 As can be seen there are four risks rated at 12 with no action plan in place. These risks have not been approved at the Risk Management Committee as they are rated below 15 and as such according to policy are managed within the Care Group Governance structure. It appears from the Datix logs that these have been approved at the Care Group level without actions plans, which is in non-compliance with the Trust Risk Policy. It also appears that the Care Group Governance Leads have requested submission of action plans at Governance meetings, however these have not been forthcoming. The

RMC had asked to escalate this issue to the Care Group Senior Management for an immediate resolution.

3.10 These risks rated at 12 requiring an action plan are:

Care Group 1 - Risk 6984 - Lack of CESR support for Dermatology Locum Consultants

Care Group 1 - Risk 7023 - Lack of emergency buzzer in x2 pre-assessment rooms in Endoscopy

Care Group 1 - Risk 7164 - Provision of NIV (Respiratory) in an appropriate setting by suitably trained staff

Care Group 2 - Risk 7068 - Lack of Medwarm Patient Warming System

The Risk Owners have been contacted with a request for action plans to be recorded in Datix.

4 New Risks rated at 15 or above discussed at the October 2024 RMC

4.1 The most recent Risk Management Committee was held on Tuesday 15th October 2024, a number of new risks were discussed and scrutinised, the following risks were newly approved, or had the ratings reduced or increased. Those now rated at 15 and above are subject to monthly review:

- Care Group 1 - Risk 7166 - There is a risk of the Division of Medicine being unable to meet the financial control total in place at the start of the 2024/25 financial year. This risk is rated at 20, a rating that mirrors the Trust-wide financial risk and risk 7140 below.

- Care Group 2 - Risk 7140 - As above this also relates to financial control and the ability for Care Group 2 to achieve Financial Control Total in the financial year 2024/25. This risk is rated at 20.

- Care Group 2 - Risk 7204 - Risk of Theatre Cancellations (incurring 65 week breaches), the Care Group have indicated this covers all cancellations however it is predominantly Orthopaedic lists that are cancelled. This risk is rated at 15.

- Care Group 2 - Risk 6958 - The risk concerns the lack of Rheumatology Consultants to meet the service need and potential impact on patient experience and safety. The risk rating was reduced from 15 to 12 as the consultant has returned to post.

- Care Group 4 - Risk 6284 - this risk was discussed with a view to increasing the rating for Cardiac Physiology Staffing Levels from 12 to 15, the risk had previously been rated at 15. The risk has a very strong action plan with additional actions being added in order to mitigate the increased risk and a business case being submitted.

5 Review of Risks Rated 12

5.1 The following section analyses Risks rated at 12 that were opened before 01/11/2022. This section has previously focused on review date compliance and progress notes, however, it will now focus on the movement in risk scoring and action plans, to delve into further examination on the management of these risks.

5.2 As part of this change in focus, the Risk Management Committee has been presented with a drill down into each Care Group over the last quarter with a full list of risks and risk details. A summary of results are as follows:

Groups	Number of Risks Identified	Movement in Risk Scoring (number of risks)		
		Update recorded within the last year to date	No change in 1-2 years	No change in more than 2 years
Care Group 1	9	3	3	3
Care Group 2	6	2	2	2
Care Group 3	7	0	1	6
Care Group 4	2	0	1	1
Corporate Services	13	3	3	7

5.3 The purpose of this review is to highlight to Senior Leaders the risks that have remained static for some time, prompting consideration to the review of these risks to reduce or horizon scanning for risks escalating in future.

5.4 Identification of those risks with little or no movement has led to a series of meetings with the risk owners in order to review the risks with a view to increase scrutiny on whether or

not the risk is still relevant after nearly two years of being open, whether the actions are suitable to mitigate the risk, that the action plans are SMART and still appropriate. This has led to a number of these risks being closed as not now applicable or merged into newer more up to date risks.

6. Risk Management Committee

6.1 The Risk Management Committee continues to meet on a monthly basis.

6.2 All meetings have been quorate with good attendance and engagement from Care Groups.

7. Issues Register

7.1 An issue is an event that has happened, that was not planned, and requires management action. As a project progresses, it may encounter issues that will need to be assessed for severity and impact to the project deliverables.

7.2 The issues register is used to capture and maintain information on all of the issues that are raised and are formally being managed and controlled. The Issues Register includes the Priority Ratings seen below, these are different to the ratings system used in the Risk Management process. The definitions associated with the Priority Ratings are sourced from Six Sigma which is an improvement method that provides organizations tools to improve the capability of their business processes.

Priority	Definition
5- Highest	These are “drop everything” issues. They’re both urgent and important, often involving crisis management or critical deadlines.
4 - High	Important tasks that are not immediately urgent. These often contribute significantly to long-term goals
3 - Normal	Tasks that are urgent but less important. They require attention but don’t contribute as much to overall objectives.
2 - Low	Neither urgent nor highly important. These tasks should be done but can be scheduled for later.
1 - Lowest	Tasks with minimal impact that can be eliminated if necessary.

Based on Six Sigma
6sigma.us/project-management/levels-of-priority/

7.3 The list below details the issues identified. All of these risks have been registered on the risk management database as at 17th October 2024.

1. Risk 6723 - Anaesthetic Medical Staffing Availability - rated 15 - permission given to over recruit. There are some new consultants starting in near future. A paper is being taken to ETM in 2 weeks regarding paybacks, annual leave and rotas. There is a review to be done on current rota system for Anaesthetics. The Risk, and Issue, remains the same, but long term future looks more positive than short term.

2. Risk 6421 - Backlog of children waiting to be seen for assessment CDC - rated 15 - multiple actions are ongoing with a task and finish group working through the risks and issues. Paper taken to ETM at request of COO. This paper had also been through Care Group 3 performance highlighting backlog and current demand versus funded capacity. Letter to be send to commissioners in relation to this.

3. Risk 6762 – Operation of SDEC in ASU trolley area - rated 15 - attempted as part of perfect week in September to introduce 8 trolleys due to bed pressures. Went to 4, then 0 after 3 days. Discussions with UECC colleagues for shared SDEC but no space. Request for surgical space in progress. Limited estate footprint. DH to favour B6 footprint - ideal for Surgical SDEC. Currently used by Medical SDEC

4. Risk 7181 – Fire Doors in Theatres - rated 12 - Current mitigations in place include Staff Training on fire and emergency procedures. Theatres Face to Face evacuation procedures Drills/Table top exercises. Daily/weekly Fire safety checks conducted by Theatres managers (tenable Recorded).Fire Advisor Attendance and support. Housekeeping monitored.

5. Risk 6166 – Absence of an Isolated Power Supply (IPS) within All Theatres -rated 16 - the works for this project have been discussed at executives meeting and Theatre upgrade works within theatres deferred until capital programme 2025. Enabling works to allow the electrical infrastructure for the UPS / IPS system could possible happen within 2024 capital budget.

6. Risk 6906 – Theatre 5&6 Ventilation - rated 16 - Risk scoring reviewed in line with risk policy, reflecting on Qualitative measures of consequences, looking at business interruption, inspection, injury. Action plan updated to clarify requirement for capital funding - date extended.

7. Risk 7092 – Ward A7 AHU and Ductwork - rated 16 - Immediate response required and in place, with works well underway to modify the ventilation system.

The current issues have been transferred to an Issues Register (Appendix 1) which is monitored by the RMC and presented to all Assurance Committees for information.

7.4 Issue numbers 4, 5 and 6 relate to the same location of the Trust and are linked for oversight of the issues that have required immediate action or escalation. Difficulties arise

in resolving issues 5 and 6 due to the capital funding required, however, the remedial action for Issue 4 (new doors) and further controls put in place, may deescalate these logs back to risk status.

8 Emerging Risks

8.1 The emerging risks have been identified by the Care Groups at the Risk Management Committee and also during Assurance Committees. None of these risks have been registered on the risk management database as at 17th October 2024. Those identified were as follows:

- Second medical opinion – Martha's Rule. It was reported in August RMC that the Trust is doing joint working with pilot sites and the Trust is already compliant with Levels 1 and 2.
- Advanced Clinical Practitioners (ACPs) roles – the Lead ACP reported that the emerging risk is in regard to a number of ACPs that can retire in the next 3-4 years. The training pathway is 3 years and recruiting qualified ACPs is extremely difficult. The other difficulty is that staff can partially retire and remain in the service so it is not easy to plan; it is likely the Trust will have unexpected service delivery gaps due to this.
- UK Covid-19 public inquiry and the likelihood of claims against the NHS. As the report has not yet been finalised and published the risk remains uncertain, however it may potentially lead to increased financial claims against the Trust from patients, families and staff.
- Visa changes for salary thresholds for international staff. It was reported at August RMC that this may only effect a small number of colleagues, but changes should be considered system wide especially when navigating complex immigration issues.

8.2 This is not a limited or completed list and the Board of Directors is asked to discuss and submit further examples to the Corporate Affairs department or at the meeting.

9 Next Steps

9.1 Risk Management training and support continues with the Care Groups, led by the Corporate Affairs Team. This quarter included individual meetings with Estates and

Facilities team members, attendance at Radiology Governance Meeting, Risk Review meeting with UECC and ad-hoc support meetings with risk owners.

9.2 The Risk Management Committee has continued to monitor and provide scrutiny to all risks and action plans as well as increased focus on risks rated at 15 or above. The attention on action plans for all risks rated 8 and above has levelled up to include scrutiny over non-active action plans to address stagnation of risks and ensure reviews consider the work completed or still required.

9.3 Details of risks rated 15 and above are provided to Executives for Care Group Performance Meetings each month. The focus on action plans has also been disseminated here.

9.4 As detailed throughout the report, there is progressive risk management across the Trust, allowing for the development to an even higher level.

9.5 This report is presented to provide assurance that the Trust continues to develop and strengthen its Risk Management function. The Care Groups are encouraged to actively horizon scan for future activity and potential risk rating increases. The aim is for these risks to be identified early at the care group level, taken forward for increased scrutiny and monitoring, with the associated action plans in place before it is raised through the Risk Management Committee, Executive Team Meeting, the Audit & Risk Committee and ultimately the Board of Directors.

10 Recommendations

The Board is asked to:

- Note the content of the report;
- Note the ongoing work carried out to further strengthen the risk register.

Alan Wolfe
Deputy Director of Corporate Affairs
October 2024

Care Group 1 - 15+ Risks

ID	Opened	Handler	Care Group / 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')
6691	28/04/2022	Reynard, Jeremy	Division of Emergency Care	Effect of un-embedded 4 hour and Acute Care Standards on Emergency Department	The lack of ACS compliance across the trust has a detrimental effect on Medical capacity in the UECC Nursing capacity in the UECC Not achieving 4 hour standard Resulting in the department being: 1. Unable to see patients. 2. Unable to offload ambulances 3. at risk of overcrowding in the Main Waiting Room. 4. have delays to time critical treatment 5. have delays to time critical medication.	High 20	High 20	Moderate 12	24/09/2024	22/10/2024	[McAuley, Heather 02/10/24 16:52:40] performance data added as a doc to the risk – looking at this you can see the progress from Jan 55% to 68% august – should the risk scoring be reflective of this? Look to reduce to 16? And then if performance decreases, there is room for escalation back up to 20.	Approved Risk	Work with Executive team on embedding the standards and engagement with the Trust	01/11/2023	05/02/2025		Reynard, Jeremy
													Transformational work, Task and finish group (ACT Programme)	01/02/2024	31/10/2024		Beahan, Dr Jo
													New staffing tool to be implemented	05/06/2023	15/07/2024	19/08/2024	Maton, Lynsey
													Escalation SOP for Paediatrics for busy periods	13/09/2024	27/12/2024		McAuley, Heather
													Cross-Care Group and cross-specialty working to develop pathways to move to a hospital-wide 4h approach.	13/09/2024	31/03/2025		McAuley, Heather
6969	18/08/2023	Staunton, Eamon	Division of Emergency Care	Lack of integration of IT services and lack of procedures/protocols against IT requests	Key Issue 1: Imaging, not being seen or delay to be seen by correct speciality /consultant. Significant increased work to sort imaging and redirect Imaging to correct Consultant and speciality. With subsequent SI and incidents arising from specialities not seeing own imaging. 2 PAs of EM Consultant time a week sorting this, and 2 hrs a day of secretarial time used. Key Cause 2: lack of electronic speciality referrals	HIgh 15	HIgh 15	Low 6	24/09/2024	29/10/2024	[McAuley, Heather 02/10/24 16:45:34] Discussed 13.09.24 – Electronic referrals still a problem but hoping to bring this in by the end of November. SOP in progress around plan for imaging and is with the Deputy Medical Director. Trajectory is for mitigation actions to reduce risk by the end of the year. Issues currently happening daily and there is significant amounts of time spent trying to contact specialties, due in-determination on ownership of patients. There is a lack of oversight ability for services to see which patients they have. Effects are felt by patients, staff and impacts on finances. It is a daily occurrence and affects capacity to operate in an effective manner.	Approved Risk	escalate to deputy medical director	05/09/2023	05/09/2023	05/09/2023	Staunton, Eamon
													Results Acknowledgement Group	02/02/2024	02/07/2024	02/07/2024	Reynard, Jeremy
													Consultant Awareness of Issue	02/02/2024	29/11/2024		Reynard, Jeremy
													progression of electronic referrals across care groups and specialities.	01/07/2024	30/12/2024		Staunton, Eamon

Care Group 1 - 15+ Risks

ID	Opened	Handler	Care Group / 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')
7001	12/10/2023	Reynard, Jeremy	Division of Emergency Care	In ability to get patients to CT in a timely manner	Delay to CT for patients in the UECC. 30% of majors and resus patients undergo a CT from the UECC, half of which are subsequently discharged. Only 50% of patients get a CT result within 2 hours of request. At 3hours 25% of patients who are discharged are still waiting for a result.	High 20	High 15	Low 4	24/09/2024	22/10/2024	[McAuley, Heather 02/10/24 16:46:41] Ground work ongoing to move in the right direction. Now need to sit down and review what we are doing and what to put in place. Issues with escorts remain.	Approved Risk	QI Project	16/11/2023	31/12/2024		Staunton, Eamon
													Portering (see action below on Transfer for ongoing actions)	01/10/2023	29/11/2024		Maton, Lynsey
													Transfer team and transfer policy	01/11/2023	30/09/2024		Maton, Lynsey
													Safer care nursing tool	01/01/2023	31/12/2024		Maton, Lynsey
													Teletracking	17/04/2024	31/07/2024	24/07/2024	Farrow, Lindsay
													Review appropriateness of scans requested in the UECC	02/09/2024	23/12/2024		Reynard, Jeremy

Care Group 1 - 15+ Risks

ID	Opened	Handler	Care Group / 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')
7027	29/11/2023	Reynard, Jeremy	Division of Emergency Care	Inability to provide analgesia and other time critical medications in UECC in a timely manner	Delays to pain relief, less appropriate pain relief been given. Delay to review. Delay to antibiotics. Delay to other time critical medications. Delay to ADREQ and therefore transfer and the 4 hour target.	High 15	High 15	Moderate 8	24/09/2024	22/10/2024	[McAuley, Heather 02/10/24 16:49:44] Discussed that the data held isn't a true reflection and missed doses are a key issue. Patient exp. Data supports that the department not good at providing analegesia, but data is limited. Discussed that data sets required for the risk – look to pull from Medication Safety Committee report (due Sept). Action plan requires a review – all actions overdue.	Approved Risk	review available PGDs	20/12/2023	24/07/2024	28/08/2024	Maton, Lynsey
													Improve access to other services	01/02/2024	30/09/2024		Maton, Lynsey
													Improve flow	01/02/2024	30/08/2024		Hammond, Lesley
													Nursing capacity to meet demand	01/02/2024	30/08/2024		Maton, Lynsey
													explore Sepia function to show patients who require time critical medicines	22/04/2024	30/08/2024		Farrow, Lindsay
7084	13/03/2024	Benton, Jennifer	Care Group 1 (UECC and Medicine)	Operational pressures, opening additional beds impact on patient safety, experience	Additional capacity beds opened within the Division. Caused by an increase in patients requiring a medical inpatient admission. Increased infection resulting in funded beds being closed from an IPC requirement. Increase in LOS and a requirement of IDT involvement. Resulting in adverse impact on patient safety, quality and experience - Increase noted in patient incidents, harm to patients (severity), judicial enquiries, concerns and complaints. Negative impact on Trust reputation/credibility.	High 16	High 20	Moderate 9	06/10/2024	18/10/2024	[Stewart, Paul 06/10/24 12:35:17] Risk discussed at Executive Performance meeting, further review required PS/GS to review	Approved Risk	Completion of the SOP for opening a decommissioned area	13/03/2024	01/05/2024	13/06/2024	Benton, Jennifer
													Identification of Golden patients	13/03/2024	01/06/2024	13/06/2024	Benton, Jennifer
													Divisional representation at LLoS review	13/03/2024	01/06/2024	13/06/2024	Benton, Jennifer
													Nurse staffing huddle	13/03/2024	01/06/2024	13/06/2024	Benton, Jennifer
													SHOP Ward round principles	13/03/2024	31/10/2024		Reynard, Jeremy
													Bed Reconfiguration Work	12/07/2024	31/10/2024		Stewart, Paul
													Utilise Perfect Week to enact de-escalation	18/07/2024	24/07/2024	22/08/2024	Stewart, Paul

Care Group 1 - 15+ Risks

ID	Opened	Handler	Care Group / 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')
7010	26/10/2023	Lunn, Mrs. Clare	Care Group 1 (UECC and Medicine)	Delay in heart failure patient reviews	delay in patients being reviewed by heart failure nurse spacialist Delay in patient being cared for on all wards including cardiology Longer length of stay due to none or less frequent reviews Poor clinical outcomes Higher heart failure morbidity cannot facilitate discharges resulting in patient deterioation when an in-patient High staff stress and potential for sickness and burnout.	HIgh 15	HIgh 15	Low 6	25/09/2024	25/10/2024	[Williams, Debbie Mrs. 25/09/24 08:36:56] Meeting arranged to update business plan on 25/9/24.	Approved Risk	data collection of referrals into the system	30/10/2023	11/12/2023	28/12/2023	Lunn, Mrs. Clare
													to discuss the data with SLT in division	13/11/2023	30/11/2023	14/02/2024	Lunn, Mrs. Clare
													data analysis of patient reviews	20/11/2023	29/02/2024	14/02/2024	Lunn, Mrs. Clare
													to complete a short business case	14/02/2024	13/06/2024	16/06/2024	Lunn, Mrs. Clare
													await outcome from panel and business brief	16/06/2024	30/09/2024		Mitchell, Samantha

Care Group 2 - 15+ Risks

ID	Opened	Handler	Care Group / 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	Care Group 2 (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	11/10/2024	11/11/2024	[Rimmer, Claire 11/10/24 14:06:03] Reviewed by DH: Patients are followed up in some capacity but non-compliant with GPIX standards for Rehab (no rehab service). Peer review due to take place 21st October, with results to follow (or aspects raised on the day) - this review should signal the next journey for the risk.	Approved Risk	Lack of Critical care Follow-Up - Business Case brief for Rehabilitation and Follow-up Service for Critical Care submitted to service manager on the above date.	01/08/2022	30/09/2024		Timms, Mrs. Deborah
6723	10/06/2022	Agger, Joanne	Care Group 2 (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 15	Low 6	11/10/2024	11/11/2024	[Rimmer, Claire 11/10/24 14:13:39] Reviewed by DH: Permission given to over recruit. Got some new consultants starting in near future. Paper going to ETM in 2 weeks regarding paybacks, AL and rotas. There is a review to be done on current rota system for Anaesthetics. Risk remains the same, but long term future looks more positive than short term.	Approved Risk	Phase two - Specification and Commissioning	08/01/2024	30/09/2024	17/07/2024	Agger, Joanne
													Phase Two - Resource agreed/appointed to undertake Phase Two work, starting late summer	01/07/2024	31/03/2025		Agger, Joanne
													Phase two - External review, comparing to national standards and benchmarking practice against other peer trusts	30/09/2024	31/03/2025		Agger, Joanne
6809	20/10/2022	Oliver, Lauren	Care Group 2 (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	11/10/2024	11/11/2024	[Rimmer, Claire 11/10/24 14:18:18] Reviewed by DH: No change. Clinical leads contacted regarding LocSSIPs. No response. Theatre matron leading on action. Potential to reduce the risk due to no safety concerns identified - needs formalising. LO to review and advise from a clinical perspective.	Approved Risk	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	13/04/2023	31/10/2024		Oliver, Lauren
													To establish Trust wide required LocSSIPs	13/06/2024	01/01/2025		Oliver, Lauren

Care Group 2 - 15+ Risks

ID	Opened	Handler	Care Group / 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')
6762	23/07/2022	Short, Mrs. Sally	Care Group 2 (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	11/10/2024	11/11/2024	[Rimmer, Claire 11/10/24 14:21:55] Review by DH: We attempted as part of perfect week in September to introduce 8 trolleys due to bed pressures. Went to 4, then 0 after 3 days. Discussions with UECC colleagues for shared SDEC but no space. Request for surgical space in progress. Limited estate footprint. DH to favour B6 footprint - ideal for Surgical SDEC. Currently used by Medical SDEC.	Approved Risk	Care Group to review impact on patient safety and quality of care	19/07/2024	21/10/2024		Timms, Mrs. Deborah
													Review bed modelling to understand bed capacity needs - Care Group 2	19/07/2024	19/10/2024		Howlett, Darren
													Care Group to review increase in long length of stay	19/07/2024	19/10/2024	11/10/2024	Howlett, Darren
													SDEC Working Group established - look at options to run SDEC models throughout winter	02/09/2024	31/03/2025		Howlett, Darren
6958	02/08/2023	Agger, Joanne	Care Group 2 (Surgery)	Lack of Rheumatology Consultants to meet service need	Failure to provide a consultant led Rheumatology Service	HIgh 15	HIgh 15	Moderate 9	09/08/2024	27/09/2024	Review by DH: 1 consultant now returned from Mat Leave - risk reduced to 12 to reflect this. 2nd consultant post out for recruitment - 2 applicants already. Locum in post covering 2nd gap in the interim to mitigate risk. Expectation is the risk to reduce further and close on 2nd appointment.	Approved Risk	consultant recruitment	02/01/2023	31/10/2024		Agger, Joanne

Care Group 3 - 15+ Risks

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')
6421	31/03/2021	Whitfield, Vicky	Care Group 3 (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	09/09/2024	31/10/2024	[Roper-Bowen, Beth 30/08/24 11:36:49] - First meeting of the task and finish group is planned for the 23rd September - outcome of this will be updated in the next review. - Demand and capacity mapping is now complete and will be presented by HON to the executive team imminently. We are in close communication with the ICB commissioners who are expecting a request for additional resource. - New ways of working are currently being rolled out. This is an ongoing process - SEND execs were briefed on the 20th July and they remain concerned and keen to find multiagency solutions. - A 'Place Board Spotlight' on the CDC planned for September - to obtain multiagency scrutiny and support. - The agreement with CAMHS is still in place - CAMHS waiting to identify additional provider to support this work before they are able to take over the case load. Service Manager for CDC is monitoring this progress. - At the moment this additional funding for the CDC has not been agreed yet and it has been decided that the additional funding for SLT will not be requested in order to focus the funding where it is most needed. - Now understand the resources needed to eliminate the backlog, awaiting outcome of additional funding request before finalising the plan. This will be updated when funding decisions have been made. - Use of Healios has been explored and it was decided that it was not a financially efficient option. [Roper-Bowen, Beth 09/09/24 13:25:41] No new update since 30th August - please see note below.	Approved Risk	No active action plan in place				

Care Group 4 - 15+ Risks

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')
5599	04/07/2018	Taylor (Cardiac SNP), Ms. Katie	Care Group 4 (Community, Therapies, Dietetics & Medical Imaging)	Community Cardiac Team capacity resulting in possible clinical risk for heart failure patients	1.Risk of patients not receiving care/ review of investigations in a timely manger and resulting in clinical risk 2. Risk of patients admitting to acute setting due to not being reviewed within recommended timescales or waiting list targets 3. Unable to support and facilitate early hospital discharge 4. Increased risk of complaints/litigations from increase in patient dissatisfaction 5. Increase staff stress sickness, burnout and turnover 6. Not meeting NICE HF guidance of patients reviewed by specialist within 2 weeks of referral/discharge	Moderate 9	HIgh 15	Low 6	24/09/2024	23/10/2024	[Taylor (Cardiac SNP), Katie Ms. 24/09/24 13:38:49] 1. 128 patients now back to GP HF Champions and 2 more surgeries have joined the pilot 2. Significant increase in referrals continue since April 3. Ban on NHSP due to CIP overspend and at establishment- this will impact on waiting list length and capacity 4. HF RAG Referral form amended and to governance this month to reflect current waiting times 5. What is the forecasted block contract figure of patients expected to be seen based on 23.24 figures 6. Clinical director email to medical director re NT PRo BNP pathway for those without an ECHO/diagnosis- awaiting reply	Approved Risk	Completion of all amber referrals back to GP HF champions	11/03/2024	29/11/2024		Taylor (Cardiac SNP), Ms. Katie
													Increase in nurse prescribers by two staff.	08/01/2024	08/01/2025		Taylor (Cardiac SNP), Ms. Katie
													increase capacity by nurses	23/08/2024	31/01/2025		Taylor (Cardiac SNP), Ms. Katie
													clarity over new NT Pro BNP HF referral in to service guidelines	23/08/2024	30/09/2024		Taylor (Cardiac SNP), Ms. Katie
													Mortality on waiting list	28/08/2024	25/08/2025		Taylor (Cardiac SNP), Ms. Katie

Corporate Services 15+ Risks

ID	Opened	Handler	Care Group / 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')
7130	22/05/2024	Hackett, Steve	Corporate Services	Ability to deliver 2024/25 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 25	High 20	Low 5	20/09/2024	18/10/2024	[Wallett, Val 20/09/24 15:01:25] M5 financial position is £1.6m variance to plan. Risk remains as previously reported, ERF CIP and additional bed capacity. The Executive Team have moved to enhanced grip and control following the I&I review. The Executive Team have met with care group leadership teams and emphasised the need for enhanced grip and control with the aim to reduce run rate by £500k per month.	Approved Risk	Development of Winter plan.	01/04/2024	01/10/2024		Hackett, Steve
													Cost improvement Efficiency Board.	01/05/2024	01/10/2024		Hackett, Steve
													Development of robust capacity plans.	01/06/2024	01/11/2024		Kilgariff, Mrs. Sally
													Theatre improvement programme.	03/03/2023	31/03/2025		Kilgariff, Mrs. Sally
													Outpatient utilisation programme.	23/03/2023	31/03/2025		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	11/09/2024	11/10/2024	[Ramsden, Daniel 11/09/24 12:57:08] The works for this project have been discussed at executives meeting and Theatre upgrade works within theatres deferred until capital programme 2025. Enabling works to allow the electrical infrastructure for the UPS / IPS system could possible happen within 2024 capital budget.	Approved Risk	Theatres require UPS/IPS systems installing - Possible locations	06/09/2023	04/11/2024		Ramsden, Daniel
													Theatres require UPS/IPS systems installing - develop plan of works to install	06/09/2023	01/11/2024		Ramsden, Daniel
6906	04/05/2023	Perry, Stuart	Corporate Services	Theatre 5&6 Ventilation	There is a danger to life and/or infection for patients due to the poor ventilation air flows within the theatre complex. The theatre ventilation has been modified at some point by removing the bottom of some doors to prevent them being blown open or noise. The Theatres require a complete refurbishment to install air transfer grilles to enable the ventilation strategy to be compliant. Also to include new UCV canopy in Th5 which is excessively noisy, install UPS/IPS and redesign the Sterile pack store in the middle of the theatres. This risk is linked with the Fire Doors in Theatres risk and UPS Risk.	High 16	High 16	Low 4	24/09/2024	24/10/2024	[Rimmer, Claire 24/09/24 16:01:44] Risk scoring reviewed inline with risk policy, reflecting on Qualitative measures of consequences, looking at business interruption, inspection, injury. Action plan updated to clarify requirement for capital funding - date extended.	Approved Risk	Refurbishment of Theatre 5&6 Ventilation (large capital funding required)	12/09/2023	31/03/2025		Martin, Linda
7092	09/01/2024	Perry, Stuart	Corporate Services	Ward A7 AHU and ductwork	The AHU is approximately 12 years old as is the ward supply and extract ductwork. Following a recent localised survey due to heating issues it looks like the side rooms have a terminal fan coil to trim the air temperature. This air then passes through the ceiling void (inducted) to the supply grilles. There are extract grilles which are open to the ceiling void with no visible ductwork or fans. Side Rooms 4&5 has switchable positive/negative pressure indication but unsure how this can be achieved given the known plant.	Moderate 12	High 16	Low 4	24/09/2024	24/10/2024	[Perry, Stuart 01/10/24 09:22:08] Works well underway to modify the ventilation system.	Approved Risk	Ward A7 AHU	26/03/2024	31/03/2025		Martin, Linda
													Ward A7 AHU and ductwork	01/10/2024	29/11/2024	01/10/2024	Perry, Stuart

Corporate Services 15+ Risks

ID	Opened	Handler	Care Group / 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')
6888	23/03/2023	Hazeldine, Victoria	Corporate Services	Lack of clinical psychology support for all services for which it is required	Not meeting national recommendations for the use of psychology support for patients receiving clinical care. Currently the workforce is not reflective of the demand for psychological support therefore creating gaps in service. This is caused by lack of funding which sits across SY ICB which then relates to staff required at each organisation, as well as, lack of clinical psychology support and availability. This results in the risk to patients' physical and phycological health and the Trust being non-compliant with national recommendations.	High 15	High 15	Moderate 9	08/10/2024	07/11/2024	[Rimmer, Claire 08/10/24 11:58:45] Risk reviewed by VH 08/10/24: Risk remains static. Not compliant across some requirements within services. Mitigations in place to provide some psychology interventions however this is limited due to capacity. No appetite for business case currently across TRFT or the ICB.	Approved Risk	Escalate Lack of Psychological support for the breast cancer patients	31/08/2023	23/12/2024	14/08/2024	Timms, Mrs. Deborah
													Review of all services which currently require psychology support	14/08/2024	14/02/2025		Hazeldine, Victoria
													Identify gaps in the provision (following the review) and escalate to ICB level	14/08/2024	14/05/2025		Hazeldine, Victoria

Board of Directors' Meeting
8 November 2024

Agenda item	P164/24
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. It focuses on the following key areas: • Operational Matters • Performance • Integrated Care Board (ICB), Acute Federation and Rotherham Place Development and Partnership Working • People
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. Chief Executive of NHS South Yorkshire update report for Sept 2024 2. Statement of Intent – Healthcare that works for Young People

1.0 Operational Matters

1.1 In September, the Trust achieved the national target of zero patients waiting over 65 weeks for elective care. This is a significant achievement and TRFT was one of only two Trusts across the SY ICB to achieve the national target. The focus will now be on sustaining this position and to reduce the number of patients waiting over 52 weeks.

1.2 Referral to Treatment 18-week standards were met in Geriatric Medicine, Rheumatology, Respiratory and Stroke and an upward progress continue to be seen in Cardiology and Haematology. The Trust has delivered Diagnostic 6 week (DM01) performance at 99% for September in accordance with our Trust ambition to sustain this position throughout 2024/25.

1.3 The Trust continues to focus on delivering the national and Trust targets for cancer Delivery for the 28-day Faster Diagnosis Standard, 31-Day Treatment Standard and 62-Day RTT standard.

1.4 **Urgent and Emergency Care Activity:** The Trust achieved 65% for four-hour emergency care performance in September. We continued to see high attendances at UECC with an increase of 516 compared to the same month last year (6.6%). Additional escalation bed capacity has had to remain open in order to support the demand and ensure that there is sufficient capacity and flow across the Trust. The additional demand has impacted on the Trust's performance and patient flow. This trend has continued throughout October 2024. I am sorry that 6 patients waited over 12 hours for a bed in September.

1.5 The Trust is one of a cohort of 20 NHS Providers to participate in the new NHSE/GIRFT Further Faster programme. The programme was launched on 28th October 2024 and will focus on going further and faster across both outpatient and theatre services. This is an excellent opportunity for the Trust to review our Elective Transformation programme and ensure that colleague focus on our most challenged services. One of the key goals is to support people to get back into employment through faster resolution of their health issues.

2.0 Industrial Action

2.1 General Practitioners are preparing for potential collective industrial action across Rotherham with an expectation that this will have an impact across both Urgent and Emergency Care and Elective services. As always, patient care and patient safety is our priority during any such action. To date, no significant impact has been detected.

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

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 Managing Director in his report to the Board of Directors.

3.2 I attach (Appendix 1) the September 2024 update report from the Chief Executive

of NHS South Yorkshire, which highlights the work of the ICB and system partners since the last update.

3.3 The Barnsley and Rotherham partnership continues to collaborate with a number of events taking place to provide an opportunity for colleagues to make connections, focus on shared learning, support and best practice. This includes a Joint Executive Team meeting held on 19th September 2024 and another Joint Senior Leaders Team meeting planned for November 2024. Colleagues from each Trust continue to meet via the Joint Executive Delivery Group (JEDG) and the Joint Strategic Partnership Group (JSPG).

3.4 Appendix 2 is the *Healthcare That Works for Young People Statement of Intent* produced by the South Yorkshire and Bassetlaw (SYB) Acute Federation and the South Yorkshire Mental Health Learning Disability and Autism Provider Collaborative. This is underpinned by the SYB Acute federation Clinical Strategy for 2023-2028 and each Trust has committed to work collaboratively to transform care And outcomes for the children and young people living in SYB.

3.5 Mexborough Elective Orthopaedic Centre of Excellence (MEOC) activity has continued to progress with list utilisation up to 72% and a significant improvement seen in terms of booking patients and the potential for more Orthopaedic Surgeons being supported to be able to operate out of MEOC.

3.6 In October, I had the pleasure of attending the NHS Parliamentary Awards with colleagues from the SY QUIT team and Yorkshire Cancer Research. The QUIT programme had been shortlisted for a national award. Although the team did not win, the recognition is well deserved for the excellent contribution the NHS provider trusts, supported by the ICB and community smoking cessation teams have made to reducing smoking in South Yorkshire. Yorkshire Cancer Research have been a generous sponsor of the work for which I would like to express thanks.

4.0 People

4.1 The monthly staff Excellence Awards winners for the months of August and September 2024 are as follows:

August 2024

INDIVIDUAL AWARD:	Aimee-Leigh Wood, A1
INDIVIDUAL AWARD:	Dr Matthew Stafford, UECC
TEAM AWARD:	Central North District Nursing Team
PUBLIC AWARD:	Acute Surgical Unit
PUBLIC AWARD:	Pulmonary Rehabilitation Team, Breathing Space

September 2024

INDIVIDUAL AWARD:	Dr Smriti Prasad, Obstetrics & Gynaecology
INDIVIDUAL AWARD:	Sadie Charlton, Paediatric Occupational Therapy
TEAM AWARD:	Health Informatics
PUBLIC AWARD:	Diabetes Team
PUBLIC AWARD:	Richard Tune, Acute Response Team

4.2 The following Consultants have accepted posts and have start dates:

- Dr H Evans, Palliative Care (06.11.24)
- Dr D Starostin, Radiology (02.12.24)
- Dr A Madhok, UECC (28.01.25)
- Dr K Lewis, UECC (24.02.25)

4.3 I am pleased to report that our new Director of Estates and Facilities, Scott Dickinson will commence in post on 1st December 2024. Scott brings with him a wealth of experience and I am sure he will be an asset to the team. I would like to take this opportunity to thank Linda Martin, our Interim Director for all her hard work and commitment over the last 11 months.

Dr Richard Jenkins
Chief Executive
November 2024

Enclosure 8

Chief Executive Report

Integrated Care Board Meeting

4 September 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

The Board is asked to note the content of the report

Board Assurance Framework

This report provides assurance against the following corporate priorities on the Board Assurance Framework (*place* ✓ *beside all that apply*):

Priority		Priority	
Priority 1 - Improving outcomes in population health and health care.	✓	Priority 2 - Tackling inequalities in outcomes, experience, and access.	✓
Priority 3 - Enhancing productivity and value for money.	✓	Priority 4 - Helping the NHS to support broader social and economic development.	✓

In addition, this report also provides evidence against the following corporate goals (place ✓ beside all that apply):

Goal 1 – Inspired Colleagues: To make our organisation a great place to work where everyone belongs and makes a difference	✓
Goal 2 – Integrated Care: To relentlessly tackle health inequalities and to support people to take charge of their own health and wellbeing.	✓
Goal 3 – Involved Communities: To work with our communities so their strengths, experiences and needs are at the heart of all decision making.	✓

Are there any potential Risk Implications? (including reputational, financial etc)?
No
Are there any Resource Implications (including Financial, Staffing etc)?
No
Are there any Procurement Implications?
No
Have you carried out an Equality Impact Assessment and is it attached?
N/A
Have you involved patients, carers and the public in the preparation of the report*?*
N/A
Appendices
N/A

Chief Executive Report

Integrated Care Board Meeting

4 September 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 July and August 2024.

2. Integrated Care System Update

2.1 Our stance against racism

At the start of August, we saw some truly awful scenes of racism and violence across the country, including here in South Yorkshire. The scenes were shocking and appalling. We are grateful for the work of South Yorkshire Police for their response, and to all those health and care staff, including those at Yorkshire Ambulance Service, who worked during this time to treat those injured and to ensure our services continued unaffected.

The work of all partners and the response from the public was heart-warming. In addition, we echo the sentiments shared by elected Mayor and Police and Crime Commissioner Mayor Oliver Coppard, who is also the Chair of the Integrated Care Partnership, and who said everyone has a right to feel safe. The ICP has already committed to become an ant-racist health and care system.

NHS South Yorkshire has been supporting colleagues who have been affected directly or indirectly. We have been providing wellbeing support and this will continue for as long as it is needed.

Our thanks also go to colleagues across the health and care system who have helped support our EPRR response to these events. Colleagues have worked exceptionally hard to fulfil our Category 1 Responder responsibilities.

NHS South Yorkshire has committed to working through the North West Race Equality Framework. This sets out a systematic approach to becoming an anti-racist NHS organisation, with clear deliverables and external scrutiny of progress. We will ensure that the Board is kept updated with our practical progress on this.

In addition, we have recently helped to establish the South Yorkshire Race Equality Network for Primary Care staff. The Network is open to all staff working across Primary Care including General Practice, Optometry, Pharmacy and Dentistry and aims to provide a support to colleagues working in primary care with the challenges they face in this regard.

2.2 Intensive and Assertive Community Mental Health care

In late August we saw the publication of the CQC's Section 48 report into the treatment of Valdo Calocane by Nottinghamshire Healthcare NHS Foundation Trust. This followed the appalling murders of Barnaby Webber, Grace O'Malley-Kumar, and Ian Coates in June 2023. In response to the CQC's findings we are working across the South Yorkshire system to undertake a review of Intensive and Assertive Community Mental Health Care Services, which will conclude at the end of September. The outcome of the review will be presented to the Board at the earliest opportunity for review and discussion, which we expect to be the November meeting.

2.3 Integrated Care Partnership Board

The Integrated Care Partnership held a development session in July, which was an opportunity to discuss progress made in tackling some of key priorities to improve the health of our population and the challenges the health and care system faces. Underpinning the four 'bold ambitions' of our strategy are some specific and measurable aims and we took the opportunity to discuss the impact so far. The next ICP public meeting takes place in October 2024, and at that time we will give an update to our communities about the measurable progress we have made through the Integrated Care Strategy in the first year since its launch.

2.4 Financial Plan 2024/25

The financial plan for the South Yorkshire ICS, agreed with NHS England, is for a year end deficit no greater than £49m. To deliver this requires the Integrated Care Board to achieve a breakeven position, for the NHS Trusts to deliver a combined deficit not exceeding £49m and for the system collectively to deliver a further efficiency requirement of £48m.

NHS South Yorkshire was one of nine integrated care systems required to participate in the 'investigation and intervention' programme by NHS England following a greater than planned deficit at Month 2 (May). A further 11 systems have been identified as high risk at Month 3 (June). This reflects a challenging financial picture across the NHS with almost three quarters of the 42 Integrated Care Systems forecasting a deficit.

The investigation and intervention process will see NHS South Yorkshire colleagues work alongside NHS England and external consultants. It will build on work already initiated by system partners during planning for 2024/25.

The review will identify recommendations for a number of key interventions to be implemented across the system to reduce the expenditure run-rate, support the delivery of efficiency programmes and achieve the plan agreed with NHS England at the start of the year. These may include reviewing workforce models particularly the use of high-cost agency staff, non-pay spending controls, back-office functions,

estate and general productivity and efficiency improvements.

We will look to minimise the impact of this review on patient services. We will also work with our wider partners, particularly the local authorities to explore joint opportunities to improve services, reduce waste and deliver efficiencies. The ICB remains fully committed to addressing health inequality and supporting people to stay healthy and out of secondary care if safely avoidable. We believe this is not only better care but is less wasteful and a better use of NHS resources and will help us achieve financial sustainability.

2.5 Industrial Action

GPs have voted to take collective action for an indefinite period following a ballot of BMA GP partners/contractors, which was brought after an offer of a 2% pay growth earlier this year in the new GP contract. However, following the announcement of the independent Doctors and Dentists Pay Review Body last month the GP contract has now been uplifted by 6% to cover increased pay for salaried practice staff. Talks are ongoing between the government and the BMA to find a resolution.

The NHS is asking the public to still come forward as usual for care during collective action by GP services, which started on Thursday 1 August. Practices are still required to be open between 08:00 and 18:30 Monday to Friday. It is vital that patients still attend their appointments unless they are told otherwise, and practices should inform patients of any changes to services.

The nature of the action means that the impacts will vary at different GP practices and from area to area but could include GPs limiting the number of patient appointments per day. NHS teams are working hard to plan for any impact where possible to ensure services continue to be provided for patients.

The BMA have published a full list of their recommended collective action, which includes referrals, data sharing, medicines optimisation and taking part in pilot programmes. The full list can be accessed here: https://www.bma.org.uk/GPcontract

For Junior doctors the BMA have agreed a 22.3% pay offer, which will now be put to members to avoid further industrial action. The Government has accepted the pay review body's recommendations for a 5.5% increase for NHS staff on the standard Agenda for Change contract, and this is now subject to approval by the NHS Council.

2.6 Specialised commissioning

From April 2023, NHS England delegated responsibility for the commissioning of pharmacy, optometry and dental (POD) services to ICBs, including NHS South Yorkshire.

Since then, NHS England has been reviewing plans for the further delegation of commissioning responsibilities to include specialised services, vaccinations, screening, and child health information services (CHIS). Specialised commissioning delegation will take place in April 2025. This will include 70 services in total. From this

time ICBs will be legally responsible for commissioning these specialised services rather than NHSE. The delegation of vaccination services etc. will follow in April 2026.

NHS England will retain responsibility for commissioning some specialised services which are not suitable and/or ready for delegation, including all highly specialised services. There are no plans to delegate the commissioning of health and justice or sexual assault and abuse service (SAAS) functions. Commissioning responsibility for these will remain with NHS England, together with healthcare for serving members of the Armed Forces and their families registered with defence medical services, veterans' mental health and prosthetic services.

Further updates will take place throughout the process of transferring the commission of the 70 services ahead of transfer next year.

3. NHS South Yorkshire

3.1 Changes to the NHS South Yorkshire Board

NHS South Yorkshire and Barnsley Metropolitan Borough Council have started the joint process of recruiting a replacement for Wendy Lowder, who retires in February 2024. Wendy's unique role combines the NHS Place Director with the local authority Place Health and Adult Social Care role.

Will Cleary-Gray, Executive Director for Strategy and Partnerships, will take up a new NHS role in Gloucester at the end of September. We will not replace the role and other colleagues will take responsibility for all aspects of this portfolio. Sarah Perkins, Director of Performance and Delivery, who has taken AEO responsibility for EPRR and operational planning, and her role will now be designated as executive to reflect this.

3.2 Data and Insight Strategy

Our communities will soon start to benefit from improved care services following publication of a new system-wide data and insights strategy for health and social care. Our new two-year data and insights strategy focuses on five areas to harness the data-driven transformation in health and care, creating a secure and privacy-preserving system that delivers for both people using health and care services and those working in them.

It means those using health and care services will see more personalised services and it will bring together more information in real-time to help those running services to ensure you are seen as quickly as possible.

To give patients greater confidence than ever that their personal information is safe, secure data environments are being rolled out nationally for NHS and adult social care organisations to provide access to de-identified data for research. This means data linked to an individual will never leave a secure server and can only be used for agreed research purposes.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

NHS providers across Sheffield are continuing to lead and develop research studies and clinical excellence across a range of conditions to improve care for patients. Recent announcements include:

- Parents-to-be at Sheffield Teaching Hospitals are being offered the opportunity to be part of a national research study aiming to improve detection of cataracts in newborn babies. The UK-wide study, funded by the National Institute for Health and Care Research, will look to see if using a new hand-held digital imaging device is a more accurate way to detect cataracts in newborn babies than the current technique.

- Diabetes clinicians have opened a groundbreaking trial aiming to reverse the lifetime risks of nerve damage in people living with type 2 diabetes. The new trial at Sheffield Teaching Hospitals, known as OCEANIC, will build on recent evidence that shows that intensive management of blood glucose (sugar) levels can prevent the progression of nerve damage in people with type 1 diabetes.

- The Neuromuscular team at Sheffield Children's recently became a Muscular Dystrophy UK Centre of Clinical Excellence with Research. The Neuromuscular team at Sheffield Children's provides care and support to children with disorders of nerves and muscles, and related conditions from birth through to transition to adult services.

4.2 Doncaster

NHS South Yorkshire leaders recently met with colleagues from Doncaster's voluntary sector to hear about their work and to discuss how they can work more closely to collaborate on prevention and tackle health inequalities.

This meeting was the third in a series of meetings arranged by the South Yorkshire Voluntary, Community and Social Enterprises (VCSE) Alliance, following similar meetings in Sheffield and Rotherham. This was held at Doncaster's creative health charity The Point, which is the largest participatory arts organisation in the UK.

This discussion included a presentation on Breathe and Connect, supported in partnership with Doncaster and Bassetlaw NHS Foundation Trust, which is a project to support adults with breathing pattern disorder, and Tuneful Chatter, which is a project supporting children with school readiness for the best start in life.

4.3 Rotherham

The Rotherham Safeguarding Children's Partnership have agreed the Child Exploitation Strategy 2024-29: A vision for managing risk outside the home. Over the last 10 years the NHS in Rotherham has worked closely with Rotherham Council and South Yorkshire Police to make sure we have robust arrangements in place to safeguard our children, and to support victims of exploitation.

The strategy sets out how organisations will keep children and young people safe from child exploitation over the next five years. Child exploitation includes child sexual exploitation, child criminal exploitation, radicalisation, modern slavery, human trafficking and honour-based violence.

The new strategy will address a number of local priorities. This includes continuing to ensure there is an effective response to tackling exploitation through effective early identification and prevention services embedded in communities, the right learning and development offer for all relevant organisations and community groups, ensuring robust safeguarding processes and systems are in place, the continued provision of support to victims and survivors of exploitation, and identifying offenders of exploitation to bring them to justice.

Preceding the ten-year anniversary of the publication of the Jay Report, the strategy demonstrates the continued commitment by partners to listening to the voice and lived experience of victims and survivors and using this to develop services. There remains a focus on community engagement and partnerships with families, parents and carers and children and young people in the strategy that will be a key priority for its duration.

4.4 Barnsley

Barnsley's Pathways to Work Commission report has been published setting out the need for a major shake-up of the benefits system and how government, councils, employers and other agencies work together to help more people back into work. The Commission has carried out the nation's biggest deep dive into 'economic inactivity', which refers to the growing number of people who are out of work and not seeking a job now.

The commission's wide-ranging research suggests seven in ten people who are currently economically inactive would like to take a job that is aligned to their skills, interests and circumstances. The unemployment rate in Barnsley is lower than the national average at 2.9%. These are the people actively looking for work. Economic inactivity is different and is a national challenge. It includes those who are currently out of the labour market due to disability, poor health, or caring responsibilities, as well as early retirees, students, and those whose illness or disability means they simply cannot work.

The panel of global experts is led by Rt Hon Alan Milburn, former Cabinet Minister and social mobility champion. The commission took evidence from employers, educators and experts and carried out interviews with 750 South Yorkshire residents affected by economic inactivity. Among wide-ranging recommendations is a pilot programme which would support 2,200 people into work over a four-year period. This would require investment of £10m, but would in turn generate almost £70m in economic benefits, including a £28m reduction in benefits payments.

5. General Updates

5.1 National Centre for Child Health Technology update

The NCCHT will be a world-class facility dedicated to creating a healthier future for children and young people through innovation, technology and outstanding care. The development has received regional and national funding from the UK Government, South Yorkshire Mayoral Combined Authority and The Children's Hospital Charity.

The centre will be built on The Olympic Legacy park in Sheffield and will have four floors with state-of-the-art facilities and all the spaces needed to design, create and test new child health technologies. It will bring together our universities, industry experts, healthcare professionals, and children and young people to focus on obesity, mental health, disease prevention, disabilities, maternal and child health, cancer, long-term conditions and transition.

The final design stage has now been completed so that contractors can be invited to register their interest, and a lease of the land has been agreed. The full business case for the National Centre for Child Health Technology is going to Sheffield Children's Trust Board in November 2024 and communications materials are being developed for a full launch to communities at that time.

5.2 Awards

Teams from across South Yorkshire have been shortlisted for the 2024 HSJ Awards, with five categories being represented. The nominees from South Yorkshire are:

- Digitising Patient Care Award - Primary Care Sheffield - Maximising access in primary care using scalability and digital triage.
- Mental Health Innovation of the Year - South West Yorkshire Partnership Foundation Trust - Perinatal peer support workers.
- Place-based Partnership and Integrated Care Award - NHS South Yorkshire Medicines Management Team - The Rotherham Care Homes Hydration Project
- Towards Net Zero Award - Sheffield Childrens Foundation Trust - Sheffield Children's Nitrous Reduction Programme
- Workforce Initiative of the Year – NHS South Yorkshire - Centralised recruitment for newly qualified midwives

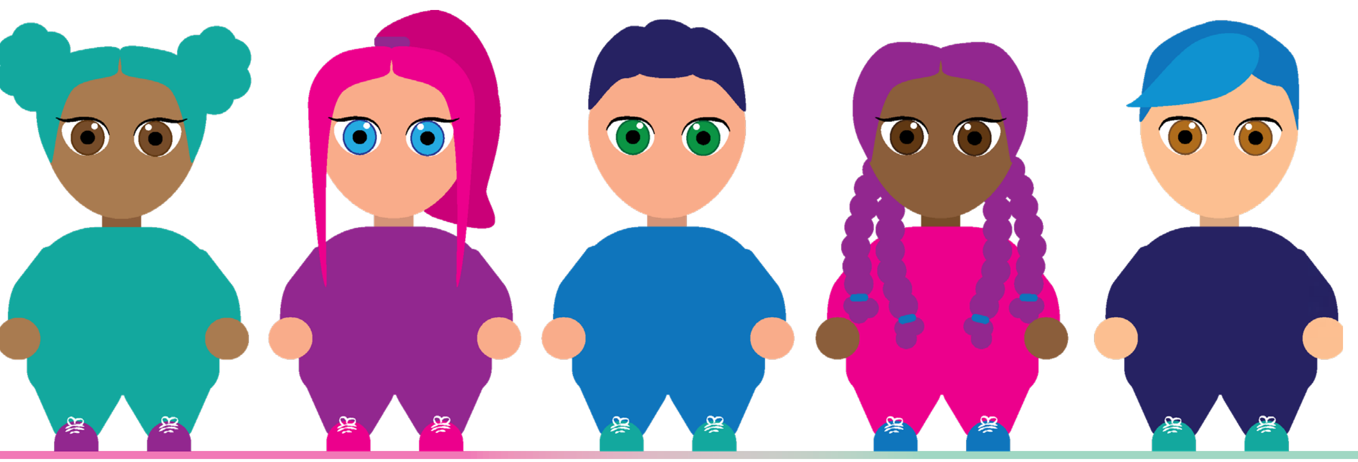
In addition, NHS South Yorkshire launched its own Star Awards, with the first winner being Katie Dowson, Programme Director for Digital Transformation from the Digital, Data and Technology team. Katie is leading a bold and innovative approach to tackling digital inclusion in Doncaster that has recently been widened to South Yorkshire.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 4 September 2024

Healthcare that works for Young People

Bridging the gap through a developmentally appropriate approach to the delivery of healthcare

Statement of Intent - September 2024



Barnsley Hospital
NHS Foundation Trust

Sheffield Teaching Hospitals
NHS Foundation Trust

Sheffield Children's
NHS Foundation Trust

Doncaster & Bassetlaw Teaching Hospitals
NHS Foundation Trust

The Rotherham
NHS Foundation Trust

Rotherham Doncaster and South Humber
NHS Foundation Trust

Sheffield Health and Social Care
NHS Foundation Trust

South West Yorkshire Partnership
NHS Foundation Trust

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Foreword

The Acute Federation of Trusts and the South Yorkshire Mental Health Learning Disability and Autism Provider Collaborative Trusts in South Yorkshire & Bassetlaw (SYB) are committed to using their collective expertise and resources to ensure the people of SYB have prompt access to excellent healthcare.

This is underpinned by the SYB Acute Federation Clinical Strategy 2023-2028. In 2023, SYB Acute Federation was selected to be one of nine national provider collaborative innovators for the Acute Paediatric Programme. The mission is to work collaboratively to transform care and outcomes for the children and young people living in SYB.

There are few things more important for a health system than ensuring the needs of children and young people are met, and their voices influence the care they receive. Yet the rights of children (0-18 years) are a relatively new concept dating back to the 1920s leading to a set of international human rights, known today as the UN Convention of the Rights of the Child. In the late 1990s research started to uncover a major knowledge gap in the brain development of adolescents and young people. We now understand that the adolescent brain transforms as it develops and is a unique part of our journey into adulthood, lasting into the mid-20s. It is essential that as complex healthcare systems, we respond to substantial new knowledge and for young people the time for this change is now.

The SYB Acute Federation collectively aims to deliver healthcare services that work for young people and their families. Yet some of our current services present us with a gap for young people aged 14 up to 15 years, with a sharp shift from family-focused and multi-disciplinary appointments in child services to the expectation of an autonomous adult capable of self-management in adult services often from the age of 16 years. Some specialist services for young people, such as those aimed at supporting mental health, end completely at 18 years old which further complicates their healthcare pathway. We are committed to bridging these historic gaps, through a developmentally appropriate approach to the delivery of healthcare for our young people in all acute SYB provider settings.

Chronic disease prevalence is rising in children and young people, with an associated increase in complexity of both disease and treatments. This has important economic implications for healthcare and the wider system. There are around 28,000 young people with chronic health conditions in SYB at any given time and for them everyday challenges are often greater than for those without a chronic health condition. This has an impact on negotiating key milestones in life successfully and can have adverse outcomes on relationships, educational and employment opportunities. Laying the foundations for key skills in this important time of development is vital to ensure our young people can flourish and develop self- management skills that will equip them to thrive in adulthood. It is also during this important period that some of our young people transition from children to adult services.

Mental health support is crucial during the transition from childhood to adulthood due to the significant developmental changes and challenges faced by young people such as health inequalities; care leavers, young carers, young people from marginalised communities including second generation immigrants and children living in poverty. As adolescents move from child-focused to adult-oriented healthcare, the abrupt shift can be overwhelming, often leading to gaps in care. Effective mental health support helps young people develop essential self-management skills, navigate key life milestones, and prevent avoidable healthcare complications. Providing holistic physical and mental health care and parity of esteem ensures young people receive continuous, coordinated support, enhancing their ability to thrive into adulthood.

Healthcare outcomes following poor transition are significant to the individual and the wider system, with increased avoidable admission rates, lack of inpatient care and bed provision and unwanted complica-

tions. Young people tell us that their experiences of navigating healthcare between child and adult providers is sometimes frightening and challenging, often feeling as though they have little control. They want holistic services built around their physical and mental health needs underpinned by excellent communication and meaningful relationships with healthcare professionals.

We aim to support the healthcare delivery for young people in the SYB Acute Federation. We want our young people to experience our system as compassionate, personalised, accessible and flexible to their changing needs. Our agreed priority areas will help us achieve this through; leadership and related structures to embed delivery; building capability and shifting culture; seamless and co-ordinated transition services; involving and empowering our young people and finally a data led approach to drive standards and measure impact. We want our young people in SYB whether experiencing healthcare for the first time aged 17 years in an adult setting, or living with one or multiple chronic conditions since early childhood to have experiences of healthcare which are holistic and personalised, enabling our young people to feel confident, cared for and equipped for adulthood. Whilst a key focus of this work related to physical healthcare, SYB Acute Federation is committed to working in partnership with mental health partners to adopt developmentally appropriate approaches across all sectors.

We are indebted and humbled by the passion and courage of the young people who have contributed to this work and continue to advocate for better healthcare services for those young people who follow them. We have much to learn from their voices and together we are committed to services which bridge the healthcare gap and make a significant difference to the lives of young people.

Ruth Brown
CEO Sheffield Children's NHS Foundation Trust
and Lead for SYB Acute Federation

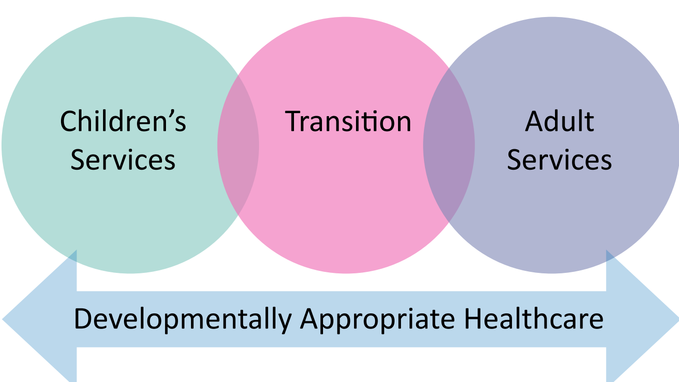
Why do we need a South Yorkshire and Bassetlaw Statement of Intent?

Developmentally Appropriate Healthcare and Transition: Definitions

In South Yorkshire and Bassetlaw, we recognise the importance and long-term benefits of healthcare that works for young people. Delivery of healthcare for adolescents and young people should be underpinned by equal importance of both physical and mental health care and parity of esteem with a personalised approach which is supported by research and national policy.

To bridge the cultural, organisation and training gap that exists between adult and children's healthcare providers, we have recommended use of a developmentally appropriate healthcare (DAH) approach.

This focuses on the biopsychosocial development of the individual, recognising their changing needs and empowering through embedding health education and importantly the bespoke design of services to meet young people's needs. It is a philosophy and approach which also acts as an umbrella term for tailored and stage appropriate care for all 10-24-year-olds.



Healthcare transition is the 'process of purposeful planned movement of adolescents and young people living with chronic diseases from child to adult orientated healthcare'.

National Guidance

It is widely recognised that the transition process does not always work well across the NHS in England and the process itself is complex as the needs to each young person are not identical. Offering effective DAH and transition can be particularly challenging when a young person has multiple complex conditions.

DAH pathways need to be developed in line with the following National Guidance and publications:

- National Institute for Health and Care Excellence (NICE) Guidance: Transition from children's to adults' services or young people using health or social care services (2023).
- Facilitating the transition of young people with long-term conditions through health services from childhood to adulthood: The Transition Research Programme. [2]
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) The Inbetweeners Review (2023).
- NHS Long Term Plan (2019).
- Assessment under the Care Act 2014 - Social care transitions guidance and the importance of 'early conversations' to prepare young people for adulthood, best use of data and minimised disruptions by combing multiple appointments where appropriate and necessary.
- https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
- Healthcare Standards for Children and Young people in Secure Settings 2019

There are several key areas that these documents focus on:

- DAH becoming core business for all involved in both children and adult services.
- Involving CYP and their families in transition planning.
- Developing, reviewing, recording and sharing transition plans.
- Effective, early co-ordination and communication between all those involved.
- Organising pathways and services to support effective DAH and transition.
- Securing skilled support for CYP transitioning

and strong leadership within organisations at all stages of transition and transfer.

Young people and their families use a variety of healthcare services from childhood to adulthood in SYB. Young people report difficulties with communication, information sharing and a lack of a consistent approach to their healthcare across SYB. It is important that partners from across the system work in collaboration, with a shared vision and purpose.

Acute Paediatric Innovator Programme: Prioritising DAH and Transition

In 2023 an Acute Paediatric Innovator Programme was established as part of a national programme work. DAH for young people was identified as a priority for this programme. The purpose of the programme is to bring key people together from across to innovate and improve outcomes. A defined workstream was established focusing on DAH supported by a Clinical Working Group (CWG) with a Clinical Lead and key stakeholders from across the SYB Acute Federation the South Yorkshire Mental Health Learning Disabilities and Autism Provider Collaborative

DAH and Transition in the SYB Acute Federation
To better understand current state, the CWG have reviewed the best available evidence, data, guidance and insights from those with lived experience. Through a series of workshops, the CWG identified both challenges and opportunities for change.

Key challenges in SYB include:

- **Workforce:** There is variation in the workforce models delivering services to young people across both acute and community settings. There are few transition focused roles / leads in both physical and mental health pathways within Trusts and Places. There is also a gap in training and a lack of understanding amongst staff on how to adapt their approach to offer true developmentally appropriate healthcare.

- **Unwarranted variation and system complexity:** There is evidence of variation in the support offered to young people across the region who are in the healthcare transition stage. There are also a lack of 'young person friendly' environments and variation in the processes for allocating beds suitable for young people, particularly within mental health. Variation exists in local Trust policies and strategies with a need for new youth-friendly and non-stigmatizing care models.

Addressing unwarranted variation is important in order to tackle health inequalities and improve the experience of young people. As young people move between healthcare providers within the region they can experience duplication and repetition, for example when they need to talk about their medical history multiple times to different teams.

Barriers also exist across health, social care and education which can lead to inequitable experience, poorer life outcomes and a high burden on young people (and their families) to navigate complex systems. Transition can become even more complex when there are safeguarding is-

> "Everything in children's seems to be more cheerful...but when you walk in (to adult services) it's really intimidating. A lot of the time when you walk into the room you're the youngest person there"

sues and multi-agency co-ordination is required. Adult services can have different and more restrictive criteria, which can lead to unmet need amongst young people.

All of this complexity can result in young people disengaging from healthcare and support, as well as lead to system inefficiencies and reduced productivity. Collaboration between partners and joined up ways of working is therefore essential.

- **Patient Experience:** The experience of young people is highly varied and is not equitable across the region. There is variable communication between healthcare partners and wider multi-disciplinary services. The transfer of information inconsistent. Young people and their families can experience stress, fear and uncertainty with a drop off in support once they transition into adult services. Inadequate planning with inconsistent processes and information can lead to sub-optimal transition. In turn this can lead to missed or duplicated appointments. Young people do not consistently receive personalised support and the healthcare system is not as 'youth-responsive' as it needs to be.

To better understand secondary care services, a baseline assessment of current state was undertaken (Appendix 1). This revealed that national guidance and recommendations are not being consistently met across SYB and Trusts have different approaches to DAH and transition:

- All Trusts across SYB have completed the NCEPOD self-assessment tool to evaluate their services against key recommendations.
- So far, only one Trust has been able to develop an action plan (as of June 2024) in response to their findings.
- Two Trusts in SYB have a Trust strategy for transitions.
- There is variation in the presence of dedicated leadership roles for transition across SYB.
- There appears to be a correlation between the level of understanding of current state and the presence of strategic Trust plans with having a nominated or funded leadership roles for transitions and DAH.

The assessment also revealed examples of good practice which included:

- **Barnsley Hospital NHS Foundation Trust (BHFT):** The Patient and Public Involvement (PPI) Team have been working in partnership with, Chilypep a young person empowerment project, on the 'You're Welcome' standards to help improve the quality of, and access to, health and wellbeing services for young people. The team at BHFT have commissioned young people to assess and give feedback on their Emergency Department. This is helping to create spaces which are young person friendly. BHFT plan to utilise the standards in other areas of the Trust (Appendix 2).

- **Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH):** DBTH introduced a Diabetes Transition Service five years ago to support the seamless transition of young people aged 16-19 years from children's to adult services. The service includes a Young Adult Clinic which has been established to better meet the needs of young people. Data provides evidence that this has resulted in improved retention of young people in the service. Reporting to the National Diabetes Audit has shown clear improvements which will have a significant impact on people's long-term morbidity and mortality.

- **The Rotherham NHS Foundation Trust (TRFT):** TRFT recently held a Transitions summit to bring together core stakeholders across Rotherham place to explore local challenges and opportunities to help update and develop strategic direction for transition.

- The Rotherham NHS Foundation Trust, in collaboration with the CYPF Consortium and Rotherham United Community Trust, has launched a new Youth Work Support project aimed at helping young people aged 11-19 with asthma, epilepsy, diabetes and other long-term conditions. The project aims to improve the quality of life and mental wellbeing of young patients with long-term conditions. Although the project has only recently launched, it has already received positive feedback from patients and their families.

- **Sheffield Children's NHS Foundation Trust (SCFT) and Sheffield Teaching Hospitals NHS Foundation Trust (STH):** SCFT and STH have funded and dedicated transition leads and a transition team. This helps the two organisations

to work collaboratively on both clinical pathways and strategic improvements. Most recently, SCFT and STH recently hosted the second Sheffield Young People and Healthcare Transition Annual Conference, a free virtual conference for colleagues supporting young people moving from children's healthcare to adults.

- **South West Yorkshire Partnership Foundation Trust (SWYPT):** Current transition policies and procedures have been updated by South West Yorkshire NHS Partnership Foundation Trust, who provide both CYP and adult mental health services in Barnsley.

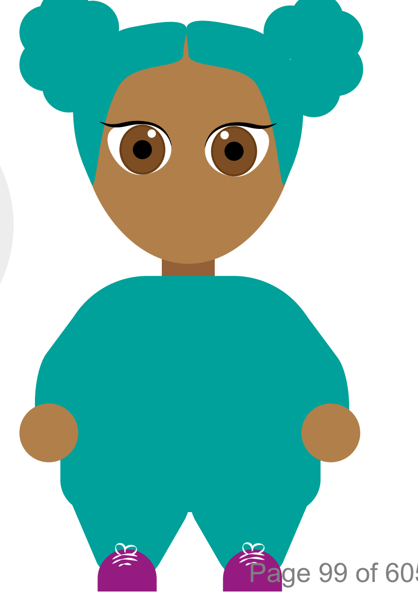
  Currently the CAMHS transition pathway begins for those aged 17.5 and a policy and flowchart support clinicians, CYP and their families with this. The pathway has been adapted recently to ensure that CAMHS clinicians keep the CYP who are transitioning into adult services on their caseload to support them during the handover period with joint appts etc.

  The CAMHS Quality and Governance Lead has transitions/DAH within their portfolio to ensure this is a focus.

- **Sheffield Health and Social Care NHS Trust (SHSC):** Sheffield Health and Social Care NHS Trust have commenced work on the development of a transitions team in collaboration with Chilypep (a voluntary community and social enterprise) to support young people moving from Child and Adolescent Mental Health services to adults. The Trust already has a clear protocol in place to guide transition for this pathway. SHSC also offer's a psycho-educational course called STEPforward which aims to provide support to young people who struggle with a variety of mental health difficulties. It has been specially designed for young people aged 16 to 25, and offers the opportunity to learn new coping skills to support wellbeing and to enable participants to move forward.

- **Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH):** RDaSH completed a service user inclusion project to hear the voices of children and young people, their families and professionals. Individual interviews, and focus groups were held to hear views on the assessment service. This revealed that CYP, their families, and educational staff valued the assessment pathway. They felt listened to and understood and reported that their individual needs were considered. However, they highlighted lengthy waiting times, not knowing where to go for support and a sense of needing to battle to have their concerns heard by wider services, prior to being accepted onto the assessment waiting list. As a result, the referral form now includes the young person's voice, their thoughts on their strengths and needs. The team now request school information prior to assessment to speed up processes and a more succinct report format has been developed. RDASH have also implemented a Neurodiversity Practitioner role to support families whilst waiting for assessment and following diagnosis. Group based and 1:1 support is offered to all families whilst waiting for assessment which has been highly valued by families. They report feeling more supported, listened to and know more about accessing support.

"Put young people and what they want and need at the centre of the service. Give consistent support to young people to make the move from child to adult mental health services smooth, if relevant to that young person.



What is our scope?

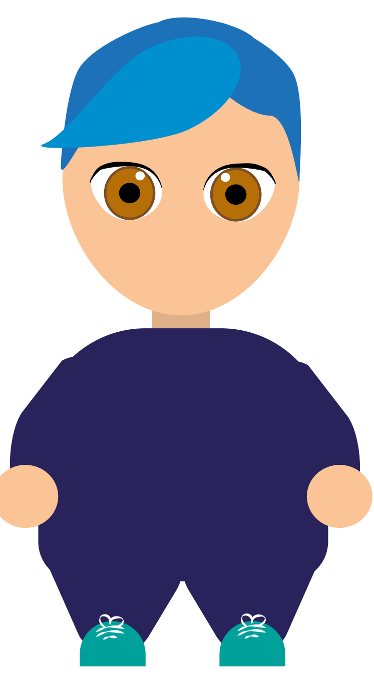
DAH and healthcare transition are everyone's core business. This document should be read by all healthcare professionals and leaders across SYB in both children's and adult hospital services. The geographical scope of this work is SYB and the following organisations have committed to work together:

- 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
- Rotherham Doncaster and South Humber NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust

Whilst the key focus of this work is on delivery within secondary services, it aims to work seamlessly with primary care and the wider multidisciplinary team including mental health services, education and social care.

The following organisations and alliances have therefore endorsed this Statement of Intent:

- South Yorkshire Children and Young People's Alliance
- South Yorkshire VCSE Alliance
- South Yorkshire Mental Health Learning Disability and Autism Provider Collaborative



"I wanted to assert my independence and take ownership of my health, but on the other hand I craved the guidance and reassurance that had been a constant in my life up to that point"

Which young people are we focussing on?

As children grow and develop into young people their specific needs change over time. Adolescence and young adulthood are a particularly unique stage of human development and a critical time for all young people. But for those with a chronic health condition, everyday challenges are often greater than for those without a chronic health condition and can impact on negotiating key milestones successfully. It is during this critical time of brain development that young people with a chronic health condition are learning about their disease, transitioning from children's service provision through to adult care, and from parent-led care to self-management whilst at a life stage characterised by change, exploration, risk-taking and identity development.

Children and young people of all ages, require healthcare that is delivered in a developmentally appropriate way. However, in acknowledgement that adolescence and young adulthood is a particularly critical stage in their long term health and wellbeing, we are focussing particularly on young people aged 14-24* years.

This is in line with current national recommendations that transition preparation commences by 14 years and the NHS long Term Plan[4] for CYP includes young people up to the age of 25 years. The World Health Organisation defines adolescence as the developmental stage between 10-19 years and youth as 15-24 years. For the purposes of this work the term young people will be used to describe those aged 14-24* years.

In South Yorkshire and Bassetlaw young people make up a large proportion of the population, with significant healthcare utilisation. Young people with long term, complex conditions frequently access healthcare from children's services initially and then adult services as they grow older.

3-4%
of secondary school children in South Yorkshire have social, emotional and mental health needs.

25k
children or young people known to have a mental disorder in South Yorkshire (age 5-17)

13.7%
There are approximately 202,000 young people aged between 14-24 in SYB and it is estimated that around 13.7% have some kind of long-term disability or long-term conditions.

Children and young people in South Yorkshire and Bassetlaw with Autism or a Learning Disability:

(0-17 year olds)

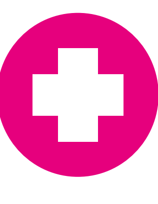
13.7k

(18-25 year olds)

7.5k

Around **51,000** young people aged 14-24 attend an SYB Emergency Department each year.

Around **19,300** young people aged 14-24 are admitted to a hospital in SYB each year.



40%
of children and young people in South Yorkshire live in poverty

Around **59,000** patients attend SYB hospitals as outpatients resulting in around **200,670** appointments.

What is Our Vision?

Our vision is for healthcare to work for young people and their families.

Young people accessing healthcare in SYB should experience care in any of our provider settings that is underpinned by a developmentally appropriate approach and is equitable. For the young person and their families, this translates to them experiencing healthcare as personalised and flexible to their current life stage.

Young people should be actively involved in the design, delivery and evaluation of services. Evidence tells us that this will provide the foundations needed to enable our young people to flourish alongside their long term physical and mental health conditions into adulthood.

We will empower, build resilience and self-management skills in young people that will translate into improved healthcare and life chances in adulthood.

What do the voices of young people tell us?

At a national level, insights have been gathered as part of the development of guidelines and polices. In developing The Inbetweeners Report (NCEPOD, 2023) a series of focus groups and interviews were undertaken with young people and their parents / carers. When they were asked what one thing would have improved their experience of the transition process to adult health services, responses fell into the following broad categories:

- The age of transfer and whether it is develop-mentally appropriate
- Having a transparent transition
- Having a key worker
- Better communication
- Having equivalent adult healthcare services
- Help and support for young people
- Help and support for parent / carers.

“I don’t really know when I’m transitioning, it’s confusing but I’m sure someone will explain it to me when I get there”

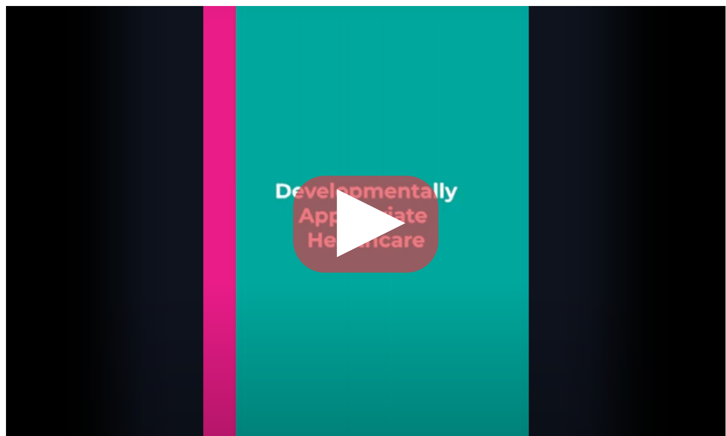
At a regional level, scoping work has been carried out with the support of Chilypep to gather insights from engagement work with CYP. Chilypep is a charity dedicated to raising the voices of young people and giving them the confidence, influence and platform to shape their world and stay connected. Young people have shared that:

- Chronic, long-term conditions can impact their physical and psychological well-being, development and quality of life.
- Multiple healthcare attendances and interactions have a profound effect on their development, life and education.
- Poor communication can negatively impact their experience of healthcare, wellbeing and future engagement with healthcare.
- They feel particularly vulnerable during the transition period between children's and adult services.

Stories from young people of their experiences have revealed that young people want:

- Improvements in relationships with staff underpinned by good communication, information and support
- Environments that are friendly and welcoming
- Help with navigating transition from children's and adult services
- Opportunities for peer support and sharing experiences with other young people
- Staff who are well informed of their case, talk to each other and work in a joined-up way

The video clip below shows a young person telling us why healthcare that works for them is so important:



Our shared purpose

All our young people with long term physical or mental health conditions across SYB will feel confident and in control of their health and wellbeing. Our systems, processes and teams will enable this to happen. We will create a forum to work together in partnership across the Integrated Care System and make positive change in line with National Guidance.

Our Priorities

To collaboratively agree priorities, we have:

- Listened to the voices of and expertise of CYP with lived experience
- Worked with experts in both children's and adult services
- Reviewed all available local Trust strategies and policies
- Reviewed available evidence and recommendations within National Guidance
- Worked with physical and mental health Trusts.

SYB Developmentally Appropriate Healthcare Key Principles

To make healthcare work for young people, embed developmentally appropriate approaches and achieve sustainable change work will need to take place within Trusts in the following areas:

Healthcare that works for Young People

Our agreed priority areas:

To have the greatest impact the following priority areas have been agreed:

1. Leadership and structures to embed delivery of Developmentally Appropriate Healthcare

Securing effective, clinical and managerial leadership at all levels of the organisation for DAH is a key priority. Consistent processes and approaches to the delivery of DAH are required, which are endorsed by all organisations detailing how coordination of staff and services is achieved across South Yorkshire and Bassetlaw. Governance and reporting structures should be in place to secure effective delivery of local action plans and subsequent collation of quality at a trust level with executive team oversight.

2. Building capability and shifting our culture

Creating a shift in culture and building capability within our workforce so that they are empowered to deliver and lead effective DAH and transition. Completion of relevant DAH and healthcare transition training. Developing a regional network to ensure professional support structures are embedded across the Federation.

3. Seamless and co-ordinated transition

Working together in partnership between and within organisations and systems to secure timely, organised and well-planned transition from child to adult services. Healthcare transition should be in the job plan of all members of the multi-disciplinary team and include a named key worker. Barriers identified to seamless healthcare transition (e.g., organisational, data sharing and professional boundaries) are examined and actioned to drive innovation. Seamless transition contributes to greater system productivity, through reducing unnecessary contacts, reducing missed appointments and empowering young people to self-manage where appropriate.

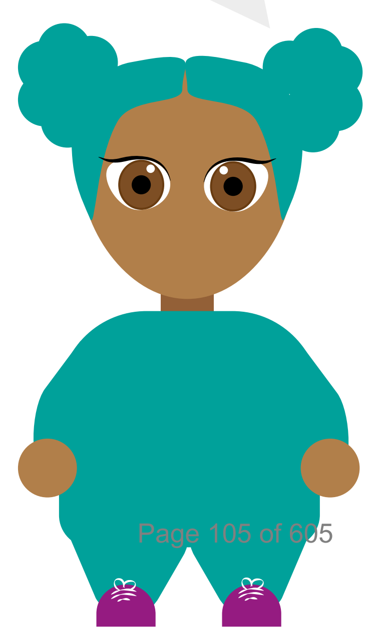
4. Involving and Empowering Young people

Ensuring that young people are actively involved in design, delivery and evaluation of services. Young people's voice and influence should inform and shape how we work and the decisions we make in SYB collectively. Working with the ICB, a range of age-appropriate methods should be used to collect experience feedback from young people and their families, at mutually agreed touchpoints through their healthcare journey.

5. A Data Informed Approach and Measuring Impact

Our approach in SYB will be data informed and the impact of any new innovations measured. There will be system oversight and governance structures in place to monitor progress and compliance against policies / guidance e.g. Trust Did Not Attend / Was Not brought policy for young people.

"Eventually I'll be the one making all the decisions. Um, it's a bit daunting. But I think I will be able to handle it"



Our 5 priority actions

Leadership and structures to embed delivery of DAH

- Defined clinical (medical and nursing) and executive leads
- Shared resources to support focused roles and experts in developmentally appropriate healthcare and transition
- Clear governance and reporting structures across the SYB Acute Federation

Building capability and shifting our culture

- Library of training resources available in a shared workspace
- Electronic Staff Record (ESR) recorded training
- A Community of Practice

Seamless and co-ordinated transition

- Healthcare transition suite: all sub-specialties to self-assess and work towards compliance with NICE transition NG43
- Underpinned by Memorandum of Understanding (MOU) across SYB

Involving and Empowering Young People

- Developmentally Appropriate Healthcare approach to evaluation and risk assessment
- Measure patient experience of Developmentally Appropriate Healthcare
- SYB easy guides to Developmentally Appropriate Healthcare and Transition

Data informed approach and measuring impact

- Baseline dataset - commitment to annual monitoring
- Sharing data with health and social care partners and systems in a timely manner, to enable appropriate sign posting and planning, the ethos is 'prevent, reduce and delay'.

Our Key Milestones

Phase 1: 2024-26

By March 2026 we will have:

- Lauched our Statement of Intent and MOU
- Implemented focussed leadership roles and training
- Launched a transition suite of resources so that all Trusts are NICE compliant
- Launched information packs for staff, young people and their families.

Phase 2: 2026-27

By March 2027 we will have:

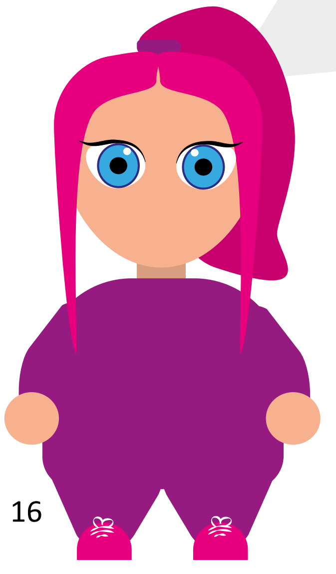
- Embedded systematic, developmentally appropriate ways to gather feedback from young people
- Embedded the new ways of working
- Measured impact
- Have an active Community of Practice

Phase 1: 2024-2026

Phase 2: 2026-2027

Phase 3: 2027-2028

""I just remember them [paediatric team] all saying goodbye to me and it made me really upset, because I was like 'I've gone from being a child now to being an adult"



Phase 3: 2027-28

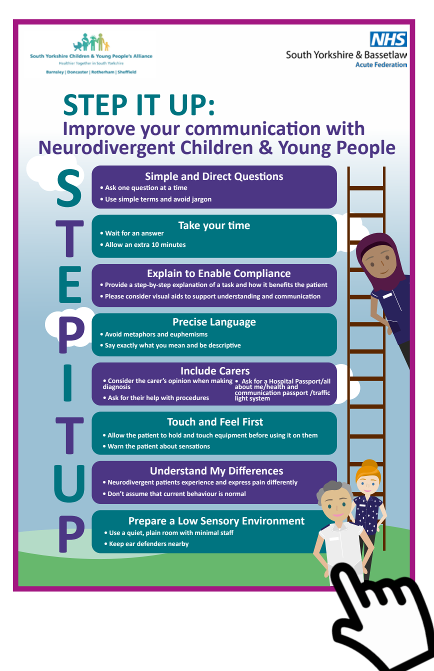
By March 2028 we will have:

- Implemented a strategic oversight board to take ownership of future work and monitor progress
- Trained all staff across the South Yorkshire and Bassetlaw Acute Federation and the Mental Health Learning Disability and Autism Provider Collaborative
- Tested new workforce innovations such as peer support roles and system employed roles
- Ensured that all pathways and services support 'transition' rather than 'transfer'.

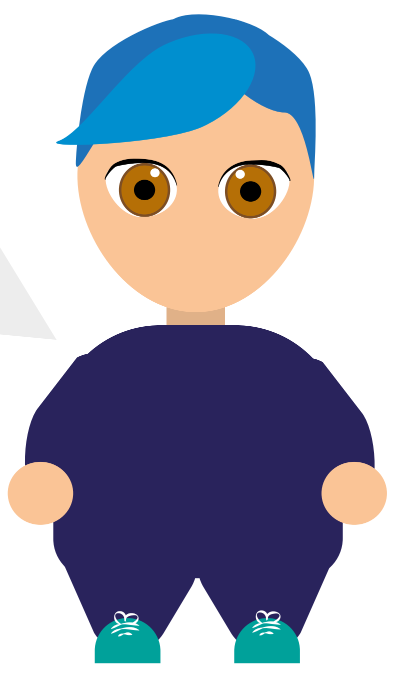
Appendices 1-3

You're Welcome Standards (BHFT)

Key Baseline Data



"I wanted to take control of things myself and not rely on Mum, because they were still contacting my mum all the time for things"



“Age appropriate facilities, tailored support programs, service user voice and participation and enhanced communication between patients and healthcare providers, would go a long way in easing the transition process and ensuring that individuals receive the best care and support they need to thrive”

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Public Board of Directors' Meeting

Agenda item	P166/24
Report	Equality Diversity and Inclusion Plan 2024-2027
Executive Lead	Daniel Hartley – Director of People
Link with the BAF	U4: Us - there is a risk that we do not develop and maintain a compassionate and inclusive culture leading to an inability to retain and recruit staff and deliver excellent healthcare to patients.
How does this paper support Trust Values	Delivering improvements in Equality Diversity and Inclusion supports our values of Ambitious, Caring and Together
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This paper follows up the commitment made in our People and Culture Strategy to produce a single Integrated Equality, Diversity and Inclusion Plan (EDI). The proposed plan attached to this paper will underpin the People and Culture Strategy, and provide a focus for how we direct and influence improvements to EDI over the medium term. Some good progress has been made in areas of the Trust's current EDI plan, whilst others have seen more limited progress. New areas of work have been taken on e.g. the Board's recent adoption of the North West BAME Assembly Anti-Racism framework. Legislation and best practice continues to develop in this area. The recent 2nd Cultural Celebration Day demonstrate the Trust's on-going commitment to celebrating and embracing different cultures and the Trust continues to grow more representative of the population that it serves. Many challenges remain, however and that is why we need an integrated plan covering the protected characteristics, and a broader approach to inclusion over the medium term. This plan phases commitments over the next 3 years providing clear and tangible actions. Care Groups, Corporate Teams and staff networks were engaged in the process of developing the plan and further engagement and listening to feedback will be important as we work collectively to deliver this plan across the Trust. Enablers for success include our staff networks and committed and visible leadership which includes oversight and personal leadership from the Board of Directors. Progress will be monitored and reported through leadership teams, the Executive Team, People and Culture Committee, and Board. These actions also constitute the Trusts action plans for the purposes of Workforce Race Equality Standard and Workforce Disability Employment Standard.

Due Diligence	The Integrated EDI Plan was recommended for approval at the Executive Team Meeting on 24th October and at People and Culture Committee on 25th October.
Board powers to make this decision	Approval of the EDI Plan is a matter for the Board and an expectation outlined in NHS England's High Impact EDI Actions.
Who, What and When	One approved, the Head of OD and Inclusion will publish this to the Trust's website. The plan will then be reported against on an annual basis with an update, encompassing WRES, WDES, High Impact Actions and other reporting requirements.
Recommendations	It is recommended that the Board of Directors approves the Integrated EDI Plan.
Appendices	Appendix 1 - Our Journey to EDI - Integrated Plan 2024 to 2027

1. Background

1.1 The People and Culture Strategy 2024 to 2027 positions inclusive and compassionate leadership as key enablers of success for TRFT to be able to deliver for patients. It also committed the Trust to developing an Integrated EDI Plan which brings together existing and new commitments into a single action plan.

2. Progress against current EDI Plan

2.1 The existing 2023 plan was largely written to address the NHS England Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Some progress was made against the actions however progress was also impacted by the gap following the departure of the previous Head of EDI in 2023 and the appointment of the new Head of OD and Inclusion who started in April 2024.

2.2 Key highlights to note include the fact that all Executive Directors now have a specific EDI objective and either a specific EDI action related to the staff survey or a wider people experience related objective as part of the Trust's 'We said, we did' plan. Non-executive director objectives are in the process of being agreed and implemented.

2.3 An EDI question bank has been developed and implemented to support recruitment. Improvements have been made to support International Medical Graduate Induction and the Trust continues to celebrate the Cultural Celebration Day. Additionally, and more recently, support is provided to the staff networks via alignment to an executive sponsor.

2.4 Areas for improvement include recruitment – more work is required on the end to end process and to promote equal opportunities through recruitment processes. Delivery of Behaviour Framework and Cultural competence team development sessions has been ad hoc and on request but has not been fully evaluated and so we are not able to report on how effective these have been other than anecdotal feedback. Actions outstanding or which have clear alignment to the reporting metrics and have potential for more development have been included in the new Integrated EDI Plan.

3. Developing the Integrated EDI Plan

3.1 Since the new Head of OD and Inclusion and Wellbeing started in May 2024, the EDI Team have been engaging with Care Groups and Corporate Teams with a focus on what tangible changes they would like to see in the organisation to embed inclusion.

3.2 Amongst the themes coming out of this engagement were mixed levels of understanding of the need to do more on EDI; some colleagues from ethnic minority backgrounds feeling like there was not enough focus on anti-racism and anti-racist practice and some lack of understanding as to how best to support different types of neurodiversity. Further feedback was provided around the lack of support or difficulty in accessing reasonable adjustments.

3.3 Taking that into account, the new Integrated Plan was developed to run concurrently with the People and Culture Strategy, address the feedback from staff and draw on best practice from both the NHS, but also public sector and further afield. Having a longer plan provides the opportunity for strategic planning and regular engagement with Care Groups and Corporate Teams, a process which has already started and has been invaluable to the Head of OD and Inclusion in curating this plan.

3.4 The concept of the plan was to make meaningful commitments phased over its duration so that everyone has clarity on the expectations of what is to be delivered and each year, the Trust is building on the prior year but also embedding practice into business as usual.

4. Contents and Structure of the Plan

4.1 The Integrated EDI Plan is split into sections and written in plain English to make it accessible and readable:

Welcome
The opening message from our Chief Executive sets the tone for the plan, noting the links to the People and Culture Strategy and clarifying this is an internal EDI plan for our People.

What is EDI?
A brief overview of what is meant by the terms Equality, Diversity and Inclusion, their legal context, the protected characteristics and what this means in practice. This also references our Anchor role in Rotherham.

2024-25: Building Our Capacity and Capability
The first section of actions is very much positioned as making sure that the Trust is meeting all of the requirements set out by NHSE such as the High Impact EDI actions. The plan reflects the Trust's commitment to addressing Reasonable Adjustments with new guidance and processes, adopting the North West BAME Assembly Anti-Racism Framework and embedding the NHS Sexual Safety charter amongst other actions.

2025-26: Maturing Our Approach
The following year's commitments focus on building positive action to tackle some of the inequalities within the workforce. Actions include but are not limited to, targeted support and action for BAME colleagues and their career aspirations, revamping the Trust's Behavioural Framework, developing a suite of EDI data/dashboards, and initiatives around neurodiversity and accessibility.

2026-27: Embedding Inclusion
The last year of the plan involves a review of action to date, as well as work on the Medical and Dental pay gap, mentoring opportunities and building on the prior year's EDI objectives for managers by asking everyone to embed EDI into their appraisal.

Enablers, Performance and Governance
The penultimate section of the plan positions Staff Networks, Leadership and Inclusive Recruitment as the Trust's enablers to ensuring success. This page of the plan also references the national standards and metrics which the Trust has to report to NHSE, and in many cases publish on our external website.

5. Expectations for Reporting, Monitoring and Oversight

5.1 The NHSE High Impact Actions set out a clear expectation that the Board of Directors have active oversight and involvement in EDI issues, including using lived experiences, data and insight to assist in delivering the Trust's ambitions in this area.

5.2 It is proposed that a single annual update would be brought to the Board which covers WRES (and MRES when the Trust is ready to report it), WDES, High Impact Actions, any other metrics we are required to report. It is anticipated the new approach to the

EDI Plan and Trust's commitments will make it easier to report both narrative and lived experiences, alongside quantitative data from the metrics that the Trust produces to track progress.

6. Recommendations

6.1 The Board of Directors are asked to approve the EDI Plan 2024/27.

Our Journey to Equality, Diversity and Inclusion

Integrated EDI Plan

Supporting our

People and Culture Strategy 2024 - 2027

Welcome

I am delighted to present our Integrated Equality, Diversity and Inclusion (EDI) Plan, which outlines our approach to directing and guiding the Trust's EDI work over the next 3 years. The plan underpins our People and Culture Strategy, by enabling us to better 'Retain and Recruit', 'Develop and Lead Inclusively' and create 'Engagement and Improvement'. It focuses on our people and every single one of us has a part to play.

This plan reflects how we create the organisational culture and behaviours that enable everyone to be welcome, supported and safe in our hospital and across our community teams. Inside, you will find commitments to anti-racism, support to our LGBTQ+ communities, initiatives to help disabled colleagues and many more commitments to improve the experience of our people.

This plan covers our approaches to addressing barriers faced by people with different protected characteristics as set out under the Equality Act (2010). We will also provide support on specific issues that are around safety and inclusion, such as sexual safety, menopause and will also focus on neurodiversity to help everyone to do their best work.

The NHS Staff survey, published EDI data and Freedom to Speak Up arrangements will ensure we understand our progress and receive feedback and address concerns. Key to delivering this plan will be supporting our staff networks to thrive, visible commitment from our Executive and Non-Executive Directors and by recruiting inclusively.

We will learn from best practice nationally and work with partners both locally and across the South Yorkshire Integrated Care System where doing so benefits our people. The plan is set out with year by year actions and in delivering the plan we will develop a culture where everyone can fulfil their potential. I look forward to working with everyone across the organisation to implement the actions in this plan.

Dr Richard Jenkins
Chief Executive

What is EDI?

Equality, Diversity and Inclusion are the ways in which we ensure that everyone - staff, patients, partners, the community or visitors to TRFT - is welcomed, treated fairly and differences are respected.

Equality

This involves treating people equally so that everyone has the same rights and opportunities. It is being treated fairly so that everyone is supported and able to reach their potential. Sometimes people assume that this means that everyone is treated exactly the same, however this is not the case as individuals who have additional needs may end up disadvantaged by not getting the additional help they need to access the same opportunities as someone else.

Example: At TRFT, we support colleagues to access additional training via the apprenticeship levy. However, someone with a learning difficulty like dyslexia may make it harder for a member of staff to engage, therefore they are likely to be given additional support. This means treating that member of staff differently to someone else, however this is appropriate and proportionate to ensure that someone with dyslexia can do an apprenticeship, the same as someone without dyslexia.

Diversity

Diversity describes the differences between human beings and the things which make us all unique. In the Equality Act (2010), some differences are defined as protected characteristics because they are underrepresented or likely to suffer inequality, discrimination or harm unless we make a conscious effort to ensure that they are welcomed, included and barriers are minimised.

The nine protected characteristics are:

- ✓ Age
- ✓ Disability
- ✓ Gender reassignment
- ✓ Marriage and civil partnership
- ✓ Pregnancy and maternity
- ✓ Race
- ✓ Religion or belief
- ✓ Sex
- ✓ Sexual orientation

Inclusion

Inclusion means actively ensuring that everyone can take part, particularly minimising barriers for those who have a protected characteristic or may have been previously excluded from being able to fully unleash their potential at work. This could include building awareness of different cultures and identities, designing services inclusively from the start, and ensuring that we are constantly considering how people interact with the Trust

By embracing Equality, Diversity and Inclusion we will:

Equality
Providing opportunities for everyone to take part and thrive

Diversity
Welcoming and respecting everyone's differences

Inclusion
Building awareness and understanding of everyone's needs and designing what we do round this

Our TRFT EDI Model

- ✓ **Retain and recruit** – through improving people experience and making progress measured by reporting requirements including the Equality Standards (WRES, WDES, MRES), Equality Delivery System, High Impact Actions and Pay Gap reporting;

- ✓ **Develop and lead inclusively –** ensuring that TRFT is a welcoming and safe place to work. Focussing on supporting and challenging everyone to role model inclusive values based behaviours every day – Ambitious, Caring and Together;

- ✓ **Create engagement and improvement** – listening to our people, supporting staff networks and Freedom to Speak up arrangement to improve how we work and how we deliver for patients

This plan also underpins our role as an **anchor institution for Rotherham** contributing to the success of the town and will be delivered in partnership with others where that helps us to maximise impact.

Our Trusts Priorities

2024/2025: Building Our Capacity and Capability

Our key priorities for 2024/2025 include:

- Putting in place action plans to address the **NHS England High Impact EDI Actions**. These actions cover the intersectional impacts of discrimination and bias across the following areas; objectives; inclusive recruitment; pay gaps; health inequalities; support for internationally educated staff and work to reduce bullying and harassment.

- Designing and launching a new **Reasonable Adjustments Process** that highlights how and why we should implement reasonable adjustments, centralising procurement of specialist equipment and providing more visibility and transparency for line manager responsibilities.

- **Adopting the North West BAME Assembly Anti-Racism Framework**, by appointing an executive sponsor and developing an action plan. This includes:
    - Prioritising Anti-Racism as an organisational priority;
    - Enhancing our understanding of lived experiences;
    - Growing our leadership so that everyone behaves inclusively;
    - Act to tackle health inequalities, including health inequalities;
    - Commit to regularly reviewing progress.

  The plan will assess where we are currently at on the framework, and outline the actions needed to take us through Framework.

A picture from our 2024 Cultural Celebration Day, inviting all colleagues to learn about different cultures and experience the richness of what they bring to TRFT.

- Launching a **new approach to tackling sexual harassment at TRFT**, addressing the government's new sexual harassment legislation (2024) and our commitments to the NHS Sexual Safety Charter. An Allegations policy will support this process, alongside information sharing between the People Team, Safeguarding Teams and external partners. This will help us to deliver our 'We Said, We Did' commitments made based on NHS staff survey feedback.

- **Relaunching our LGBTQ+ Awareness Training**, as previously offered under the Rainbow Accreditation Scheme, to ensure that our staff are aware of the experiences of LGBTQ+ communities.

- Embedding EDI into Executive and Non-Executive Director objectives; **each director will have an EDI objective** measured in their appraisal.

A picture of our staff delivering patient-centred care, taking into account everyone's personal circumstances and needs. Staff from all different backgrounds work together to ensure the best outcome for patients.

2025-2026: Maturing Our Approach

Our key priorities for 2025-2026 include:

- Reviewing approaches to leadership and management development across the Trust. This has particular importance for **ensuring that our BAME colleagues and colleagues with a Disability progress** and will see a more intentional approach developed.

- In conjunction with staff networks, develop a clear TRFT approach to **allyship and active bystander** behaviours drawing on best practice and in doing so promote inclusion and actions to deliver equality

- Launch a **programme of work that supports women at TRFT**, understanding their needs and how best to support them including developing leadership, supporting career progression and developing a women's network.

- Benchmark the medical and dental workforce to begin the process of **creating a Medical Workforce Race Equality Standard (MWRES) action and development plan**.

In 2024, TRFT welcomed NHS England's New Chief Nurse to the Trust to meet nursing colleagues and find out how we support staff every day.

- A review and **refresh of our Behavioural Framework**, to ensure that it is still fit for purpose and takes into account the diverse needs of our people today and in the future to underpin EDI.

- **A more sophisticated data suite/dashboard for EDI information**, we will develop a model for measuring our impact and evidencing our work, including a more integrated and embedded approach to the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and other related metrics.

- Support the review and **implementation of inclusive recruitment processes** - attraction, recruitment and selection.
- **Launch specific campaigns that support neurodiversity** such as 'dyslexia at work', using technology to ensure staff can do their best work for improved patient care.
- **Review our progress against the NW Anti-Racism Framework**, ensuring our diverse workforce and professions are engaged and part of on-going commitment and discussions.
- **Create an inclusive environment for LGBTQ+ people to work at TRFT**, through supporting community events and initiatives like Rotherham Pride and Rainbow Laces.
- Work collaboratively across teams to **implement Accessibility improvements, including Web Accessibility**, in line with Public Sector Accessibility Regulations.
- Embed EDI into the Care Group Leadership and Senior Leader appraisals; **each senior leader will have an EDI objective** measured in their appraisal.

Ahead of the launch of this plan, the Trust was proud to appoint Maysoon Shafiq as the Lead Chaplain. This marks the first time a female Muslim has held this position within the Trust.

Commenting on the role, Maysoon said,

"I have always advocated for women's rights, and this position will inspire other female Muslims who may feel hesitant or shy about applying for similar roles. I hope to be a role model and pave the way for them."

2026-2027: Embedding Inclusion

Our key priorities for 2026 to 2027 include:

- **A review of current progress on this plan**, and any additional actions required as the law and national guidance develops.
- **Reduce our Medical and Dental Workforce gender pay gap** through introducing more flexible working and ensuring efforts are made to diversify the workforce through outreach. This will link to the MRES metrics and report.
- **Launch a second disability and/or neurodiversity campaign** based on staff needs and our data.
- **Achieve a Silver Award against NW BAME Anti-Racism Assembly Framework**, to demonstrate TRFT's commitment to anti-racism and embedding this into our practice.
- Support the organisation to **create mentoring opportunities for underrepresented groups** including reverse mentoring.
- **Ensure that everyone has EDI embedded into their appraisal** and be able to explain how their work contributes to the delivery of the Integrated EDI Plan.

A picture from 2024's PROUD Awards, celebrating the achievements of our colleagues.

- Managers will have specific EDI objectives as part of their appraisal; **managers will have a SMART EDI objective,** to be measured in their appraisal.

Enablers

To achieve the outcomes and progress outlined in this plan, we recognise that there are two key components: **everyone taking responsibility for being inclusive every day**, and **providing the resources and infrastructure to enable changes to how we do things**. This includes the following enablers:

Staff Networks

Thriving staff networks are key to ensuring that our staff voices can be heard and we are responding to feedback.

Leadership Commitment

- All Directors have all have an SMART EDI objective and Executive Directors sponsor the staff networks;
- EDI objectives will be rolled out across the Trust.

Inclusive Recruitment

- A recruitment process that is accessible and inclusive to everyone who applies.
- Developing our anchor institution status, ensuring there are opportunities for local people.

Performance and Governance

We will report on our progress in the following ways:

- Workforce Race Equality Standard (WRES) and Medical Workforce Race Equality Standard (MWRES);
- Workforce Disability Equality Standard (WDES);
- EDI High Impact Actions (HIAs);
- Gender Pay Gap (GPG) and Ethnicity Pay Gap (EPG) reporting;
- EDS2 (Equality Delivery System 2);
- Staff survey metrics relating to inclusion and diversity.

Performance will be monitored, reported and led through the Care Groups and Corporate Leadership, the Executive Team, People and Culture Committee, and the Board. This plan will also help to shape director appraisal objectives.

Building a Supportive and Open Culture

We recognise that we have made progress as a Trust and there is also a lot of work ahead to deliver this plan. It is important to recognise that support is available to colleagues to ensure we care creating a supportive and open environment, where concerns can be raised, listened to and acted on. Colleagues are invited to discuss any issue with their line manager but may also choose to access support from the following teams.

Equality, Diversity and Inclusion team - The Trust's EDI team is available to support managers and colleagues. You can contact us by emailing: rgh-tr.edi@nhs.net

Freedom to Speak Up - Freedom to Speak Up is another route to share concerns, particularly if you feel you have nowhere else to go. Concerns might include; anything which gets in the way of patient care or impacts your working life; something which doesn't feel right e.g. a process which isn't being followed or behaviours of others which is impacting your wellbeing, or that of other colleagues or patients. Visit the Hub to find out who your local champion is or speak directly to the Trust's FTSU Guardian.

Thank You

A big thank you to everyone who has contributed to developing this plan. Equality, diversity and inclusion are not new to TRFT and lots of excellent work has taken place over the past few years. The new Integrated EDI Plan for 2024 to 2027 strengthens our position and commitments.

It builds on the pride and passion that we all have for our Trust by providing a framework for how we can embrace difference, provide more opportunities and continue to ensure that TRFT is a safe, fair, equal and welcoming place to work. As the Trust's Head of Organisational Development and Inclusion, I am looking forward to working with everyone to deliver this exciting plan and see the impact that we can all make together.

I would like to end with my favourite quote from the excellent author Vernā Myers, which describes in one sentence what we are trying to achieve here at TRFT –

"Diversity is being invited to the party. Inclusion is being asked to dance."

Hashim Din (he/him)

Head of OD and Inclusion,

People Team

Public Board of Directors' Meeting

Agenda item	P167/24
Report	Progress on WRES and WDES 2024
Executive Lead	Daniel Hartley – Director of People
Link with the BAF	U4: Us – there is a risk that we do not create and maintain a compassionate and inclusive culture which leads to an inability to retain and recruit staff and deliver excellent healthcare for patients
Trust Values	Delivering improvements in Equality Diversity and Inclusion supports our values of Ambitious, Caring and Together
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This paper provides oversight of the progress TRFT has made against both the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). These papers, whilst factual in terms of the data collected from ESR and the NHS Staff survey are required to be agreed by the Board and published to the Trust's website. In terms of WRES, BME representation in the workforce continues to increase across non clinical roles, clinical roles (excluding medical and dental) and the medical and dental workforce. Discrimination and harassment at work between colleagues has fallen and continues the trend which has seen the gap between BME and White colleagues narrow. However, harassment from patients and relatives has increased although the Trust is above the benchmark median for this measure. The Trust continues to support staff safety through its work on violence and aggression and sexual safety. On the WDES, the Trust continues to make small incremental improvements in representation however bullying, discrimination and harassment from patients has narrowly deteriorated from the previous year. On both measures further work on inclusive recruitment is required to address the measures of equal opportunities for promotion. For both reports progress against the last year's actions is set out and actions to improve the WRES and WDES are set out in the proposed EDI plan 2024-27, found elsewhere on this agenda.
Due Diligence	This paper has been presented to the Executive Team and People and Culture Committee in October 2024
Recommendations	It is recommended that the Board agree the WRES and WDES reports for publication on the Trust website
Appendices	Appendix 1 – WRES 2024 Appendix 2 – WDES 2024

WORKFORCE RACE EQUALITY STANDARD (WRES) ANNUAL REPORT 2024

1. Introduction.

The Workforce Race Equality Standard (WRES) is an annual mandated national reporting scheme first introduced in 2016. It uses defined indicators to measure the experience of black and minority ethnic (BME) staff against white staff, drawing on data from Electronic Staff Record (ESR), NHS Jobs and the National Staff Survey. ESR and NHS Jobs data is for the period 1 April 2023 to 31 March 2024, with snapshot data as of 31 March 2024. Staff Survey data is from the 2023 Staff Survey.

Trusts are required by the NHS Standard Contract to use this data to develop action plans aimed at reducing the gap in experience between these two groups, in line with their obligations under the Public Sector Equality Duty. For the purposes of WRES, the BME category does not include staff from white minority groups.

The report covers the statistical measures as per the WRES indicators with relevant commentary and as such is relatively dry in nature. It is important to remember that the numbers contained in the report represent real people and their experiences. Where performance has improved, there is often still a disparity between the workplace experience of BME and white staff and TRFT is committed to making significant progress in this area to ensure the Trust can provide the best possible care for patients.

2. The WRES Indicators.

1. Percentage of staff in each of the Agenda for Change (AfC) bands 1 - 9 or medical and dental subgroups and Very Senior Managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.
2. Relative likelihood of white staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.
3. Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. Relative likelihood of white staff accessing non mandatory training and CPD as compared to BME staff.
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. Percentage believing that trust provides equal opportunities for career progression or promotion.
8. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/ team leader or other colleagues
9. Percentage difference between the organisations' board membership and its overall workforce disaggregated: by voting membership and executive membership of the board.

3. Actions and progress made since WRES report 2023

A number of the actions have been implemented however some progress against last year's actions has been impacted by the gap following the departure of the previous Head of EDI in 2023 and the appointment of the new Head of OD and Inclusion who started in April 2024.

Action	Progress
Ensure that each staff network has an assigned Executive sponsor, and that supporting and advocating on behalf of the network forms part of the Executive's role	An executive sponsor has been assigned to each staff network, and one has been assigned the task of launching a new Women's network
Divisions to support and promote attendance to colleagues. To work with Staff Network chairs to improve active membership and discuss divisional contribution regularly at divisional SLT meetings	The CEO and Director of People have attended staff network meetings as have the Medical senior leadership team. The Deputy Director of People has encouraged Senior Leaders to promote the networks and encourage attendance. Ongoing promotion takes place through communications and the new HR newsletter for line managers. The new Head of OD and Inclusion is considering options to help re-launch the networks.
Work with EDI group to conduct end-to-end of analysis of candidate journey and organisational policy and practice throughout attraction and recruitment via an inclusion lens and use findings to improve recruitment (Agenda for Change and VSM)	EDI question banks for all bands has been created and is available on the staff intranet. The EDI team have been assisting senior role interviews by taking part in the stakeholder panels. 4 Restore nurses have been placed within the trust following an event for Refugees. The recruitment team is working with the Workforce Lead for Rotherham Council to bring in job candidates. The end to end analysis of recruitment has not yet taken place and this will form part of the upcoming EDI plan.
Work with services to increase the promotion of jobs with local communities at all levels including apprenticeship provision	A new Head of People Services has been recruited and is developing an improving recruitment programme, of which this will be part. The Trusts Apprentices Manager has linked expressions of interest for apprenticeship programmes to the new Study Leave process which provides improved oversight. Attendance at careers fairs has taken place, although this ad hoc. The Trust has signed up to Skills Street which will see a permanent Health and Care presence developing the brand to local school children and students from next year.

Develop and standardise induction of International Medical Graduates	A handbook to support international colleagues has been developed and the plan is to develop this further in the future as well as create a toolkit and provide further support to IMGs.
Apply for the National Pastoral Care Quality Award. Showcase a Cultural Celebration event - a chance to network, dance, sing and eat together. All IENs who have progressed their career at TRFT will be recognised with a certificate of their achievement.	The Trust received the Pastoral Care Quality award. The second Cultural celebration day took place in October 2024 and as well as been a great showcase of the heritage and diversity of our people saw celebrations of diversity across many teams throughout the day. Certificates were handed out to Internationally Educated Nurses in recognition of their hard work.
Discrimination to be a standing agenda item for violence and aggression group	This is now in place and improved approaches to tackling violence and aggression are in place including greater use of body worn cameras, stronger warnings and letters to patients that abuse staff.
Develop approach to reverse/mutual mentoring based on completion of cohort 1	Reciprocal mentoring was not continued past the initial pilot however the People team is exploring options for this with the SY ICB as part of the new EDI plan.
EDI team to continue to develop and deliver training, working with divisions and corporate areas to focus on areas and subjects where need is greatest based on WRES and WDES data and insight	Training continues to take place where requested, or if a need is identified. Training takes place around behaviours and values and cultural awareness training is delivered with teams as requested.
Embed a learning culture around people management, ensuring that lessons are learned and embedded from external and internal cases and reviews - e.g. Michelle Cox ET case	The People Team reviews the 'top 5'casework cases, and a new manager newsletter is in place to update on changes to policies or practices. Team brief and team time outs allow for more dedicated learning and development.
Board of Directors to consider recommendations from new NHSE Equality	This will be used to inform a new EDI action plan. Some of these recommendations are currently being worked on, such as the High Impact Actions.

Diversity and Inclusion plan and recommendations from National NHS Disabled Directors' Network. Refresh and develop this action plan in Q1 2024/25	
Ensure that all Non Executive Directors and the CEO have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and are assessed against these as part of their annual appraisal process	The Chair and Chief Executive have taken this forward respectively this year with support from the Director of People and objectives are being included in mid-year reviews in Q3.
Ensure that all Executive Team members and Divisional leadership teams have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and are assessed against these as part of their annual appraisal process	All Executive Directors have been given two objectives: ○ To understand and take steps to improve the experience of work for everyone in your service(s), especially people with protected characteristics where there is a negative gap (inclusion). Measure 2023 staff survey and 2024 staff survey Diversity and Equality and Inclusion sub themes. ○ To improve the diversity of your service/key service areas so that they are representative of the population of Rotherham (diversity). Measure year start and year end team demographics, especially diversity of senior leadership roles 8a+ Additionally, Executive members have either been given an objective to align and sponsor one of the staff networks, or sponsor one of the staff survey 'We said, We did' work streams.
Work with EDI team to develop and deliver divisional/directorate EDI commitments, taking into account WRES, WDES, staff survey and other relevant data on the refreshed action plan	Head of OD and Inclusion is developing an EDI information pack for each Exec Team member, providing a base-starting point to measure objectives against. Executive team will be offered 1:1 session with Head of ODWI to discuss specific issues relating to their area and consider how to operationalise commitments for their care group/corporate area.

4. WRES assessment against the national indicators

Metric 1: The composition of our workforce

TRFT employed 5143 staff as at the 31st March 2024. Of these, 15.7% (808 people) are BME, 83.2% (4278 people) are white, and 1.1% 57 do not have an ethnicity recorded on ESR. There has been an increase of approximately 1.5 percentage points in the proportion of our workforce who are BME over the last year. The ethnic diversity of our workforce varies significantly between different departments and staff groups.

(a) Our non-clinical workforce

Band / VSM / NED / Medical and Dental Breakdown	White	BME	Not Stated/ Blank	Total	% BME 2024	%BME 2023	%BME 2022
Bands 2	433	26	5	464	5.6%		
Bands 3	252	9	2	263	3.4%		
Bands 4	135	8	1	144	5.6%		
Bands 5	87	8	0	95	8.4%		
Bands 6	80	4	0	84	4.8%		
Bands 7	54	5	1	60	8.3%		
Bands 8a	47	1	0	48	2.1%		
Bands 8b	16	1	0	17	5.9%		
Bands 8c	10	0	1	11	0.0%		
Bands 8d	8	0	0	8	0.0%		
Bands 9	7	0	0	7	0.0%		
VSM/Board	9	3	0	12	25.0%		
Totals	**1138**	**65**	**10**	**1213**	**5.4%**	**4.5%**	**4.3%**

Our non-clinical workforce primarily consists of corporate staff (e.g., Finance, IT, HR), administrative staff and estates and facilities staff. As shown in the table above, there is limited ethnic diversity with a particular lack of BME staff at senior levels (other than VSM/ Board level).

(b) Our clinical workforce (excluding Medical and Dental)

	White	BME	Not Stated/ Blank	Total	% BME	2023	2022
Bands 2	604	70	1	675	9.90%		
Bands 3	333	18	2	353	5.10%		
Bands 4	196	10	0	206	4.85%		
Bands 5	494	251	10	755	33.25%		
Bands 6	744	100	8	852	11.74%		
Bands 7	370	17	5	392	4.34%		
Bands 8a	174	18	3	195	9.23%		
Bands 8b	22	5	0	27	18.52%		
Bands 8c	14	2	0	16	12.50%		
Bands 8d	7	0	0	7	0.0%		
Bands 9	1	2	0	3	66.67%		
VSM	2	0	0	2	0.0%		
Totals	**2961**	**493**	**29**	**3483**	**14.2%**	**12.6%**	**10.8%**

Our clinical workforce includes nurses and midwives, healthcare support workers, allied health professionals (e.g., physiotherapists, occupational therapists, podiatrists, dietitians, operating department practitioners, orthoptists, osteopaths, physios, radiographers), healthcare scientists and pharmacists. It is the largest section of the workforce, and there is far greater ethnic diversity within our clinical workforce than within our non-clinical workforce. Our clinical workforce is most ethnically diverse at Band 5. Whilst there is good ethnic diversity at and above Band 8B (where there are very few staff overall), BME staff are still under-represented at Bands 6-8a, both in comparison to the clinical workforce and the Trust's overall workforce, however this picture has shown some improvement over the last year. BME staff continue to be underrepresented in bands 2-4.

(c) Our Medical and Dental workforce

	White	BME	Not Stated/ Blank	Total	% BME 2024	2023	2022
Medical & Dental Staff, Consultants	77	104	5	186	55.91%		
Medical & Dental Staff, Non-Consultant career grade	52	47	8	107	43.93%		
Medical & Dental Staff, Medical and dental trainee grades	47	99	5	151	65.56%		
Medical & Dental Staff, Other	3	0	0	3	0.0%		
Totals	**179**	**250**	**18**	**447**	**55.93%**	**53.6%**	**52.4%**

Metric 2: appointment from shortlisting

The relative likelihood of white staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting in 2023/24 was 1.53, and in 2022/2023 it was 1.33.

This data shows that a white person shortlisted for a post is 1.53 times more likely to be appointed than a BME person shortlisted for the same post. This result is outside the expected range of 0.8-1.2.

Metric 3: entry into disciplinary processes

In 2023/24, BME staff were 0.69 times as likely as white staff to enter the formal disciplinary process. This is slightly outside the expected range of 0.8-1.2, however not significantly so, and indicates that BME staff continue to be proportionately slightly less likely to enter the disciplinary process than white staff. 26 staff entered the Trust's formal disciplinary process during 2023-24 – this number has increased in 2022/23 17 members of staff entered the Trust's formal disciplinary process.

Metric 4: staff accessing non-mandatory training and CPD

During 2023/24, the relative likelihood of white staff accessing non-mandatory training and CPD as compared to BME staff was 0.91. This is within the expected range of 0.8-1.2, indicating that both groups were roughly equally likely to access non-mandatory training and CPD.

Metric 5: percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months

In the 2023 staff survey, 33.7% of BME staff reported that they had experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months, compared to 22.9% of white staff. This metric has deteriorated compared to last year (28.6% in 2022), and the national benchmark median has improved by 3.5% (27.3% 2023). The Trusts performance has decreased than the benchmark median, a negative of 6.4%.

Metric 6: percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

23.4% of BME staff responding to the 2022 staff survey said that they had experienced harassment, bullying or abuse from staff in the last 12 months, compared to 16.9% of white staff. This metric has improved slightly for BME staff. The Trust continues to perform better than the benchmark median.

Metric 7: percentage believing that trust provides equal opportunities for career progression or promotion

In the 2022 staff survey, 49.3% of BME staff said that they believed the Trust provided equal opportunities for career progression, compared to 64.5% of white staff. This metric has deteriorated slightly, and the Trust is performing slightly under the benchmark median.

Metric 8: in the last 12 months have you personally experienced discrimination at work from any of the following? Manager/ team leader or other colleagues

In the 2023 staff survey, 12.8% of BME staff reported experiencing discrimination at work from managers, team leaders or other colleagues, compared to 4.1% of white staff. This metric has continued to improve for BME staff from 2022, and the Trust is performing better than the benchmark median.

Metric 9: percentage difference between the organisations' board membership and its overall workforce disaggregated: by voting membership and executive membership of the Board

15.7% of the Trust's overall workforce is BME. As of 31 March 2024, 15.8% of the Board was BME, 21.4% of voting Board members were BME and 0% of Executive Board members were BME. It should be noted that WRES data only includes staff on the Trust's payroll, and as of 31st March 2024, TRFT shared one Executive Board member with Barnsley Hospitals NHS FT – the Chief Executive, the Chief Executive is on Barnsley's payroll, and so is not included in TRFT's WRES data. As of 31st March 2024, 23.0% of the Trust's Non-Executive Directors were BME.

5. Conclusion

BME representation within the Trust's workforce continues to increase, with most progress being made in clinical areas. This increase has been significantly supported by international recruitment and more work is required to address the underrepresentation of the BME population within the Trust's workforce, with a particular focus on diverse local recruitment.

This year has seen improvements for metric 8 but there has been a deterioration in metric 5 and the Trust is now under the median benchmark. However, the Trust is performing better than the benchmark median on WRES metrics 6 and 8 relating to staff experience and there are still significant opportunities for further improvement. These improvements are essential to deliver on the Trust's ambition for 'Us' – 'we will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work'. Only by achieving that ambition will we be able to provide the best possible care for patients.

6. Next steps

The new Trust EDI plan 2024-2027 contains actions to address WRES indicators and an annual review of progress will be reported each year.

WORKFORCE DISABILITY EQUALITY STANDARD (WDES) ANNUAL REPORT 2024

1. Introduction

The Workforce Disability Equality Standard (WDES) is an annual mandated national reporting scheme first introduced in 2019. It uses defined indicators to measure the experience of Disabled staff against Non-disabled staff, drawing on data from ESR, NHS Jobs and the National Staff Survey. ESR (Electronic Staff Record) and NHS Jobs data is for the period 1 April 2023 to 31 March 2024, with snapshot data as at 31 March 2024. Staff Survey data is from the 2023 Staff Survey. Trusts are required to use this data to develop action plans aimed at decreasing the gap in experience between Disabled and non-disabled staff.

Whilst 5.5% of the Trust's staff have declared a disability on ESR (an increase from 5% last year), approximately 24% of staff survey respondents answered "yes" to the question: "Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?" Although the staff survey question is not entirely analogous to the definition of disability, as it does not ask about impact on daily life, the staff survey results are suggestive of continued significant under-reporting of disability via ESR, which is replicated nationally.

2. The WDES Indicators

1. Percentage of staff in each of the AfC bands 1 - 9 or medical and dental subgroups and VSM (including Board members) compared with the percentage of staff in the overall workforce.
2. Relative likelihood of non-disabled staff being appointed from shortlisting compared to that of Disabled staff being appointed from shortlisting across all posts
3. Relative likelihood of Disabled staff entering the formal capability process, compared to that of non-disabled staff entering the formal capability process, as measured by entry into a formal capability process
4. a) i) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

   ii) Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months

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

   b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.
5. Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

8. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

9. a) The staff engagement score for Disabled staff, compared to non-disabled staff.

   b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)

10 Percentage difference between the organisations' board membership and its overall workforce disaggregated: by voting membership and executive membership of the Board.

3. Actions and progress made since WDES report 2023

A number of the actions have been implemented however some progress against last year's actions has been impacted by the gap following the departure of the previous Head of EDI in 2023 and the appointment of the new Head of OD and Inclusion who started in April 2024.

Action	Progress
Ensure that each staff network has an assigned Executive sponsor, and that supporting and advocating on behalf of the network forms part of the Executive's role	A Director sponsor has been assigned to each staff network, and one has been assigned the task of launching a new Women's network
Divisions to support and promote attendance to colleagues. To work with Staff Network chairs to improve active membership and discuss divisional contribution regularly at divisional SLT meetings	The CEO and Director of People have attended staff network meetings as have the Medical senior leadership team. The Deputy Director of People has encouraged Senior Leaders to promote the networks and encourage attendance. Ongoing promotion takes place through communications and the new HR newsletter for line managers. The new Head of OD and Inclusion is considering options to help re-launch the networks.
Work with EDI group to conduct end-to-end of analysis of candidate journey and organisational policy and practice throughout attraction and recruitment via an inclusion lens and use findings to improve recruitment (Agenda for Change and VSM)	EDI question banks for all bands has been created and is available on the staff intranet. The EDI team have been assisting senior role interviews by taking part in the stakeholder panels. 4 Restore nurses have been placed within the trust following an event for Refugees. The recruitment team is working with the Workforce Lead for Rotherham Council to bring in job candidates. The end to end analysis of recruitment has not yet taken place and this will form part of the upcoming EDI plan.

Work with services to increase the promotion of jobs with local communities at all levels including apprenticeship provision	A new Head of People Services has been recruited and is developing an improving recruitment programme, of which this will be part. The Trusts Apprentices Manager has linked expressions of interest for apprenticeship programmes to the new Study Leave process which provides improved oversight. Attendance at careers fairs has taken place, although this ad hoc. The Trust has signed up to Skills Street which will see a permanent Health and Care presence developing the brand to local school children and students from next year.
Develop improved information to support disabled candidates and disabled staff	Draft guidance to support employing and recruiting disabled colleagues has been created. This is currently being reviewed, and will be launched and added to The Hub. The EDI Team can also support training sessions on disability and work with members of staff and managers to ensure reasonable adjustments are made.
Discrimination to be a standing agenda item for violence and aggression group	This is now in place and improved approaches to tackling violence and aggression are in place including greater use of body worn cameras, stronger warnings and letters to patients that abuse staff.
Develop approach to reverse/mutual mentoring based on completion of cohort 1	Reciprocal mentoring was not continued past the initial pilot however the People team will explore options for this with the SY ICB as part of the new EDI plan.
EDI team to continue to develop and deliver training, working with divisions and corporate areas to focus on areas and subjects where need is greatest based on WRES and WDES data and insight	Training continues to take place where requested, or if a need is identified. Training takes place around behaviours and values and cultural awareness training is delivered with teams as requested.
Embed a learning culture around people management, ensuring that lessons are learned and embedded from external and internal cases and reviews - e.g. Michelle Cox ET case	The People Team reviews the 'top 5'casework cases, and a new manager newsletter is in place to update on changes to policies or practices. Team brief and team time outs allow for more dedicated learning and development.

Board of Directors to consider recommendations from new NHSE Equality Diversity and Inclusion plan and recommendations from National NHS Disabled Directors' Network. Refresh and develop this action plan in Q1 2024/25	This will be used to inform a new EDI action plan. Some of these recommendations are currently being worked on, such as the High Impact Actions.
Ensure that all Non Executive Directors and the CEO have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and are assessed against these as part of their annual appraisal process	The Chair and Chief Executive have taken this forward respectively this year with support from the Director of People and objectives are being included in mid-year reviews in Q3.
Ensure that all Executive Team members and Divisional leadership teams have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and are assessed against these as part of their annual appraisal process	All Executive Directors have been given two objectives: ○ To understand and take steps to improve the experience of work for everyone in your service(s), especially people with protected characteristics where there is a negative gap (inclusion). Measure 2023 staff survey and 2024 staff survey Diversity and Equality and Inclusion sub themes. ○ To improve the diversity of your service/key service areas so that they are representative of the population of Rotherham (diversity). Measure year start and year end team demographics, especially diversity of senior leadership roles 8a+ Additionally, Executive members have either been given an objective to align and sponsor one of the staff networks, or sponsor one of the staff survey 'We said, We did' work streams.
Work with EDI team to develop and deliver divisional/directorate EDI commitments, taking into account WRES, WDES, staff survey and other relevant data on the refreshed action plan	Head of OD and Inclusion is developing an EDI information pack for each Exec Team member, providing a base-starting point to measure objectives against. Executive team will be offered 1:1 session with Head of ODWI to discuss specific issues relating to their area and consider how to operationalise commitments for their care group/corporate area.

4. WDES assessment against national indicators

Metric 1

Percentage of staff in each of the AfC bands 1 - 9 or medical and dental subgroups and VSM (including Board members) compared with the percentage of staff in the overall workforce.

Clinical / Non Clinical	Band	Disabled	Non-disabled	Unknown	Total	% 2024 Disabled	% 2023 Disabled
Non Clinical	Band 2	29	371	62	460	6.3%	5%
	Bands 3	14	227	22	263	5.3%	5%
	Bands 4	6	124	14	144	4.2%	3%
	Bands 5	9	80	6	95	9.5%	11%
	Bands 6	7	70	7	84	8.3%	7%
	Bands 7	10	48	2	60	16.7%	7%
	Bands 8a	1	46	1	48	2.1%	8%
	Bands 8b	0	16	1	17	0.0%	7%
	Bands 8c	0	11	0	11	0.0%	10%
	Bands 8d	0	7	1	8	0.0%	0%
	Bands 9	0	6	1	7	0.0%	0%
	VSM	0	7	5	12	0.0%	0%
	Other	0	2	0	2	0.0%	0%
Clinical	Bands 2	27	592	56	675	4.0%	4%
	Bands 3	20	307	26	353	5.7%	3%
	Bands 4	10	183	13	206	4.9%	3%
	Bands 5	39	673	43	755	5.2%	5%
	Bands 6	60	732	60	852	7.0%	7%
	Bands 7	21	342	29	392	5.4%	5%
	Bands 8a	9	163	23	195	4.6%	5%
	Bands 8b	3	23	1	27	11.1%	7%
	Bands 8c	0	14	2	16	0.0%	0%
	Bands 8d	2	5	0	7	28.6%	22%
	Bands 9	0	3	0	3	0.0%	0%
	VSM	0	1	1	2	0.0%	0%
	Other	0	1	2	3	0.0%	0%
Medical and Dental	M&D Staff - Consultants	5	159	22	186	11.8%	3%
	M&D Staff Non-consultants career grade	5	87	15	107	4.6%	1%
	M&D staff, trainee grades	5	139	7	151	14.0%	5%
Grand Total		Disabled	Non-disabled	Unknown	Total	% 2024 Disabled	% 2023 Disabled
		282	**4439**	**422**	**5143**	**5.5%**	**5%**

Due to the relatively small numbers of staff who have declared a disability, it is useful to analyse this data utilising the banding clusters used within the WDES reporting template, as below.

Staff type	Band / VSM / NED / M&D Breakdown	% Disabled	% Non-Disabled	% Unknown	Total
Non-Clinical	Cluster 1: AfC Bands 2 to 4	5.6%	83.1%	11.3%	869
	Cluster 2: AfC bands 5 to 7	10.9%	82.8%	6.3%	239
	Cluster 3: AfC bands 8a and 8b	1.5%	95.4%	3.1%	65
	Cluster 4: AfC bands 8c to VSM	0.0%	81.6%	18.4%	38
	Total Non-Clinical	**6.3 %**	**83.7%**	**10.1%**	1213
Clinical	Cluster 1: AfC Bands 2 to 4	4.6%	87.7%	7.7%	1234
	Cluster 2: AfC bands 5 to 7	6.0%	87.4%	6.6%	1999
	Cluster 3: AfC bands 8a and 8b	5.4%	83.8%	10.8%	222
	Cluster 4: AfC bands 8c to VSM	7.1%	82.1%	10.7%	28
	Total Clinical	**5.5%**	**87.2%**	**7.3%**	**3377**
Medical and Dental	M&D- Consultants	2.7%	85.4%	11.8%	186
	M&D- Non-Consultant career grade	4.7%	81.3%	14.0%	107
	M&D- trainee grades	3.3%	92.1%	4.6%	151
	Total Medical and Dental	**3.4%**	86.7%	9.91%	444
Totals	**Number of staff in workforce**	**5.5%**	**86.3%**	**8.2%**	**5143**

There has been a slight decrease in the number of "unknown" individuals across all staff groups, reducing from 9.0% to 8.2% over the last year. Declared disability rates among medical and dental trainees has improved from 0.7% to 3.3%. The proportion of disabled staff within the medical and dental workforce remain lower than the rest of the Trust. The Trust continues to have no Board members with a declared disability.

Metric 2

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.

The Trust offers a guaranteed interview scheme and is a Disability Confident Employer. In 2023-24, the Trust shortlisted 212 disabled candidates, and 36 disabled people were appointed to roles within the Trust.

The relative likelihood of non-disabled candidates being appointed from shortlisting compared to that of disabled candidates being appointed from shortlisting was 1.45 – i.e. non-disabled candidates were 1.45 times more likely than disabled candidates to be appointed once shortlisted. This has declined from 1.26 in 2023. The 36 disabled people appointed to roles within the Trust in 2022-23 represent 4.4% of total new hires.

Metric 3

Relative likelihood of disabled staff entering the formal capability process, compared to that of non-disabled staff entering the formal capability process, as measured by entry into a formal capability process.

This metric is based on a two-year period. During 2022-2024, 27 staff entered formal capability processes. Of these, 18 staff members were not disabled, 6 had not stated whether they had a disability, and 4 were disabled. Of the 17 staff members entering the capability process on the grounds of ill-health, 2 were disabled, 11 were not disabled and 4 had not declared disability.

The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is calculated at 2.24 – i.e. disabled staff are 2.24 times more likely to enter the formal capability process than non-disabled staff. This metric is very slightly higher compared to last year, however it should be treated with caution due to the very low numbers involved when calculating this.

Metric 4

Harassment, bullying and abuse.

Data in this section is taken from the Trust's 2023 staff survey results.

(a) (i) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months

29.77% of Disabled staff reported experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months (non-disabled 24.76%). This metric has improved for Disabled staff by 0.99%, but has deteriorated by 1.88% for non-disabled staff.

(ii) Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months

8.55% of disabled staff reported experiencing harassment, bullying or abuse from managers in the last 12 months (non-disabled 6.01%). This metric has improved for disabled staff (improved by 3.25% compared to 2022) and worsened slightly for non-disabled staff (by 0.18% compared to 2021). The gap in experience between disabled and non-disabled staff has decreased to 2.5%, whilst in 2022 it was 6%.

(iii) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

18.39% of disabled staff reported experiencing harassment, bullying or abuse from other colleagues in last 12 months (11.99% non-disabled). This metric has improved for disabled staff 3.30%, and for non-disabled staff 0.51%. The gap in experiences has also decreased from 9.19% to 6.44%

(b) Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

57.75% of disabled staff said that they or a colleague had reported their last experience of harassment, bullying or abuse at work (non-disabled 51.22%). This metric has improved sharply for disabled colleagues, with a rise of 12.55% and improved for non-disabled

colleagues with a rise of 1.13%. Disabled staff are more likely to report harassment, bullying and abuse, with a gap in scores of 6.53% The Trust is performing better than the national median benchmark in the experience of harassment bullying and abuse WDES metrics.

Metric 5

Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.

In the Staff Survey, 63.66% of non-disabled staff felt that the Trust provided equal opportunities for career progression, in comparison to 59.37% of disabled staff. This has increased very slightly or disabled staff, and the gap in experience between the two groups has reduced slightly to 4.29%. Both these figures are above the national benchmark.

Metric 6

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

25.82% of disabled respondents to the staff survey said that they had felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (non-disabled 20.36%). This metric has improved for both groups, but more significantly for disabled staff (by 3.08% compared to 2022).

The Trust's performance on this metric is slightly worse than the national benchmark for disabled staff, but around the same as the benchmark overall.

Metric 7

Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

43.47% of disabled staff report feeling satisfied or very satisfied with the extent to which the Trust values their work, in comparison to 51.42% of non-disabled staff. This metric has considerably improved for both groups; 7.79% for disabled staff, and 5.01% for non-disabled staff. The gap between both groups has reduced by 2.78%. The figure for disabled staff is slightly below the benchmark median, but the overall score is above.

Metric 8

Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

79.8% of disabled staff responding to staff survey said that the Trust had made adequate adjustments to enable them to carry out their work, slightly decreasing by 1% from 2022. The Trust remains significantly above the national benchmark.

Metric 9

(a) The staff engagement score for disabled staff, compared to non-disabled staff.

The staff engagement score for disabled staff was 6.8, and the score for non-disabled staff was 7.05. This is a increase for both groups, with an increase of 0.47 for disabled staff and 0.09 for non-disabled staff, narrowing the gap in experience slightly. These scores are both approximately equal to the national benchmark score of 6.91.

(b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)

Yes. The Trust has a Disability Staff Network, which is sponsored by the senor leadership team and has an Executive Director sponsor . The Staff Network has a defined role and terms of reference. The CEO has attended the Disability Staff Network to listen to views of disabled colleagues.

Metric 10

Percentage difference between the organisations' board membership and its overall workforce disaggregated: by voting membership and executive membership of the Board.

The Trust has no Board members who have declared that they are disabled, therefore there is a 5.5% difference between the Trust's Board membership and its overall workforce. This gap has increased slightly since last year.

5 Conclusion

This year's data suggests that there have been some improvements in the experience of disabled staff in the Trust overall, with a large improvement in staff reporting harassment, discrimination or abuse from colleagues. However, a gap in experience between disabled and non-disabled colleagues still remains. There are slightly more disabled staff in the workforce than last year, however this increase is mainly seen in staff below band 7, with a reduction in disabled staff at bands 8a and above. There is also no member of the Board with a declared disability. Reflecting the diversity of the patient population would help to deliver both inclusive care for patients and an inclusive workforce, which is a key part of the new People and Culture Strategy of the Trust.

6 Next Steps

The new Trust EDI plan 2024-2027 contains actions to address WRES indicators and an annual review of progress will be reported each year.

Board of Directors' Meeting
8 November 2024

Agenda item	P168/24
Report	**Sexual Safety Update**
Executive Lead	Helen Dobson / Daniel Hartley
Link with the BAF	U4: Us – there is a risk that we do not create and maintain a compassionate and inclusive culture which leads to an inability to retain and recruit staff and deliver excellent healthcare for patients
How does this paper support Trust Values	**Ambitious**: Ensuring the Trust is meeting targets in relation to new sexual safety legislation requirements but more importantly that this is done in a compassionate way taking account of the individual's feelings. **Caring:** Ensuring our colleagues are fully aware that they will be supported in raising sexual safety concerns. **Together:** Managers and colleagues to work together to ensure that all sexual harassment is reported and investigated and that everyone is supported during this process and that continuous improvements are made to minimise this happening.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The paper is sharing the current requests from NHS England plus an update of current status in relation to the work being undertaken in relation to sexual safety. The Trust has signed up to the NHSE sexual safety charter that promotes the healthcare system working together to tackle unwanted and inappropriate/harmful sexual behaviours in the workplace. NHS England » Sexual safety in healthcare – organisational charter Following changes in legislation relating to sexual safety in the workplace, NHSE have asked all Trusts and ICBs to appoint a domestic abuse and sexual violence (DASV) lead. The Chief Nurse has undertaken this role. This request is further supported by NHSE who have developed a number of materials, template policy and training package for organisations to consider. TRFT have adopted the principles in these documents and launched an awareness campaign this month. This is jointly led by the Chief Nurse and Director of People with the aim of both meeting the national requirements but also, improving working conditions for our teams.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper was discussed at ETM on 24 October 2024; and a presentation with similar content shared at the Trust's senior leaders meeting, 31 October 2024. It is also due to be presented at the Operational workforce Group (OWG) in November 2024.

Board powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Chief Nurse and Director of People will lead the work to improve sexual safety at TRFT and will update the Board of Director's quarterly on progress.
Recommendations	The Board of Directors' are asked to formally support the principles of the NHSE Sexual Safety Charter and the work being undertaken internally to promote and uphold this.
Appendices	None

1. The Sexual Safety Charter

The Sexual Safety Charter was launched by NHS England in September 2023. It seeks to ensure that support will be provided to NHS staff who have suffered harassment or inappropriate behaviour. It includes 10 pledges that organisations including TRFT have made.

	Sexual Safety Charter – Organisational Pledge
1	We will actively work to eradicate sexual harassment and abuse in the workplace.
2	We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3	We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4	We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5	We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6	We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7	We will ensure appropriate, specific, and clear training is in place.
8	We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9	We will take all reports seriously and appropriate and timely action will be taken in all cases.
10	We will capture and share data on prevalence and staff experience transparently.

These commitments will apply to everyone in our organisation equally.

2. Planning Guidance 2024/25

The NHS Operational planning guidance 2024/25 asks all organisations to implement the actions set out to improve safety at work by having:

Planning Guidance – 2024/25 priorities	TRFT Status
Policies on both sexual misconduct and domestic abuse developed by an expert advisory group including trade union representation.	
Training materials, including on how to respond appropriately to disclosures of sexual misconduct or abuse.	
Improved support offers for staff	
A toolkit signposting to sources of further support following a disclosure	

3. TRFT - Current Situation

There is commitment from the Executive Team to fulfil the pledges set out in the Charter above, and TRFT signed up to the charter earlier in the year.

Those who work, train and learn within the healthcare system / TRFT have the right to be safe and feel supported at work. Organisations across the healthcare system need to work together and individually to tackle unwanted, inappropriate and / or harmful sexual behaviour in the workplace.

We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.

Sexual Safety - TRFT Action(s) & Update 2024/25	TRFT Status
Policy on domestic abuse in place - which includes support for staff.	✓
Policy on sexual misconduct is included in the bullying and harassment policy.	✓
A new Allegation policy has been approved and is currently awaiting document ratification - this includes a standardised approach to all allegations and identifies sexual misconduct within the policy as one of the examples. The new Allegation policy has been shared with relevant stakeholders; the Patient Experience Team, People Team and with Safeguarding who are finalising it through the appropriate governance route.	✓
Training for 50 staff has been funded through CPD application and dates are arranged: • Tuesday 10 December 2024 (which coincides with the international 16 days of action campaign) and • Thursday 13 March 2025.	✓
The training is being provided by Safer Places and will include: **(i)** Sexual Harassment in the workplace (in line with new legislation). **(ii)** Active Bystander (what we as individuals can safely do if we observe it) **(iii)** Sexual Safety. Spaces for the 50 will be shared across all Care Groups and the training is initially being aimed at team manager/ward and leadership/matron level as these are in a position where concerns & allegations are heard and potentially not being identified. There will be some opportunities for a small number of other colleagues to attend. A Trust wide training needs analysis will be developed.	✓
The new NHSE e-learning package is being added to ESR. No decision has yet been made as to whether this should become 'essential' training but staff will be able to access it whilst the decision is being considered.	✓
Support to colleagues is currently available via the Employee Assistance Programme, Safeguarding Team and the Health and Well-being Team	✓
A toolkit is not currently in place for managers supporting staff following a disclosure. This will be developed.	−

4. Other Supporting Activity

An all-user email was communicated w/c 28 October to launch the Sexual Safety campaign internally at TRFT. The four poster designs are shown below for your reference. **See Appendix 1**

4.1 Posters

Snap shots of the posters key messages are shown below. QR codes are on the posters which take you to the sexual safety tile on the Hub which will be refreshed to take account of the new legislation and supporting materials.

4.2 The Hub

A sexual safety tile has been created on the Hub, this has the policies, how to raise a concern (including line manager, police, FTSUG, HR, Safeguarding team), and details of the support options. Once the training has been completed, names of those that have attended will be included as 'champions/ambassadors' as alternative people for staff to speak up to.

4.3 We said, We did

Sexual safety is one of the key priorities from the 2023 national staff survey and will be promoted as part of this year's "we said, we did" NSS communication campaign with specific messages being highlighted w/c 28 October 2024.

In last year's survey, 8% of people responded yes to the question have you been the target of unwanted behaviour of a sexual nature in the workplace from patients/service users, their relatives or other members of the public which is near the national average. 2% of people responded yes to the same question but from staff/colleagues which whilst above average (i.e. better than most Trusts) is 2% too many.

This was re-enforced at the senior leaders meeting on 31 October 2024 where the Executive leads used part of the session to discuss sexual safety and the role of senior leaders in supporting this work.

A further 'we said / we did' all-user email will be issued to support our Staff Survey campaign on w/c 04 November 2024 in relation to violence and aggression, which could include a supporting video featuring the Chief Operating Officer.

4.4 New Legal Duty to Prevent Sexual Harassment

- From 26 October 2024 there is a new duty on employers to take reasonable steps to prevent sexual harassment.
- The Worker Protection Act comes into force.

- The Equality & Human Right Commission is updating the 2020 technical guidance on sexual harassment.

5. Summary

All of the actions contained in the above sections are to support and protect the organisation in identifying, reporting and appropriately dealing with allegations of sexual harassment in the workplace.

TRFT as a signatory to the sexual safety charter commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the 10 pledges and to the actions already being implemented but will continue to work with stakeholders across the system, at TRFT and with all colleagues to minimise this risk.

Board of Directors' Meeting
8 November 2024

Agenda item	P169/24
Report	**Freedom to Speak up Guardian Quarter 2 update**
Executive Lead	Helen Dobson, Executive Chief Nurse
Link with the BAF	U4: There is a risk that we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.
How does this paper support Trust Values	Promoting a culture of Speaking up within TRFT supports all three of the Trust values of ambitious, Caring and Together
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	To provide the Board of Directors with an update of the concerns which have been raised through the Freedom to Speak up Guardian and the themes which have been raised through the Freedom to Speak up Champions To provide an update of how the profile of the Speaking up agenda is being raised and embedded within The Rotherham NHS Foundation Trust. **<u>Summary of Key Points:</u>** The key points arising from the report are • Increase in number of staff raising concerns • Increase in Champion representation across care groups and staff groups • National Freedom to Speak up Policy for the NHS available on the internal and external website • Positive feedback received from concerns closed in Q2
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report was presented at People Committee on 25 October 2024 prior to being submitted to the Board of Directors' Meeting.
Board powers to make this decision	N/a

Who, What and When (what action is required, who is the lead and when should it be completed?)	No further action required from the Board of Directors
Recommendations	It is recommended that the Trust Board note the Q2 report.
Appendices	Freedom to Speak Up Policy **(In the review room)**

1. Introduction

1.1 The National Guardian's Office and the role of the Freedom to Speak Up (FTSU) Guardian were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015). The aim of FTSU Guardian (FTSUG) is to help create a culture of openness within the NHS, where staff are encouraged to speak up, their voices heard, lessons are learnt and care improves as a result. The FTSUG's responsibility is to ensure workers can speak up about any issues impacting on their ability to do their job

1.2 The Trust introduced FTSUG in 2015, with a Lead FTSU Guardian appointed in October 2016.

2. Background

2.1 The report aims to provide the People Committee with a high-level overview of the activity undertaken by the FTSUG during quarter two 2024, highlighting the number of concerns raised, actions taken and resultant learning**.**

2.2 FTSU will help our organisation deliver on the People Promise for workers, by ensuring they have a voice that counts, and by developing a speaking up culture in which leaders and managers value the voice of their staff as a vital driver of learning and improvement.

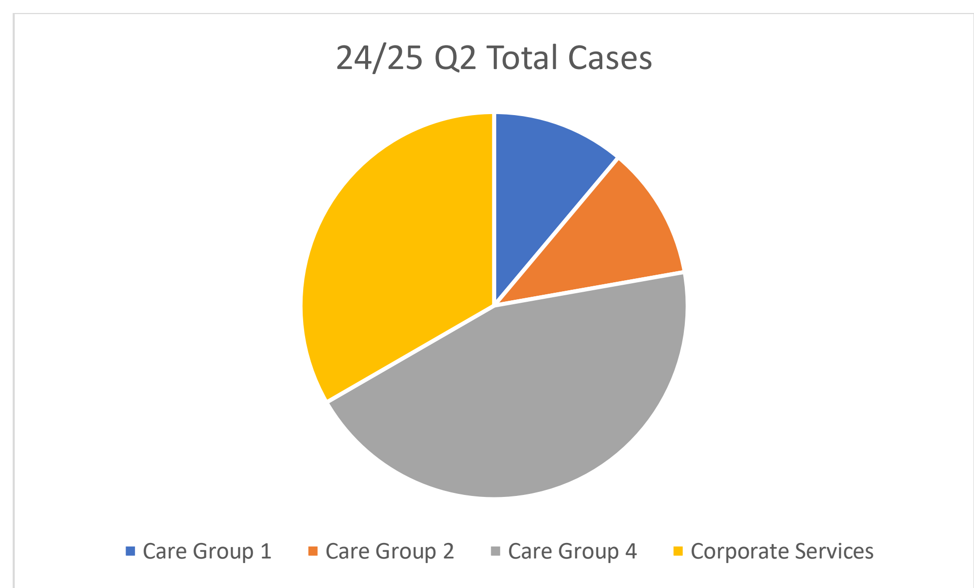
3. Policy, Reporting and Governance

3.1 The NGO in collaboration with NHSE developed a National FTSU policy template. All NHS organisations are required to adopt the national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. The Policy was approved at Operational Workforce Group and Joint Partnership Forum in July prior to being ratified at the Trust's Document Ratification Group in August 2024. The National Policy is available on TRFT's internal and external web page and can be seen in Appendix 1.

3.2 The Lead FTSUG has remained the responsibility of the Chief Nurse. The lead role with increased hours to 0.6 WTE has been in post since March 2024. Since March in line with recommendations from the National Guardian's Office (NGO) the FTSU Lead role is a standalone role.

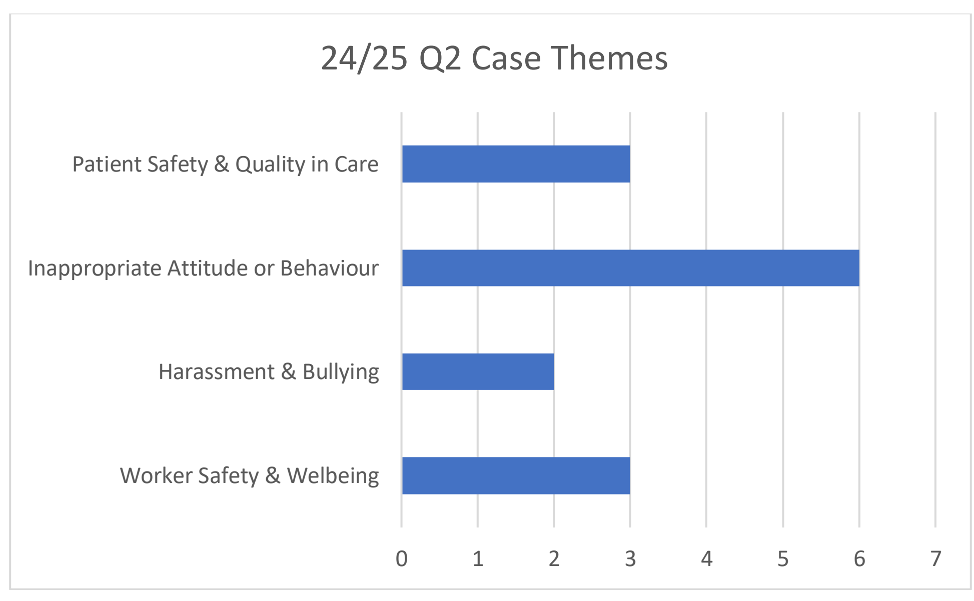
3.3 During this reporting period nine concerns have been raised directly with the FTSUG, with 4 of the 9 concerns raised from within Care Group 4 as shown in Figure 1.

Figure 1



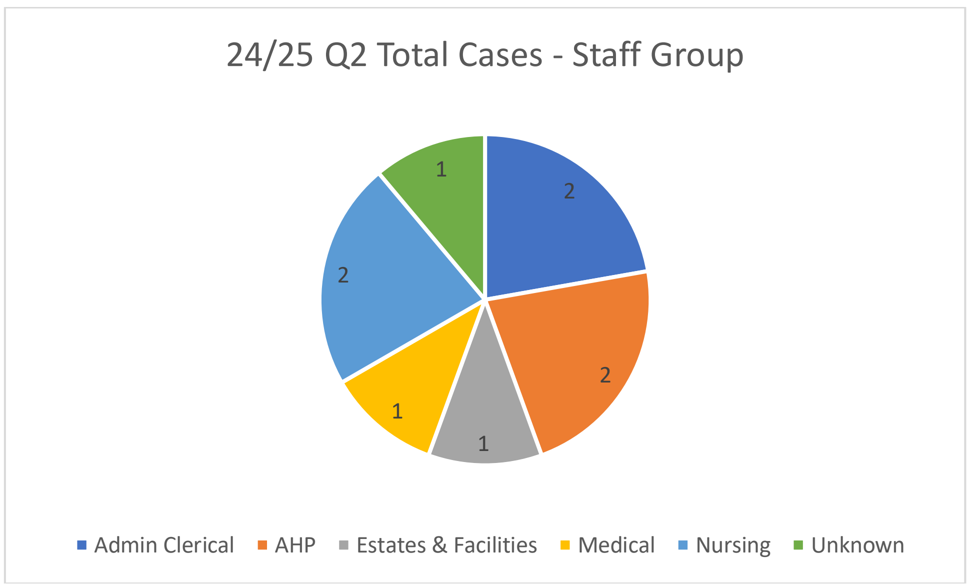
3.4 A breakdown of the themes underpinning the concerns can be seen in Figure 2. Each concern raised with The FTSUG may have multiple themes associated with that concern, therefore the number of themes will exceed the total number of cases reported. Inappropriate attitudes and behaviours was a common theme found in 6 of the 9 cases reported. 4 of the concerns have now been closed and resolution has been achieved for the individuals that have raised the concerns.

Figure 2



3.5 Figure 3 represents the number of concerns raised across staff groups within the Trust. The concerns raised across the staff groups demonstrates representation across a number of the staff groups within the Trust. Of the 9 concerns raised with the FTSUG, 2 were anonymously reported, with 1 of the concerns being completely anonymous and the individual not wishing to disclose their staff group.

Figure 3



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

3.7 The Trust has an overall compliance rating of 83.03% which is an increase from Q1 of 79.93% for FTSU Mast e-learning training. Corporate being the only Care Group below the Trust target of 85%, with performance of 63.72%. This is a focus for the FTSUG, who has raised the recent fall in compliance with the SLT.

	Freedom to Speak Up - for all workers MAST
Care Group	**Sum of % Compliance**
Care Group 1	**86.09%**
Care Group 2	**91.00%**
Care Group 3	**87.44%**
Care Group 4	**86.90%**
Corporate	**63.72%**
Grand Total	**83.03%**

4 Summary of FTSU Concerns for TRFT

4.1 It remains difficult to identify common themes and trends across the quarterly concerns raised as the number of concerns is low despite an increase from Q1. Inappropriate attitudes and behaviours has been identified in a third of the concerns raised in Q2, however there is no pattern across staff groups or care groups.

5. Feedback following Raising a FTSU concern

5.1 It continues to be a challenge to get feedback from staff who have raised concerns via the questionnaires, there is a reluctance to respond once the concerns have been addressed. Feedback forms were sent to the 3 of the 4 cases resolved in Q2, 2 questionnaires were returned to the FTSUG. The feedback received was positive with both individuals stating that they would use FTSU again in the future. The feedback also stated that they had heard of FTSU from a variety of methods including, word of mouth, posters and the HUB page. They found the service easy to access and reported that their concerns had been dealt with appropriately and that they felt listened too.

6. Raising the Profile of FTSU within TRFT and Champion Network

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

The promotional material produced in Q2 includes:

- ‘Speak up to me’ posters distributed throughout the Trust and Community Settings.
- HUB updates have been completed on FTSU with Guardian and Champion contact details updated and Champion posters
- The Staff App has been updated with the relevant contact details for the FTSUG

6.2 The activities relating to increasing FTSU visibility can be seen in the table below:

Date	Area	Method of delivery	Participants	Staff Group	Quarter
01/08/2024	UECC Handover	Face to face	20	Nursing, domestic staff, HCSW, Student Nurses, Nursing Associates	2
01/08/2024	UECC Medical Handover	Face to face	8	Medic's, ANP's	2
27/08/2024	Community Service Leads Meeting	Face to face	7	Nursing, AHP's	2
30/08/2024	Neonatal Unit	Face to face	5	Nurses, HCSW, Nursery Nurses	2
03/09/2024	Employee Relations Team meeting	Face to face	9	HR BP, HR advisors General managers	2
03/09/2024	Matron's meeting	Face to face	7	Matron's	2
09/09/2024	Therapies & Dietetics Governance meeting	Face to face	13	Service Leads AHP's,	2
19/09/2024	Disability Staff Network	Virtual	8	Mixed staff group	2

6.3 In addition to the lead guardian, there are 11 Freedom to Speak Up Champions within the Trust. The Champions provide representation across the Care Groups, with the recruitment of 5 new Champions from the Medical, Nursing, AHP Admin and Clerical staff groups. The recruitment process for new Champions is on-going with new interest in the role continuing to increase as the profile raises across the Trust. The FTSUG is looking to increase the number of Champions to 20 which is aligned to other local and similar sized organisations. Although there is Champions representation across the care groups, the FTSUG would like to increase the champion profile to provide a more reflective representation of TRFT staff demographics, ensuring that Champions represent the workforce population and staff groups with protected characteristics.

6.5 The FTSU Champions' have highlighted the role and associated agenda through various forums and local area staff meetings. The FTSUG has at the request of a number of Champion's attended local area meetings to assist in raising the FTSU profile and to address local concerns. The FTSUG lead is continuing to work with the OD&I Lead to increase awareness amongst all staff groups and embed a FTSU culture across the organisation.

7. National Guardian Office Data

7.1 The Trust has submitted data on a quarterly basis to the National Guardians Office. Quarter 1 data for FY 2024/25 has been submitted, Q2 data is due to be submitted at the end of this month.

8. TRFT Comparison with National Data

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

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

9. National Guardian Office Case Reviews

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

10. Conclusion

10.1 The number of cases for Q2 (9) have increased in comparison to Q1 (3), the FTSUG feels it is worth noting that the increase in concerns raised is reflective of a positive reporting culture. The increase in cases is aligned with the work undertaken by the FTSUG and Champions in raising awareness of the FTSU. Data for Q3 indicates a movement towards an increase in the number of concerns raised. This is a signal of a positive FTSU culture and an increasing awareness of how to speak up, promoting

an environment where staff feel encouraged to raise concerns. The responses to the staff survey are extremely encouraging and the FTSUG and Champions will continue to promote a positive speaking-up culture, to prevent harm and improve outcomes for both colleagues and patients.

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

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

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Board of Directors' Meeting
8 November 2024

Agenda item	P170.24
Report	**National, Integrated Care Board and Rotherham Place Update**
Executive Lead	Michael Wright, Managing Director
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 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: The Chancellor has confirmed an additional £22.6 billion for day-to-day spending over two years for the Department of Health and Social care, supporting the NHS to deliver an extra 40,000 elective appointments per week, delivering on one of the Government's first aims in office to reduce waiting times in the NHS. New NHS data shows there has been 1.2 million more accident and emergency (A&E) attendances so far this year compared to the same period before the pandemic, as the NHS ramps up its preparations for winter. The Trust was represented at the most recent meeting of the Health Select Commission, at which the Chief Operating Officer, Chief Nurse and Managing Director presented the Trust's Annual Report for 2023/24. Attendance at this forum continues to provide the Trust with important feedback on the local population's views on how services are run and can be improved. Positive feedback is also received.
Due Diligence (include the process the paper has gone through prior to presentation at	The Executive Team receives a weekly verbal update covering key Place and South Yorkshire Integrated Care Board (SYICB) level activities in addition to specific papers periodically, as and when required.

Board of Directors' meeting)	
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Board note the content of this paper.
Appendices	1. Rotherham Place Partnership Update September and October 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 The Chancellor has confirmed an additional £22.6 billion for day-to-day spending over two years for the Department of Health and Social care, supporting the NHS to deliver an extra 40,000 elective appointments per week, delivering on one of the Government's first aims in office to reduce waiting times in the NHS

2.2 New NHS data shows there have been 1.2 million more accident and emergency (A&E) attendances so far this year compared to the same period before the pandemic, as the NHS ramps up its preparations for winter. The huge pressure on services saw many patients waiting too long for care, with four-hour performance remaining below the constitutional standard of 95%.

NHS staff in A&E experienced their busiest ever September with 2.21 million attendances, and 530,824 emergency admissions. This followed the NHS' busiest summer on record.

There have been 20.4 million A&E attendances so far this year (Jan to Sep), 1.2 million more than the same year pre-pandemic (19.14 million in 2019).

The continued surge in demand for services comes after the NHS set out its winter plan last month, which includes around-the-clock system control centres, better reporting of long patient delays, and more care in the community including falls services, virtual wards and same day emergency care.

The data also shows the total waiting list rose in August by 18,614 to 7.64 million, while the estimated number of patients rose by 30,000 to 6.42 million. Only 58.3% of patients had been waiting less than 18 weeks, the constitutional standard.

The number of waits longer than a year for treatment has fallen to 282,664, down 28% on last year (395,170 in Aug 2023) and now make up 3.7% of the waiting list, the lowest proportion since September 2020.

NHS staff have delivered 11.96 million treatments so far this year, 570,263 or 5% more than the same year pre-pandemic (11.39 million in the year to August 2019).

In August, the NHS met the cancer 28-day faster diagnosis standard for the fourth month in a row with three quarters (75%) of patients receiving a definitive diagnosis or all-clear within four weeks. More than 195,000 (195,991) people were informed within the target.

Overall, a quarter of a million (253,841) people were referred for an urgent check by GPs and more than 50,000 (53,226) cancer treatments were started, with over nine in ten happening within a month.

2.3 Visits for prostate cancer symptoms advice on the NHS website rose by 672% following Sir Chris Hoy's announcement about his terminal prognosis. New figures from NHS England show that in the 48 hours after the six-time Olympic champion revealed his cancer was incurable, there were 14,478 visits to the page on prostate cancer symptoms.

3.0 South Yorkshire Integrated Care Board (SYCIB)

3.1 On 1st April 2024 three out of the eight English NHS regions approved the delegation of commissioning responsibilities from the NHS to ICBs. There is now the expectation that the other five English NHS regions will devolve those responsibilities on 1st April 2025. A full team of staff who currently administer the commissioning of these services will also be transferring to the ICBs. The North East and Yorkshire (NEY) region has a project group including the four NEY ICBs to work with NHSE to deliver the work programme to enable that delegation. Each NEY ICB has an Executive level lead for this project group and the SY Executive lead is the Chief Finance Officer.

It was agreed that South Yorkshire will host the staff, and the Committee in Common, associated with the delegation of specialist services. A high-level option appraisal of the options for the delegation suggested that at least in the first instance, the delegation process would be best supported by this arrangement. There is now much work to complete to ensure that SYICB can successfully achieve an NHSE approval of the delegation at the national NHSE Board meeting on 5th December 2024.

3.2 The SYICB made a positive commitment following the rioting at the start of August, where there were some truly awful scenes of racism and violence across the country, including in South Yorkshire. The Chief Executive of the SYICB and other leaders across South Yorkshire were grateful for the work of South Yorkshire Police for their response, and to all those health and care staff, including those at Yorkshire Ambulance Service, who worked during this time to treat those injured and to ensure that services continued unaffected. The work of all partners and the response from the public was heart-warming. The Integrated Care Partnership has already committed to become an anti-racist health and care system. NHS South Yorkshire has been supporting colleagues who have been affected directly or indirectly. This included providing wellbeing support and this will continue for as long as it is needed. Colleagues have worked exceptionally hard to fulfil Category 1 Responder responsibilities. NHS South Yorkshire has committed to working through the North West Race Equality Framework. This sets out a systematic approach to becoming an anti-racist NHS organisation, with clear deliverables and external scrutiny of progress. In addition, the SYICB have recently helped to establish the South Yorkshire Race Equality Network for Primary Care staff. The Network is open to all staff working across Primary Care including General Practice, Optometry, Pharmacy and Dentistry and aims to provide support to colleagues working in primary care with the challenges they face in this regard

4.0 Rotherham Place

4.1 The Rotherham Place Board received several updates including the plans to manage winter. The challenges from last winter and the initiatives to support this winter were covered. The key challenges for last winter included:

- High incidences of acute respiratory infections, flu peaked in January, alongside D&V (impacting on acute beds and care home closures)
- Increased demand for primary care appointments
- Unprecedented growth in attendances at UECC (reflecting national trend)
- Industrial action impacting on planning time /staffing and recovery lag with over 20 incidences in 2023-4

The Place level plans for this winter has several actions including:

- Develop and embed Transfer of Care Hub/Discharge to Assess Model.
- Increase enablement capacity
- Spot purchase additional community winter bed capacity according to demand.
-

4.2 Rotherham Place Board received an update in relation to Rotherham Doncaster and South Humber Healthcare NHS Foundation Trust (Rotherham Care Group) who were recently nominated and shortlisted for the National HSJ Patient Safety Award. The nomination was to recognise the pilot undertaken on the Psychiatric Intensive Care Unit "Improving patient safety through an organisational culture intervention on a PICU" which included the appointment of a Reducing Restrictive Interventions (RRI) Advocate. The impact of having an RRI Advocate on the ward was demonstrated through a reduction in restrictive practice. The data presented demonstrates less full restraints, less use of the seclusion room and lower-level holds.

4.3 The SYICB held the mid-year review for Rotherham Place on 23rd October 2024. Key areas of focus discussed at the meeting relating specifically to the Trust included the outcomes in relation to the utilisation of the Virtual Ward and the achievement of the Urgent Community Response target and cancer targets.

At the meeting, it was noted that the Trust continues to meet the 70% standard and has done so since its launch in April 2022. From January 2024 to August 2024 there have been 2061 admissions, with 63% of these being a step up and 37% step down. This equates to a minimum of 519 hospital admissions avoided.

With regard to Cancer, in 2024/25, the national planning guidance set an objective to improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025. Five out of the last six months have seen achievement of the national target, and it was noted that The Rotherham NHS Foundation Trust (TRFT) have set a further ambition to improve performance to 80% by March 2025, which was achieved in June, July and August 2024.

The SYICB leadership team heard that the 31-day standard continues to show normal variation patterns and achieved the target in June and August 2024. TRFT have improvement plans in place to support sustainability of performance.

The national planning guidance also sets the objective to improve the 62-day performance to 70% by March 2025. As the Trust is consistently achieving this standard, TRFT have set a further ambition to improve performance to 77% by March 2025. The Trust met this target in June, July and August 2024 and plans are in place to support sustainability of performance.

The midyear review also picked up on areas requiring further work, with an emphasis on the four-hour target and the mean time in the UECC Department, which are key areas of focus for the Trust.

4.4 The Rotherham Pace Workforce Lead continues to get traction on workforce initiatives. The Strategic Steering Group is well established in Rotherham and has representation from each organisation to ensure the workforce objectives for Rotherham are met (previously shared with the Trust Board at TRFT).

The Recruitment and Employability Group is established and working very effectively. Partners across place regularly attend the monthly meetings and we have

representation from all employers in the partnership network including the Rotherham NHS Foundation Trust (TRFT), Rotherham Doncaster and South Humber NHS Trust (RDASH), Rotherham Council (Social Care), Voluntary Action Rotherham (VAR) and the Primary Care Networks.

The well-established Ambassador Programme has 16 ambassadors signed up who will go into schools to promote the sector, ensuring we have a wide range of partners across health and social care to promote the sector to the next generation of workforce.

Work Experience opportunities for the sector are being developed. A new programme "Experiences of the Workplace" offers group sessions for students in a particular job role. This will give students an immersive experience of a particular job role, the model has been used successfully in other parts of South Yorkshire.

There are seven colleagues across partner organisations who will become Training for Careers Advisors by completing the Level 6 Apprenticeship in Advice and Guidance. This will enable staff to upskill or train to become a careers adviser and we are using the levy to fund this training so there will be no cost to providers.

Work continues with schools and colleges to support T-level placements. So far four placements have been secured at TRFT for Rotherham College, and two students are going to RDASH on placement. An event is being held in November with social care providers to promote work experience and T-Level placements. Our aim is to provide placements across all partners at place to maximise students' placements as T-Level numbers increase.

There is also close working with colleagues across Rotherham Place to increase the number of SEND/Supported Internship places in Rotherham. There has been some success over the last few months supporting this agenda with RMBC departments taking on more placements. There are currently 39 placements across place secured which has almost doubled from last year.

Skills Street is an immersive careers experience for children aged between 5 and 18 based at Gulliver's Kingdom in Rotherham. The Health and Social Care pod at Skills Street will enable children to gain a better understanding of the sector through a range of interactive activities for all age groups. Skills Street is due to open in March 2025. The project is funded jointly by RMBC and TRFT.

4.5 The Trust was represented at the most recent meeting of the Health Select Commission, at which the Chief Operating Officer, Chief Nurse and Managing Director presented the Trust's Annual Report for 2023/24. Attendance at this forum continues to provide the Trust with important feedback on the local populations views on how services are run and can be improved. Positive feedback is also received.

4.6 The Trust's Consultant in Public Health, who is employed jointly by the Trust and the Local Authority and has been in post for eighteen months. They are leading a programme of work to manage population health within Rotherham, based on tackling health inequalities and developing preventative interventions. The Rotherham Population Health Management Operational Group continues to develop population-focussed initiatives and interventions across the Place. Current ongoing and planned initiatives include:

- A process has been established for extracting demographic information including ethnicity information to the reporting layer of the data warehouse. Once this work is complete, we will be able to draw the most updated demographic information from across our Meditech and SystmOne to a reporting table, which will allow us to report the majority of our performance information by ethnicity and other demographics. Work is also

continuing through the contact centre to identify gaps in ethnicity record and ensure that patients who are booked in to our services are approached for this information.

- Continuing to roll out our Making Every Contact Count training, which incorporates health inequalities, brief advice, and health coaching training to support preventative interventions. Sessions delivered this month include: training for F1 doctors; cancer care navigator training; bespoke sessions for wards and an overview session for Board development. Next month, the Public Health Consultant be delivering sessions for UECC and Cancer services and will also be putting a specialist lunchtime lecture on about housing, damp and mould for respiratory conditions.

- Stoptober has been launched and colleagues are signing up to the swap to stop scheme, which will provide access to vapes and other nicotine replacement for those of our staff who smoke. We are also supporting the respiratory showcase and patient support events at Breathing Space in November and linking into the wider prevention message. The QUIT programme has been nominated for a Parliamentary award

- The Trust continues in developing the work on missed appointments in cancer and have begun to make changes to letters and other communication through the patient portal, alongside training the care navigator staff in identifying patients at risk and the appropriate interactions to support. A brief patient survey via the contact centre once we obtain clearance from research governance. The Public Health Consultant will also be working with Patient Experience to develop engagement with identified groups of need. Finally, we're rolling out this process to the 0-19s service to examine 'was not brought' incidence.

4.7 The Trust continues to work with South Yorkshire Police (SYP) to tackle violent and aggressive behaviour against colleagues working on the front line at the Trust. SYP continue to attend the Trust on a weekly basis offering advice and guidance in addition to taking forward cases of violent and aggressive behaviour.

4.8 Further information in relation to Rotherham Place activity can be seen at appendix 1

Michael Wright
Managing Director
November 2024

Rotherham Place Partnership Update: September/October 2024

Sustainable Food Bronze Award

Rotherham Food Network has won a prestigious award for tackling the food challenges that are faced by communities and making local, healthy, and sustainable food available to all residents across the borough.

The Sustainable Food Place award recognises the holistic approach taken towards food and honours the positive changes made towards food issues ranging from healthy food for all to reducing food waste.

Rotherham Food Network was formed in 2022 and is a partnership made up of 26 organisations including Rotherham Council, Voluntary Action Rotherham, Rotherfed, and many more.

Achieving the bronze award recognises the steps that Rotherham has taken to raise awareness of food challenges, promote and produce locally sourced produce, tackle food poverty, and more. As well as celebrating the success of the network and its members who are actively making positive changes to Rotherham's food sector, system, and to the way food is viewed as a society.

Rotherham Food Network is at the very beginning of their journey and welcome others to join to help improve the food system. Find out more about the Rotherham Food Network and how you can get involved here.

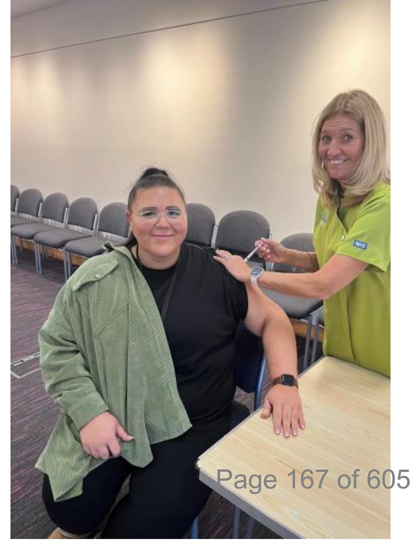
Winter Plan and Winter Vaccinations

The Rotherham Place Winter Plan was developed in collaboration with all partners, aligned to Urgent and Emergency Care priorities and based on learning from previous years. It includes strong relationships with agreed escalation to executive level for assurance. The plan was signed off at both the Urgent and Emergency Care Group and Place Board in October.

Rotherham Vaccination Plan
As at mid-October Rotherham had the highest uptake rate in South Yorkshire at 23.6%

Our plans include:

- All Primary Care Networks (PCNs) and GP practices are signed up to the Covid and Flu programme
- Working closely with ICB Communications team to promote vaccinations
- Proposed pop-ups at:
    - Breathing space to increase respiratory patient uptake
    - Riverside for Rotherham front line health and care staff
- Discussions are also taking place across the Rotherham system to address other at risk groups



Update from the Rotherham Place Workforce Lead

The Strategic Steering Group is well established in Rotherham and has representation from each organisation to ensure the workforce objectives for Rotherham are met. The objectives were signed off by the Place Board in April, and are now being implemented.

The Recruitment and Employability Group is established and working very effectively. Partners across place regularly attend the monthly meetings and we have representation from all employers in the partnership network including the Rotherham NHS Foundation Trust (TRFT), Rotherham Doncaster and South Humber NHS Trust (RDASH), Rotherham Council (Social Care), Voluntary Action Rotherham (VAR) and the Primary Care Networks.

Workforce Development Objectives 2024-25

1	2	3	4	5
Develop a Place Employer's Brand	Build Effective Partnerships	Employability Programmes	Embed Equality, Diversity and Inclusion	Develop Education and Careers offer

The well-established **Ambassador Programme** has 16 ambassadors signed up who will go into schools to promote the sector, ensuring we have a wide range of partners across health and social care to promote the sector to the next generation of workforce.

We are aiming to develop **Work Experience** opportunities for the sector. A new programme "Experiences of the Workplace" offers group sessions for students in a particular job role. This will give students an immersive experience of a particular job role, the model has been used successfully in other parts of South Yorkshire.

There are 7 colleagues across partner organisations who will become **Training for Careers Advisors** by completing the Level 6 Apprenticeship in Advice and Guidance. This will enable staff to upskill or train to become a careers adviser and we are using the levy to fund this training so there will be no cost to providers.

Work continues with schools and colleges to support **T-level placements**. So far four placements have been secured at TRFT for Rotherham College, and two students are going to RDASH on placement. An event is being held in November with social care providers to promote work experience and T-Level placements. Our aim is to provide placements across all partners at place to maximise students' placements as T-Level numbers increase.

Social Care Development connections established with key strategic leaders across RMBC who deliver social care. Moving forward, we will focus on key pieces of work that need progressing to support the workforce. A Social Care Recruitment Event is taking place 13th November where a bespoke recruitment model will be used to match candidates directly into vacancies and so removing the barriers to employment in the process. This is part of the widening participation strategy to recruit candidates from all parts of society.

Secondary Care work with TRFT and RDASH is well underway, and we are working in partnership with the lead at TRFT to help fill vacancies. Candidates identified by partners are now guaranteed interviews under the widening participation agenda and we have had several candidates that have successfully secured positions via the project. This model will be rolled out to other departments.

Working closely with VAR to support the **Volunteering Programmes** for TRFT and RDASH to help recruit volunteers for any vacant positions at the trusts.

Good connections made with **Primary Care and PCN managers** in Rotherham, moving forward we will work to support their recruitment programme. We are also developing local partnerships between GP practices and schools to support work experience and recruitment into the sector. Maltby Academy Trust are now connected with their local GP practice and are developing the partnership.

Working closely with colleagues to increase the number of **SEND/Supported Internship** places in Rotherham. We have had some success over the last few months supporting this agenda with RMBC departments taking on more placements. We now have 39 placements across place secured which has almost doubled from last year.

Skills Street is an immersive careers experience for children aged between 5 and 18 based at Gulliver's Kingdom in Rotherham. The Health and Social Care pod at Skills Street will enable children to gain a better understanding of the sector through a range of interactive activities for all age groups. Skills Street is due to open in March 2025. The project is funded jointly by RMBC and TRFT.

Satisfaction with NHS inpatient care The CQC's 2023 inpatient survey covered 63,500 patients who stayed in acute or specialist hospitals for at least one night in November last year.

The **CQC singled out eight trusts** which it determined had significantly improved their scores, this included the **Rotherham NHS Foundation Trust** who have demonstrated an increase over the last three years.

Nursing Times Awards 2024 Shortlist

The Rotherham NHS Foundation Trust have been shortlisted for 3 awards at the prestigious Nursing Times Awards for 2024:

- Best UK Employer of the Year for Nursing Staff
- Best Employer for Diversity and Inclusion
- Best Employer for Staff Recognition and Engagement

Congratulations to everyone!

Congratulations to **Adult Care and Integration and Children and Young People's Service colleagues**, who were successful again at the **South Yorkshire Teaching Partnership Awards** which were held on the 10 October 2024.

The awards are about recognising and rewarding the contributions of Social Workers, Social Care Assessors, Occupational Therapists, Managers and Teams. We are delighted that several of our staff won or were runners-up and well done also to those who were shortlisted.

Winners

- Cath Jay – Student Learner of the Year (OT)
- Localities – Team of the Year

Runners-Up

- Sophie Smith - Student Learner of the Year
- Peter Swainston – Practice Educator of the Year
- Patricia Muflihi – Approved Mental Health Professional of the Year
- Nikki Russell – Social Care Practitioner of the Year

Rotherham's biggest **free** cultural festival, **the Rotherham Show**, returned to the stunning surroundings of Clifton Park in September.

The two-day event was delivered by Rotherham Council and partners and offered visitors the opportunity to celebrate the borough and the people who call it home with an inspiring programme including outdoor theatre, live music, horticultural, sport activities, circus delights, pop-up performances, comedy and fairground thrills.

The Children's Capital of Culture Area included talented young people, workshops, live music performances and a pop-up adventure playground. Rotherham organisations such as Grimm and Co., Wentworth Woodhouse provided taster sessions of things to expect from their festival year, which kicks off on 1 January 2025.

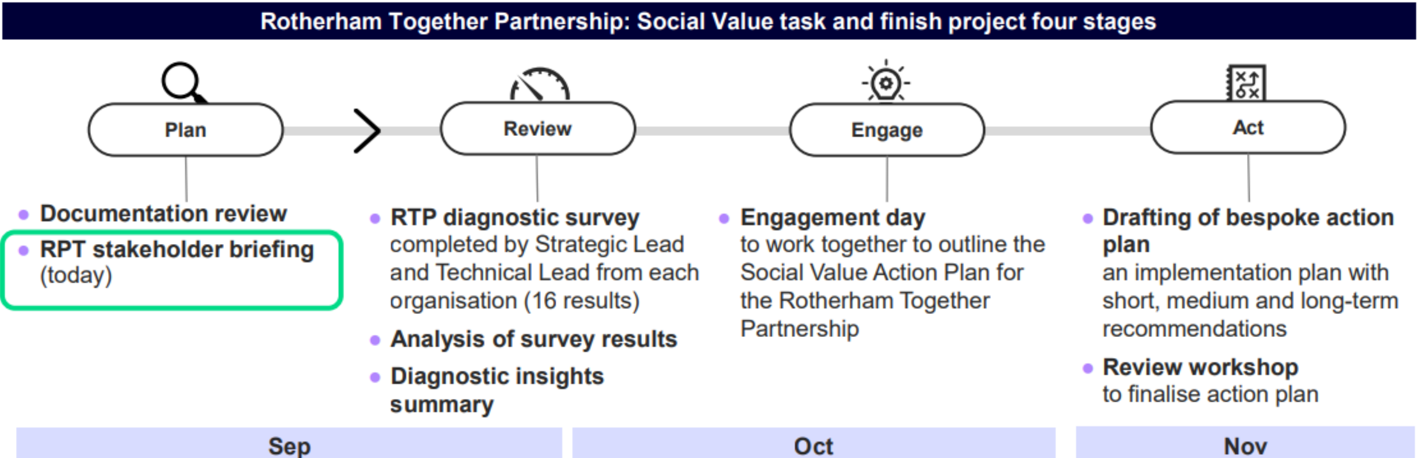
Attendees were able to chat to the Councils Climate team in the new Eco Village and were asked for their views to help shape the refresh of the Health and Wellbeing Strategy.

Alongside all of that were stalls to browse, food and drink and show favourites including Strongmen Competitions, Companion Dog Show, Vintage Vehicle Display, roaming performances and more.

Rotherham Show offers a wide range of entertainment for the whole family to enjoy, celebrating the uniqueness and spirit of the borough and giving people the chance to make lasting memories together.

Maximising Social Value in Rotherham

The Rotherham Together Partnership is undertaking a collaborative task and finish project to agree a shared plan of action that embeds and operationalises Social Value across the partnership, building on the shared commitment set out in the Social Value Charter. The first session in September brought colleagues together for the first of four stages to align on the project aims and opportunities.



Session two will build on that work to explore how Social Value outcomes can be maximised for our communities, focussing on co-creating an action plan to operationalise Social Value, including:

- Exploring the key Social Value outcomes partners could most effectively work together to unlock
- Digesting the results of the Social Value Maturity Diagnostic survey each member has taken
- Identifying key actions partners can commit to, which addresses gaps highlighted in the survey - including organisationally and together as a partnership

> ***Rotherham is a great place to live:*** *leading the way on equal pay, volunteering opportunities, staff wellbeing and local supply chain!*

> ***Happier, Healthier and Aspiring Population:*** *Social Value boosts educational attainment, skills, training and employment opportunities and reduces NHS pressure*

> ***Rotherham Residents Awarded with Great Opportunities for All:*** *realising public benefit on all contracts helps Rotherham eradicate child poverty and achieve unemployment all time low*

All 8 Rotherham Together Partners organisations are engaged in the work. They explored the process, common myths around social value and the benefits and challenges from the process

Colleagues created a newspaper front page for September 2030, the articles set out the key outcomes Social Value has the power to transform over the next 6 years.

Since our Social Value policy was adopted in late 2019, local spend through contracts has increased by 72%, from £44.8m in 2019/20 to £77.2m in 2022/23. This represents nearly 30% of our contracted spend and the ambition is to see another significant increase when we get the latest year's figures next month.

In the last reporting year, both the social value commitments delivered through our contracts doubled, from £4 million to £8 million, and the commitments secured on new contracts, from £13.6m to £27.8m.

That's an extra £8 million of value, and a further £27.8m of committed value to directly benefit people and places in Rotherham.

There are commitments to deliver over 1,500 training weeks – that's around 30 years' worth of training.

There'll be £1.8 million of dedicated hours to support young people into work and the equivalent of 19 full-time long-term unemployed people hired on contracts.

£135,000 will be donated to local voluntary and community organisations, in money, equipment and resources.

And commitments to save over 4,300 tonnes of carbon emissions have been secured, helping us work towards our ambitious but vital net zero targets.

Health Inequalities Strategy Update

People in Rotherham live well for longer

↓ Priorities and Actions ↓

Strengthen our understanding of health inequalities	Develop the prevention pathway	Support the prevention and early diagnosis of chronic conditions	Tackle clinical variation and promote equity of access and care	Harness partners' roles as anchor institutions
• Improve the understanding of health inequalities in Rotherham • Ensure that partners have access to bespoke data products • Ensure that data around health inequalities informs commissioning, decision-making and service-delivery	• Reduce the prevalence of smoking in Rotherham and narrow the gap between our most and least deprived communities • Increase the proportion of people in Rotherham who are a healthy weight • Reduce alcohol-related harm for people in Rotherham • Support older people in Rotherham to retain their independence and age well	• Reduce the health burden of cardiovascular disease in Rotherham • Improve the management of diabetes • Reduce the health burden of chronic respiratory disease in Rotherham • Increase the proportion of cancer diagnoses made at stage 1 or 2 • Ensure people get support with their mental health at the earliest possible stage	• Narrow the gap in maternity outcomes for ethnic minority women and women from deprived communities • Reduce premature mortality for people with learning disabilities, autistic people and those with severe mental illnesses • Improve access to social prescribing for ethnic minority communities • Mitigate against digital exclusion	• Improve the health and wellbeing of our workforce across the place • Employ people from deprived communities and inclusion groups in Rotherham • Increase our local spend to support Rotherham's economy • Reduce our environmental impact
Advocate for prevention across the wider system				
↓ Progress ↓				
• Publication of Rotherham's Health Inequalities Framework, with quarterly updates to Place Board • JSNA updated to include Ward Profiles • Delivery of JSNA workshops for staff across the system • RODA delivering bespoke intelligence products with support from Rotherham's Population Health Management Operational Group	• Smoking prevalence continues to reduce • Recruitment of Public Health funded Trading Standards post focus on illicit tobacco & vapes • Community Smoking Cessation service focus on inequalities - most deprived communities & manual occupations • Rotherham Healthwave mobilised, delivering a compassionate approach to weight management / access to physical activity • Bid to Sport England's Expansion Programme • Significant investment in Rotherham Alcohol and Drug Treatment Service to deliver harm reduction &treatment • Adult Social Care Prevention Team established	• Successful medicines management programmes delivered on hypertension and diabetes delivering reductions in clinical variation • Transformation programmes focus on Respiratory, Frailty, Diabetes and Ambulatory Care • Roll out of Targeted Lung Health Checks focused on areas of high smoking prevalence • Continued focus on early intervention for Mental Health with the Rotherhive website, Rotherham's Be The One suicide prevention programme and the Mental Health Community Connector Programme	• Health Inequalities Framework helped to identify the need to focus on BAME communities in the roll out of the Continuity of Care model in Maternity • Significant improvements in the proportion of patients with SMIs receiving all 6 physical health checks • Significant improvements in the number of health checks delivered to those on the Learning Disability Register • Data Bank initiative set up with the Good Things Foundation • RDaSH initiated a 2 year programme to poverty proof all services • Social Prescribing review underway	• RMBC Social Value programme recognised at 2023 Public Sector Leadership Awards and 2024 Social Value Awards • Employment Fayre approach reducing barriers to local jobs • Rotherham Food Network achieved Sustainable Food Places Bronze Award • Workplace Health Checks Programme being rolled out

The Challenges

- People in Rotherham are living shorter lives and living in poorer health for longer than they should.
  - ➢ Life expectancy at birth for men is 77.5 years and for women is 81.0 years compared with 79.4 years and 83.1 years for England.
  - ➢ Within Rotherham there is a 9.2 year gap in male life expectancy and a 10.0 year gap in female life expectancy between the most and least deprived communities.
  - ➢ Healthy Life expectancy at birth is 58.7 years for men and 56.5 years for women, compared to 63.1 years and 63.9 years respectively for England.
- 36% of Rotherham residents live within the 20% most deprived communities of England.
- Rotherham has a high prevalence of behaviours likely to cause harm.
  - ➢ Smoking prevalence is 14.5% compared with 11.6% for England
  - ➢ 73.7% of the population are overweight or obese (64% for England)
  - ➢ and the borough sees 624 alcohol related admissions per 100,000 residents (475/100,000 for England)

Board of Directors
8th November 2024

Agenda item	P171/24
Report	**Five Year Strategy, Six Month Review**
Executive Lead	Michael Wright, Managing Director
Link with the BAF	P1, R2, OP3, U4, D5, D6
How does this paper support Trust Values	This paper sets out the our delivery against the Trust's Strategy, which was developed in line with and clearly articulates the Trust values of *Ambitious, Caring, Together.*
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	The Trust launched its current strategy 'Our new journey, together 2022-2027' in early 2022. This strategy set out the Vision, Values and Strategic Ambitions of the Trust over the coming years. As part of this development, it was agreed that a bi-annual update would be provided to the Trust Board on progress made in delivering these ambitions Through Q1 and Q2 of 2023/24 the Trust refreshed its strategy. This was in part due to the want to the ability to be more ambitious when considering what could be achieved over the final two and a half years of the strategy. This refresh created 'Our Journey to Excellence'. This set out the Trusts key ambitions to deliver by the end of the strategy as well as prompting areas which may need to change or be different to deliver these ambitions. 'Our Journey to Excellence' does not replace but compliments and joins with the Trusts strategy. This update presented within this report is aligned, as with previous updates against the Trusts five strategic objectives (Patients, Rotherham, Our Partners, Us and Delivery (P.R.O.U.D).

Due Diligence	
Board powers to make this decision	In order to be assured of the delivery of the Trust Strategy, the Board agreed that it was appropriate to receive a bi-annual update on delivery to date.
Who, What and When	The delivery of the strategy is subject to ongoing monitoring at Trust Board level for the remaining period of the current strategy.
Recommendations	It is recommended that the Board of Directors note the Trust's progress in delivering its strategic ambitions
Appendices	

Our New Journey, Together

Update to the Board of Directors: November 2024

1.0. Background

The Trust launched its current strategy 'Our new journey, together 2022-2027' in early 2022. This strategy set out the Vision, Values and Strategic Ambitions of the Trust over the coming years.

As part of this development, it was agreed that a bi-annual update would be provided to the Board on progress made in delivering these ambitions. It was recognised that a degree of flexibility would be needed in how the ambitions were planned to be delivered in order reflect the changing landscape, emergent opportunities and threats as well as changing national directives, all of which may require the Trust to adapt and respond to in a way which was not originally envisaged.

1.1. Our Journey to Excellence

Through Q1 and Q2 of 2023/24 the Trust Strategy was refreshed. This was in part due to the ability to be more ambitious when considering what could be achieved over the final two and a half years of the strategy.

This refresh created 'Our Journey to Excellence'. This set out the Trusts key ambitions to be delivered by the end of the strategy, as well as prompting areas which may need to change or be different to deliver these ambitions.

'Our Journey to Excellence' does not replace but enhances the Trusts strategy.

2.0. Progress to Date

As the Trust was developing 'Our Journey to Excellence' in Q1/Q2 2023/24, the Trust did not formally agree a 'Delivery Plan' for the Strategy as it had in previous years.

Going forward, the intention is that strategic plans for the coming year will form part of the usual organisational priorities development and allow for alignment between the 'day to day' priorities and the strategic priorities of the organisation. This is enabled by the alignment of the organisational priorities and the ambitions agreed within 'Our Journey to Excellence' across the four key domains – Quality of Care, People and Culture, Operational Delivery and Financial Sustainability. As such future updates may be more aligned to these domains.

P/171.24.i.
This update presented within this report is set as with previous updates against the Trusts five strategic objectives (Patients, Rotherham, Our Partners, Us and Delivery (P.R.O.U.D).

The updates pulls out key areas of delivery against these objectives.

P/171.24.i.

2.1. 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

Initiative	Progress
Delivering high quality, holistic care	The Trust has developed and launched an Exemplar Accreditation system. A clear, measurable set of standards has been launched so that areas of improvement can be identified, and areas of excellence celebrated. To date 13 ward areas have undertaken accreditation with 5 achieving the bronze award. Work has now been completed to develop standards for maternity and children's areas with Urgent and Emergency Care (UECC) set to follow and Community areas in future periods. The Trust is also delivering 'Making Every Contact Count' training across teams which incorporates health inequalities, brief advice and health coaching to support preventative interventions.
Involving and working with our patients	The Trust has been developing, trailing and implementing a patient feedback tool within UECC. This was initially deployed last year and is now live, allowing for a much greater insight into patients' experiences Additionally, the Trust has focused on the development of an online engagement portal with around 1,000 patients using this portal for appointment booking, surveys (currently in pilot in pre-operative assessment to allow triage) and waiting list validation.
Always looking to improve the quality of care	The Trust has continued to embed Quality Improvement (QI) across the organisation. A complication in this has been the removal of the Trusts original NHS England supported approach known as QSIR (Quality, Service, Improvement and Redesign). This has required a local solution to be developed, which has been done with partners across South Yorkshire with the launch of Improvement Learning South Yorkshire.

	The Trust held its first Improvement / QI week in September, aligned to the national QI week. A variety of events and showcases took place. This will be adopted as a yearly event. Outside of the yearly event, several ad-hoc / semi-regular improvement events take place. This includes the launch of 'Dobsons Den' for nursing staff to feedback their improvement projects.

2.2. 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.

Initiative	Progress
Being Green	The Trust undertakes a significant amount of recycling and is in a good place for the updated recycling regulations which come into place in March 2025. A number of initiatives also continue to be implemented. The 'Bin the Bin' initiative has resulted a 50% reduction in black bag waste due to better segregation. Plans are in place to start recycling disposable curtains, introduce reusable mops and the new Styker system in theatres should also reduce orange bag waste in that area.
Championing out local business and people	Working alongside Rotherham Metropolitan Borough Council (RMBC) and other local partners, the Trust is jointly funding the Health & Care Zone at Skills Street, Gulliver's Kingdom. The zone forms part of a careers education space and centre, providing opportunities for young people to find out more about careers and opportunities across the district. The Trust, alongside RMBC, engaged in Social Value events which encourages local businesses to submit tenders for work.
Improving Health Equality	The Trust now has an established process for extracting demographic (inc ethnicity) information into the reporting

	layer of our data warehouse. Once this work is complete, The Trust will be able to report the majority of performance / information by ethnicity and other demographics Work has also taken place in cancer services to reduce missed appointments. This includes changing the communication with patients and training of staff in identifying those at risk and the appropriate interactions to support. This work will be undertaken in collaboration with the Trusts patient experience teams to identify and engage with groups of need.

2.3. OUR PARTNERS

We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care

Initiative	Progress
Joining up services	The Rotherham Share Care Record continues to be developed and go from strength to strength allowing more clinicians to have the right information available to them when they need it, regardless of service or organisation. A recent survey undertaken showed that 93.5% of users have saved time as they don't need to call the GP for information, 87% had been able to make better, faster decisions and 51% has seen a reduction in wasted home visits because clinicians can see if the patient is in hospital and/or has an appointment.
Delivering Safe and Sustainable Services	The Trusts approach to undertaking Sustainability Reviews has been adopted by the Acute Federation with the Federation now leading on work across 5 services across South Yorkshire. The Trusts work to develop a sustainable Gastro service with Barnsley Hospital NHS Foundation Trust was transitioned into 'business as usual' following an intensive programme of work with the two Trusts now undertaking a programme of work to collaborate across Haematology

	with elements of the service planned to be undertaken collaboratively. Additionally, a Joint Service-Learning Programme is being developed which will facilitate service to come together in an informal way to share learning and ideas.

2.4. US

We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work

Initiative	Progress
Realising Everyone’s Potential	The Trust has made progress on its EDI plan and on a number of measures from Workforce Race Equality and Workforce Disability Equality Standard. These measures will sit in a single plan that runs concurrently with the People and Culture Strategy and contains commitments to diversifying our leadership. The Trust has made it easier for staff to request and managers to track flexible working request as it is now all online. A key part of improving flexible working has been the roll out of Team Rostering which NHS England are using the Trust as a case study for. We continue to invest in the rollout of Rostering and the ambition is that the whole Trust will be on the roster system in the future. The Trust was part of the NHS England ‘Flex for the Future’ pilot focused on improving and enabling flexible working. This has formed a significant part of our work on retention within our nursing workforce.
Enhancing our Leadership	The Trust, in collaboration with Barnsley Hospital has undertaken a Senior Leadership Development programme targeted at our Care Group Leadership teams, recognising the importance that these senior leaders play in delivering high quality services. The programme has run over the last year and an evaluation will take place later this year. This evaluation

	will inform decisions about future leadership and management development. In 2025/6, the Trust will develop both a line management skills framework and a framework for leadership to support peoples' career ambitions. Nursing colleagues are already able to explore careers through conversations with the Professional Nurse Advocate network.
Treating Each Other Well	The Trust has continued to embed its Behaviour framework with a number of team developing team charters to re-inforce this. The EDI team delivered a number of lunchtime lectures which supported upskilling and knowledge of EDI subjects, as well as helping to organise the Trust's Cultural Celebration Day, which we have run for the last 2 years. The Trust continues to develop its approach to recognition including the PROUD awards, excellence awards and other forms of recognition e.g. long service awards and retirement awards. 2024/5 has seen the relaunch of Freedom to Speak up arrangements, with a new Guardian appointed and a refreshed network and new policy increasing the ease with which people can speak up on issues they want assistance with or that require further investigation.

2.5. DELIVERY

We will be proud to deliver our very best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation

Initiative	Progress
Delivering Excellent Performance	The Trust has developed its Integrated Performance Report (IPR) based on best practice to provide a clearer understanding of current performance including a more analytical approach to tracking deterioration and improvement.

	Post embedding of the Trust level IPR, plans are to expand this into Care Group and Clinical Service Unit Performance, providing consistency and clarity through the full performance structure.
Improving What We Do	The Trust continues to be a digital pioneer. For the last 12 months the Trust has been using Gleamer AI, a x-ray decision support tool. The system is available 24/7/365. The system will now expand to include inpatient Musculoskeletal X-ray imaging. The system will continue to be evaluated before a longer-term decision is made regarding its continued use.
Making Things Easier	The implementation of a QI culture across the organisation is enabling and empowering staff to fix issues locally. This has started to allow staff to reduce the ‘hassle’ within their roles – even when relatively ‘small’. This has included the creation of an easy to understand contact list for community teams and a review stock levels held in cars for district nurses.

Board of Directors' Meeting
8th November 2024

Agenda item	P172/24
Report	**Operational Objectives 2024/25 for review**
Executive Lead	Michael Wright, Managing Director
Link with the BAF	P1, R2, OP3, U4, D5, D6
How does this paper support Trust Values	Ambitious – The paper provides detail of the delivery of the ambitious operational objectives for 2024/25. Caring – the operational objectives will deliver improvements in the quality of care that we provide and ensure that all of our people have a great experience of work and can fulfil their full potential. Together – colleagues work together to ensure that the continual monitoring and assurance of operational objectives is underpinned by robust governance arrangements that will deliver the main change actions set out in this year's programmes of work covering Quality of Care, People & Culture, Operational Delivery and Financial Sustainability.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	The purpose of this paper is to present to the Board of Directors a review of progress against the 2024/25 Operational Objectives and associated programmes during the period April to September 2024. In the first three months of delivery (April to June) the Executive leads concentrated on formalising and embedding the work streams created to deliver the programmes of work and to ensure alignment with operational leads and their key areas of focus. This structured approach has enabled the teams involved to progress the work at pace during quarter two and ensure plans are in place during the next six months to achieve the aims set out in the original mandates approved at trust board in May 2024. A summary of achievements and any specific delays to delivery during Quarter 1 can be found on pages 3 and 4 of this report. The highlight reports at Appendix 1 inform the board of directors of the key achievements and any delays to delivery during the most recent reporting period (Quarter 2).

	So far this year there have been no significant escalations to the Executive Management Team that would warrant a formal request to assurance committees in order to make a fundamental change to the overall aim of any particular priority.
Due Diligence	All highlight reports have been signed off by the Executive Director Leads and have been reviewed and confirmed by the appropriate Assurance Committee.
Board powers to make this decision	The principal purpose of the Board is to support the timely delivery of the Trust's strategic objectives / Annual Operational Plan, whilst being assured as to compliance with appropriate statutory and legislative requirements, such as those determined, inter alia, by the Care Quality Commission (CQC).
Who, What and When	Individual Executive Directors act as Executive SROs (Senior Responsible Officers) for each area for ensuring achievement of the Operational Objectives and are responsible for realising the delivery of the key change actions as set out in the agreed Mandates.
Recommendations	It is recommended that Board consider any actions or additional assurance required as a result of this report.
Appendices	1: Operational Objectives 2024-25 – Highlight reports for priorities 1 – 4 – July to September 2024

1.0 Introduction

1.1. The Operational Objectives for 2024/25 are built around the following four key programmes:-

- ***QUALITY OF CARE: Focus on providing high quality care & improving the experience of our patients***
- ***PEOPLE & CULTURE: Focus on improving the experience of our people and developing our culture***
- ***OPERATIONAL DELIVERY: Focus on our operational delivery and improving access to care***
- ***FINANCIAL SUSTAINABILITY: Focus on becoming a financially sustainable and productive organisation***

1.2 The formal mandates agreed at the Trust Board meeting in May 2024 set out fifteen key change actions that will ensure achievement of the objectives.

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

1.4 This paper presents a high level update on progress made during the first six months of delivery and reports by exception any areas of concern with recommendations for continuance into the next planning cycle.

2.0 Conclusion

2.1 The Board Assurance Committees play a key role in ensuring effective oversight and delivery of the Operational Objectives. Updates are provided quarterly to assurance committees where discussions take place around progress and any specific exceptions to plan that may impact on achievement of objectives and benefits and where recommendations for corrective actions are decided.

2.2 In July the Board Assurance Committees considered reports on progress made in all of their associated areas during the first three months of the year and confirmed their assurance on progress and delivery as at the end of Quarter 1. A high level summary of achievements made during Quarter 1 is supplied in the tables below.

Priority Title	Achievements Q1 - Summary
Quality of Care	• **W**orking groups identified for each priority • **Acute Pain Management (experience)** – overall score January - June 2024 - 77% (number of patients receiving a pain score in UEC and/or admission). Scope of work agreed in line with Faculty of Pain Management core standards 2021 • **Frailty Assessments (effectiveness)** - Quality improvement project set up with first process mapping workshop completed and agreed metrics. Self assessment completed. • **Diabetes Management** (**patient safety)** – confirmed scope of work includes GIRFT and National Diabetes audit recommendations for admitted patients • **Patient Experience Improvement Plan –** Completed preparation work on 5 new domains (End of Life Care, Carers & Care Partners Charter, PALS, Facilities Improvement, Communication Support)

Priority Title	Achievements Q1 - Summary
	• **Exemplar Accreditation Programme - 9 wards completed the process** with 4 achieving bronze, the remainder green or white scores
People & Culture	• People Strategy launched • Staff turnover – positive performance • Appointed new Health & Wellbeing Lead (replaced former Head of Engagement and Wellbeing role on an interim basis). • New Head of Organisational Development and Inclusion commenced in post (replaced former Head of OD and Equality, Diversity and Inclusion lead roles) • Head of People Services will join 01 July 2024 – this post holder will manage recruitment and E-roster teams as well as contracts for Occupational Health and NHS Professionals
Operational Delivery	• **Deliver 4 hour performance of 80% before March 2025** • Achievement of the 4 hour standard is off track, albeit improving • Acute Care Transformation programme developed to focus on reducing ambulance conveyancing, same day emergency care (SDEC) and frailty pathways, patient flow, workforce, digital systems and processes • **Long-waiting patients (target 10 patients) and Referral to Treatment (RTT) performance (target 92.0% in 8 specialties)** • 65 weeks + trajectory achieved • Notable improvements in RTT in cardiology, dermatology, general surgery, gynaecology and ophthalmology • Transformation programmes have been developed to improve performance in Theatres, Outpatients, Endoscopy with a focus on GIRFT (further faster), Patient Experience and digital insights. • **Consistently deliver the Faster Diagnosis Standard (FDS) by Q4 (local target 80% (Standard is 77%)** • FDS above 80% (latest month - May) • Cancer Delivery Programme work stream mandates established. Targeted improvement work in high priority tumour groups of Lower GI / Upper GI / Urology. Skin FDS data validation process change, Skin FDS > 80% April-May 2024.
Financial Sustainability	• **Efficiency/CIP** - For the next two to three months, the focus will be on improving all areas with a view to achieving 70% of the forecast by the end of September. Care Groups and Corporate Areas carrying a high risk of not delivering their targets will be met with outside of the normal Efficiency Board process. • **Financial Plan** – to improve and maximise income, additional schemes are being funded to deliver against the ERF target. Care Groups and Corporate services are developing financial recovery plans as significant improvements are required against their efficiency programmes. • **Elective Recovery** – is being monitored and challenged at Elective Recovery Group meetings. Additional funding has been agreed for specific schemes to maximise elective activity across Care Groups and to reduce the risk of income deterioration.

2.3 The following risks and issues remained open at the end of quarter one with action plans in place to mitigate impact on delivery in quarter two:-

2.3.1 Quality of Care

Care Partners Charter delayed to September as the launch is dependent on securing catering facilities through a formal tendering process.

2.3.2 People & Culture

Issues relate mainly to significant change programmes taking place across the trust that require Human Resource services support and capacity e.g. Care Group re-alignment (also impacts on Finance systems), Band 2/Band 3 Restructure Programme and the new employee online system (Loop) which will need to be implemented by the end of Dec 2024.

2.3.3 Operational Delivery

Capacity challenges due to significant increase in demand particularly in anaesthetics which has affected theatre scheduling and utilisation targets.

Cancer Faster Diagnosis Standard in Urology, lower and upper gastro-intestinal cancer pathways was consistently less than 70% in quarter one.

2.3.4 Financial Sustainability

The slow start to forecasting efficiencies represents a significant risk to delivery of the Cost Improvement (CIP) target and ultimately the financial plan.

Additional bed capacity remains open over and above winter capacity which is unfunded.

2.4 The Highlight reports attached at Appendix 2 confirm the status of the four Objectives for the three month period ending September 2024.

The Highlight reports were submitted to the relevant Board Assurance Committees in October. Their subsequent confirmation of assurance in terms of process and/or delivery and any agreed recommendations, actions and decisions is provided below as applicable.

2.4.1 Quality Committee

The Quality Committee discussed the highlight report (Appendix 1) in relation to **Quality of Care** at their meeting held on 30th October. The report confirmed that all key change actions aligned to this objective are in delivery and that good progress has been made to deliver plans during the period July to September.

The Committee identified additional assurance needed to tie the key elements of the programme together such as staffing and incidents and mapping these against

Exemplar Accreditation. Further discussions will take place in the coming weeks with lead officers around process and outcome improvements with actions linked to how we can achieve a higher level overview.

2.4.2 People Committee

The People Committee discussed the highlight report (Appendix 1) in relation to the **People and Culture objective** at their meeting held on 25th October. The report confirmed that good progress has been made against all key change actions during the period July to September 2024 and noted the positive position in relation to staff turnover.

The Committee noted that challenges remain in terms of sickness absence levels which are not reducing at the desired rate to achieve target. Working groups have been set up to support delivery of the trust's Health and Wellbeing Programme, therefore initiatives to improve sickness absence will form part of their work.

The Committee were content that they are assured that there is progress and a good grip on issues that need further focus.

2.4.3 Finance and Performance Committee

The Finance and Performance Committee reviewed the highlight reports (Appendix 1) in relation to **Operational Delivery and Financial Sustainability** at their meeting held on 30th October. The reports confirmed that all key change actions aligned to the two objectives are in delivery and good progress has been made so far this year.

Linked to a presentation delivered by Care Group 1, the Committee discussed at length the increase in non-elective activity and the impact this is having on their current operating model.

The financial position at the end of month 6 remains challenging including the forecast position for the CIP programme.

Therefore whilst there is assurance that progress is being made, delivery of the financial plan remains at significant risk.

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

Michael Wright
Managing Director
November 2024

APPENDIX 1
OPERATIONAL OBJECTIVES 2024-25 : HIGHLIGHT REPORTS JULY TO SEPTEMBER 2024

QUALITY OF CARE
FOCUS ON PROVIDING HIGH QUALITY CARE AND IMPROVING THE EXPERIENCE OF OUR PATIENTS

PEOPLE & CULTURE
FOCUS ON IMPROVING THE EXPERIENCES OF OUR PEOPLE AND DEVELOPING OUR CULTURE

OPERATIONAL DELIVERY
FOCUS ON OUR OPERATIONAL DELIVERY AND IMPROVING ACCESS TO CARE

FINANCIAL SUSTAINABILITY
FOCUS ON BECOMING A FINANCIALLY SUSTAINABLE AND PRODUCTIVE ORGANISATION

Quality of Care

Focus on providing high quality care & improving the experience of patients

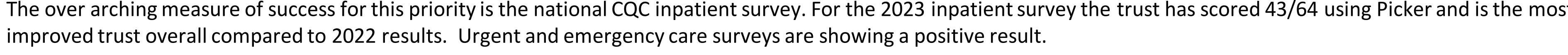
Executive Lead(s)

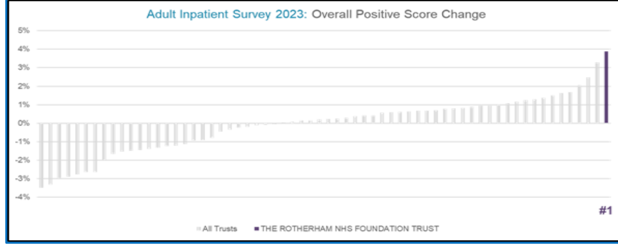
Medical Director
Chief Nurse

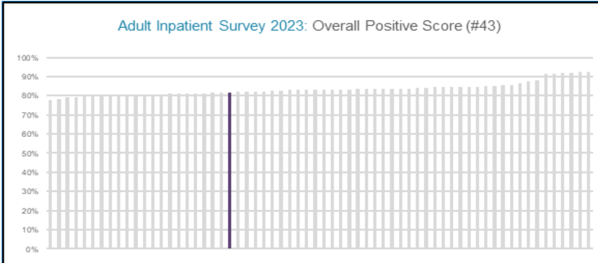
Objectives

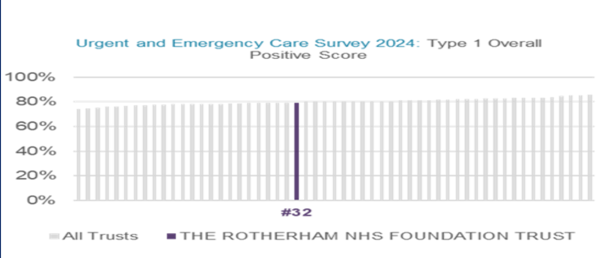
Deliver care that is consistent with CQC "Good" by the end of 2024/25; ensure improved performance in at least one quartile in the national inpatient and UEC patient experience surveys

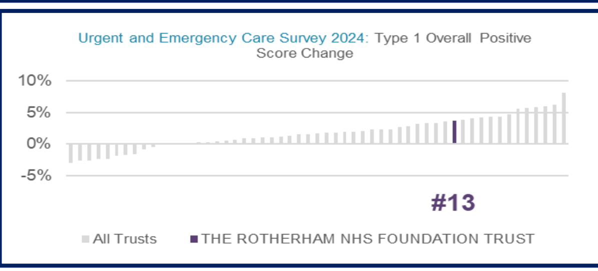
Summary Position


The over arching measure of success for this priority is the national CQC inpatient survey. For the 2023 inpatient survey the trust has scored 43/64 using Picker and is the most improved trust overall compared to 2022 results. Urgent and emergency care surveys are showing a positive result.









Delivered this period

Quality Priorities

- **Pain Management** – Base line data has been collected. Pain Champions launched and promoted. Changes in Meditech completed (quality indicators in power BI also for assessments)
- **Frailty Assessments –** Draft Dashboard developed to capture percentage of patients with a clinical frailty score of 6 or above who then have a Comprehensive Geriatric Assessment (CGA). Frailty Self Assessment has been completed.
- **Diabetes Management –**Diabetes Quality Improvement group has now commenced with meetings scheduled monthly. Three working groups are in place to support the work streams: – (1) Digital Transformation, (2) Pathways and Guidance, (3) Electronic Prescribing. Leads allocated to each working group which are also supported by a QI Facilitator and Data Analyst.

Patient Experience Improvement Plan – The new PALS is now open and the new team is fully recruited. New purple butterfly boxes for end of life care have been launched. Cultural considerations after death QI exercise completed. Care and Care Partners Charter has launched. Monopoly board training is rolling out. New wheelchair store is in place.

Exemplar Accreditation Programme – Since June a further 9 adult inpatient wards have completed accreditation with 2 of those achieving Bronze award. This has exceeded the original ambition of 6 and subsequently completes the Exemplar Accreditation Programme for Adult inpatient wards for 2023-24.

Planned next period

Quality Priorities

Pain Management – Pain assessments will be measured and to show an improvement against base line. CQC in patient survey data improved

Frailty Assessments

- Capture mortality and virtual ward data
- New registrar in post to increase number of CGAs completed
- Re-allocation of bed base confirmed
- Review CGA documentation and clearly define the frailty offer
- Frailty Power BI dashboard switch to live environment

Diabetes Management – Governance arrangements around Diabetes Quality improvement group will be in place

Patient Experience Improvement Plan – Plan must be completed before November each year in readiness for the following year's inpatient survey. Calendar of events will continue throughout the year.

Exemplar Accreditation Programme – Maternity and Paediatric areas will be accredited with a plan to re-start the programme in 2025-26

Risks/issues/escalations to delivery of the objectives

Patient Experience Improvement Plan – All planned initiatives launched before the deadline of the end of October as planned.
Quality Priority Frailty – Issue relating to data quality is continuing. Action plan in place to review data before switching dashboard into live environment

People and Culture

Focus on improving the experience of our people and developing our culture

Executive Lead(s): Director of People

Objectives

Achieve a top quartile engagement measure in the 2024-25 staff survey, improve attendance by reducing sickness by 1%, retain our people by achieving a healthy turnover rate of between 8% – 9.5%

Summary Position

Staff turnover performance is currently stable and within the desired target range that is between 8% and 9.5%. Sickness absence rates are not reducing sufficiently to achieve 4.8% target at year end

Turnover Rate Rolling 12 Months (%)

Sickness Absence Rate Rolling 12 Months (%)

Delivered this period

- Completed 360 internal audit relating to sickness absence. Working group set up to improve compliance
- "We said we did" plans developed for all Care Groups
- South Yorkshire ICS Sharing Event for Staff Survey Results was held on 25th June in Doncaster. Rotherham shared best practice on how we achieved good levels of engagement and subsequent high level response rates which have increased from 61%-68%
- Working closely with Barnsley to identify specific areas that are challenging to both Trusts around health and wellbeing support and recruitment and retention
- Progressed business case approved to improve timeliness of completing employment checks. New online ID system will commence w/c/ 21 Oct 2024.

Planned next period

- Health and Wellbeing programme in place with 5 supporting working groups set up to deliver 10 areas of focus
- Complete the Health and Wellbeing diagnostic
- Audit policy and assurance working group in place
- Scheduled meetings with Barnsley to explore opportunities to improve and stream line recruitment processes
- Go live with new on line identify checks
- Share 6 monthly update with ETM on progress against People and Culture Strategy
- Undertake a diagnostic around mechanisms to design and develop a new workforce strategy
- Sign up to North West BAME Framework and assign new BAME Staff Network lead (internal replacement)
- 2024 Staff Survey completed

Risks/issues/escalations to delivery of the objectives

- Issues relate mainly to significant change programmes taking place across the trust that require HR support and capacity remain in place e.g. Band 2/Band 3 Restructure Programme and the new employee online system (Loop) which will need to be implemented by the end of Dec 2024. Care Group re-alignment (also impacts on Finance systems) has now been implemented therefore no longer an issue
- Sickness absence target is at risk as levels are not reducing at the desired rate. Working groups have been set up to support delivery of the Trusts Health and Wellbeing programme therefore initiatives to improve sickness absence will form part of their work.

Operational Delivery

Focus on our operational delivery and improving access to care

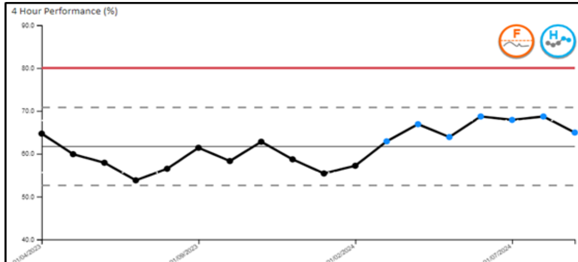
Executive Lead(s): Chief Operating Officer, Director of Operations

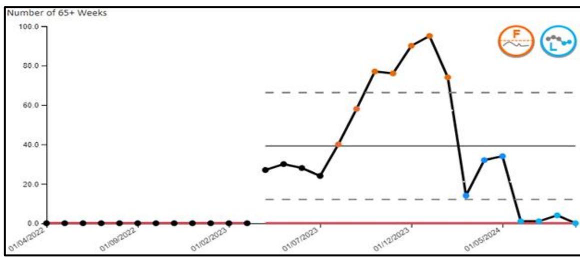
Objectives

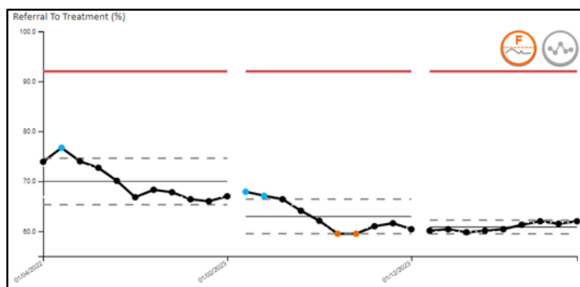
Deliver 4 hour performance of 80% before March 2025; go beyond the national ambition on long waiters and RTT performance; consistently deliver the Faster Diagnostic Standard by Q4

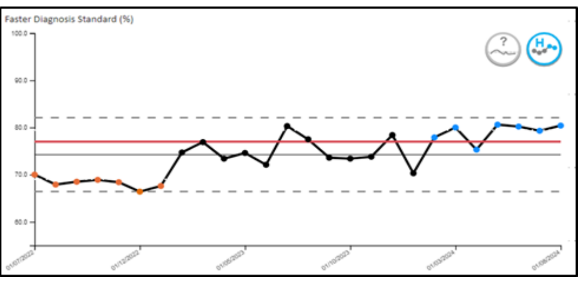
Summary Position

Three out of four metrics are now showing statistically significant improvement. 65 week waiters has achieved trajectory. Faster Diagnostic Standard has achieved locally set target (80%) and is achieving national standard of 77%. RTT is now achieving in 4 specialities with improvements and recovery trajectories in others; T&O, ENT and OMFS remain a concern. Although the 4 hour standard is not achieving trajectory it is showing a sustainable step change in improvement.









Delivered this period

Deliver 4 hour performance of 80% before March 2025

- Medical bed base reconfiguration plans developed
- Gap analysis in service provision within SDEC, Medical, Gynaecology and Surgery underway
- SDEC quality improvement events held in September
- Digital radiology tracker implemented and now live
- Data sharing agreement with YAS finalised and in place.
- E-Meet and Greet (Phase 1 – welcome text) pilot successful and now live; repatriations tracker developed within Meditech; UECC E-Referral SOP signed off and finalised

Long-waiting patients (target 10 patients) and RTT performance (target 92.0% in 8 specialties)

- Electronic triage now developed to allow light touch pre-op for low risk patients
- Booking lists 2 weeks out has Daily theatre huddle started to support safety and flow
- Review of clinic utilisation data to have better understanding of vacant slots
- Process for declining referrals in Meditech improved to reduce admin burden on clinicians.
- Referral Management review across all services to understand where it is done well and to share good practice across specialties.
- Agreed straight to test focus on ENT and Cardiology

Consistently deliver the Faster Diagnosis Standard (FDS) by Q4 (local target 80% (Standard is 77%)

- FDS August 2024 - 80.4%
- Straight to test prostate MRI pilot launched September 2024
- Retrospective data validation work continues to elevate Skin FDS > 90%
- Best practice timed pathways reviewed for all tumour groups; pathway analysis undertaken for all non-compliant pathways ; Improvement plans in place for LGI and Urology; LGI and UGI STT pathway reviews completed and monitoring metrics established
- Nursing led / Consultant supported triage established in UGI
- Endoscopy Transformation Programme established

Planned next period

Deliver 4 hour performance of 80% before March 2025

- YAS "Respiratory Car" initiative finalised ready for pilot during November 2024
- TOCH/YAS single point of access (SPA) co-location model scoped and in delivery
- Review long term suitability of Repatriations Tracker built in Meditech
- UECC E-Referral implementation
- E-Meet and Greet phase 2 roll out
- Repatriations tracker finalised and rolled out
- Work up plans to expand Surgical SDEC for winter

Long-waiting patients (target 10 patients) and RTT performance (target 92.0% in 8 specialties)

- Finalise Trust wide PIFU (patient initiated follow-up) SOP
- Introduce AI tools to support with reducing DNA's
- Finalise Access Policy
- OSA (obstructive sleep apnoeoa) equipment to reduce wait for sleep studies
- Review criteria for reducing/ stopping pre-op for low acuity patients in Ortho

Consistently deliver the Faster Diagnosis Standard (FDS) by Q4 (local target 80% (Standard is 77%)

- Progress to trial good news clinic in Gynaecology
- Finalise improvement plan for UGI
- Evaluate straight to test prostate MRI pilot
- Develop cancer DNA/CNA action plan
- Develop cancer navigator roles in support of FDS
- Evaluate STT (straight to test) prostate MRI pilot, transfer to BAU
- Monitoring new UGI triage model impact on STT utilisation
- Develop LGI triage model to support increased STT utilisation
- Endoscopy data insights development with focus on utilisation and productivity

Risks/issues/escalations to delivery of the objectives

- Risk - Highly challenged LGI, UGI, Urology pathways with FDS < 70% - Mitigation - LGI and Urology improvement plans in place, UGI improvement plan in progress. Dedicated Cancer Improvement Team resource for these pathways. Additional Cancer Improvement Officer due to commence 04/11/24.
- Risk - Cancer navigator vacancy in Urology - Previous unsuccessful recruitment cycle, fixed term role March 2025. Mitigation - Currently out to advert with 12 month extension to March 2026. Navigator functions partly covered by clinical/operational team. Potential impact on Urology FDS and patient experience.
- Risk – Staff shortages leading to last minute cancellations – Mitigation – 6-4-2 and utilisation meetings in place to help resolve issues sooner
- Risk - increase in demand is affecting Non-elective and Elective pathways

Financial Sustainability

Focus on becoming a financially sustainable and productive organisation

Executive Lead(s)

Managing Director
Director of Finance

Objectives

Deliver the financial plan for 2024-25 and deliver Year One of the plan to return the trust to a break even positon for the 2026-27 financial year; ensure significant improvement of at least one quartile across the full range of system productivity measures

Summary Position

We are behind plan on 2 of the 3 delivery targets

Efficiency/CIP

	Jul-24	Aug-24	Sep-24
	£'000	£'000	£'000
Actual	1,337	1,534	2,257
Cumulative target	2,954	3,884	4,822

Financial Plan

	Jul-24	Aug-24	Sep-24
	£'000	£'000	£'000
Actual	(4,219)	(5,217)	(2,180)
Cumulative target	(2,978)	(3,591)	0

Elective Recovery

	Jul-24	Aug-24	Sep-24
	£'000	£'000	£'000
Actual	19,642	24,257	28,896
Cumulative target	20,287	25,300	30,312

Delivered this period

Efficiency/CIP - At the end of Q2, £2,257k had been delivered/transacted year-to-date against a £4,822k target. The overall forecast outturn position shows that £7,769k has been identified against the overall target of £12,741k.

Financial Plan – The year to date position is adverse to plan by £2,180K. The key areas contributing to this position are the under-delivery of CIP, additional unfunded bed capacity, premium rate pay, and elective recovery income being below target. Monthly financial recovery meetings are continuing to focus on these areas, to reduce the expenditure run rate and recover the income position. An Improvement Group, Chaired by the Chief Executive, is in place to deliver Back to Balance and the recommendations published in the Deloitte report.

Elective Recovery – is adverse to plan and is being monitored and challenged at the Elective Delivery Group and financial recovery meetings. Additional funding has been agreed for specific schemes to maximise elective activity across Care Groups and to reduce the risk of income deterioration.

Planned next period

Efficiency/CIP - Further opportunities around Procurement consumables/inflation (c£320k) and Pharmacy Procurement (c£600k) are under review, and it is anticipated that a proportion of this will show in the Q3 numbers following validation. In addition, deep dive meetings are to be held with Care Groups and specific Corporate areas, led by the Managing Director during Q3.

Financial Plan – Care Groups and Corporate Services have been set financial targets to reduce the run rate over the next six months and support the Trust in delivering its financial deficit plan. The Trust has implemented additional control measures and senior leaders in the organisation are continuing to attend monthly financial recovery meetings chaired by the Chief Executive Officer. The Improvement Group is scheduled to meet monthly to oversee delivery of Back to Balance and the Deloitte report of recommendations.

Elective Recovery – is a key area of focus, at the current run rate it will impact on the ability to deliver the deficit financial plan. Underperforming areas are being reviewed to consider the actions required to recover the position.

Risks/issues/escalations to delivery of the objectives

The current position, and particularly the slow start to forecasting efficiencies, represents a significant risk to delivery of the CIP target and ultimately the financial plan. The key actions will be to improve CIP delivery and to also increase grip and control. The Chief Executive has scheduled weekly finance meetings with the Managing Directors and Directors of Finance across both Rotherham and Barnsley to improve the positions going forwards.

Additional bed capacity remains open over and above winter capacity which is unfunded.

Elective recovery income has deteriorated and at the current run rate will impact on the ability to deliver the deficit financial plan.

Board of Directors
8th November 2024

Agenda item	
Report	**Winter Plan 24/25**
Executive Lead	Jodie Roberts, Director of Operations
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** ☐
vExecutive Summary	This report is provided to the Board of Directors for assurance around the planning that has taken place in preparation for Winter. This includes a joint planning session with Barnsley, evaluation of Winter 2023/24, fortnightly meetings of the Winter planning group and a robust confirm and challenge session with the General managers to manage proposed schemes and associated finances. In addition the Trust has received planning guidance from NHS England outlining the national approach to winter planning. This focuses on a number of key areas for winter: • Continue to deliver on UEC recovery plan year 2 • Complete operational and surge planning • ICBs to ensure effective system working across all parts of the system and that there is a risk based approach. • 7 day service are supported through acute and community services • The fundamental standards of care are maintained • Supporting our workforce These requirements have been taken into account as part of the development of the Trusts winter plan. A presentation has been included as part of the papers in order to identify the key actions the Trust will take as part of Winter this year. This also includes working closely with ICB and Place to support flow and capacity.

	The draft winter plan has been to Finance and Performance Committee and Executive Team Meeting. With suggested amendments included in this final version. The likely spend on costed schemes is currently £1.2 million which leaves a deficit of approx. £250K based on current planned schemes and a start date of December. The additional schemes and cost can be associated with the increase in demand through the Non-elective services and are needed to support flow through the trust.
Due Diligence (include the process the paper has gone to prior to presentation at FPC Meeting)	A number of meetings have taken place with Care Groups and corporate services to ensure that the right support has been identified for Winter.
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?)	The Board is asked to note the contents of the report, including the levels of finances that are available and required to support the Trust during Winter 24/25.
Recommendations	It is recommended that the Board of Directors approve the winter plan 2024/25 noting the risk to finance, patient safety and performance.
Appendices	1. Winter Planning 2024 / 25

NHS
The Rotherham
NHS Foundation Trust
Winter Plan 2024/2025
Working together well
this Winter.

Planning for Winter

Creating a comprehensive winter plan for the NHS is essential to ensure that the healthcare system can effectively manage the increased pressures typically seen during the winter months. Below is a structured winter plan focusing on key areas such as resource management, patient care, staffing, and contingency planning.

The winter months often see a surge in demand for NHS services due to seasonal illnesses, exacerbations of chronic conditions, and the additional pressures posed by cold weather. This plan outlines the strategies and measures TRFT will implement to ensure high-quality care for patients and to support the healthcare workforce during this period.

Winter in the southern hemisphere has indicated that the UK will see a stable season for Flu and COVID and a surge in childhood respiratory diseases.

Planning for Winter

- Ensure timely access to care: Reduce waiting times and avoid delays in treatment.
- Maintain patient safety: Prevent adverse outcomes due to system overload.
- Support NHS staff: Provide adequate support and resources to avoid burnout.
- Manage bed occupancy: Optimise the use of hospital beds to meet increased demand.
- Enhance community care: Reduce hospital admissions through robust community care services

Preparations for Winter 2024/25

- Reflections on last winter across PLACE, system and in collaboration with Barnsley FT
- TRFT winter plan alongside PLACE
- Bed Capacity and Surge
- Protecting Elective Capacity
- Confirm and challenge sessions with General Managers
- National planning guidance for Winter- continuing to deliver year 2 of the UEC recovery plan, maintain patients safety and experience, full use of the OPEL framework across systems, risk based approach across systems, GIRFT, SCC.

Key Asks

- The national planning letter for NHS England has highlighted that the focus of winter is a system based approach where early identification of people with long term health conditions should be a priority and alternatives to hospital admission sought.

- The acute trusts is asked to ensure there are surge plans in place (full capacity tested and planned for), fundamental standards of care are maintained, flow though the trust is supported 7 days a week and where long waits are experienced they are reported at board level.

- In addition there will be a focus on delivering the UEC recovery plan which will focus on 4 hour delivery, ambulance handovers and G&A bed capacity.

- ICBs to ensure effective system working across all parts of the system

- Supporting our workforce

Winter preparedness – Key National Metrics

Needs to support key ambitions for UEC Recovery:

- 78% of ED patients admitted, transferred or discharged within 4 hours by March 25
- 12 hours in department
- Bed occupancy
- On average Cat 2 ambulance response incidents reduced to 30minutes 2023-4, with further improvement 2024-5 (39:13 in 22/23 to 28:36 in 23/24 for Rotherham)
- High impact interventions- regular consistent SDEC opening, Frailty model across place, community flow and inpatient flow.

Winter Preparedness

Bed Capacity

- **Increase available beds**: Open additional beds
- **Utilise 'surge beds**': Prepare and deploy 'surge beds' in case of critical demand spikes.
- **Rapid discharge protocols**: Enhance discharge planning to free up beds quickly, including coordination with social care services to ensure continued care at home or in the community.

Equipment and Supplies

- **Stockpile critical supplies**: Ensure adequate stocks of key medical supplies, including personal protective equipment (PPE), flu vaccines, antiviral medications, and oxygen.
- **Maintenance of equipment**: Prioritise the maintenance and servicing of critical medical equipment to avoid breakdowns during peak times.

Winter Preparedness

Patient Care Pathways

Emergency and Urgent Care

- **A&E Triage**: Implement enhanced triage protocols to quickly assess and direct patients to appropriate care pathways.
- **Ambulance Services**: Increase ambulance service capacity and reduce handover times at hospitals.
- **111 Services**: Strengthen the NHS 111 service to provide rapid advice and reduce unnecessary A&E visits.

Elective Procedures

- **Prioritisation**: review of non-urgent elective procedures during peak periods to free up capacity for emergency cases.
- **Communication**: Clearly communicate with patients about any changes to scheduled procedures to manage expectations and reduce anxiety

Winter Preparedness

Vulnerable Populations (Primary care/ community teams)

- Targeted care plans: Develop specific care plans for the elderly, those with chronic illnesses, and immunocompromised patients.
- Outreach programs: Enhance community outreach to support vulnerable individuals in managing their health during the winter.

Winter Preparedness

Staffing

Workforce Planning

- **Staffing levels**: Ensure adequate staffing levels by utilising bank staff and fixed term contracts.
- **Cross-training**: Provide cross-training for staff to allow flexible deployment across different departments.
- **Wellbeing programs**: Enhance staff wellbeing initiatives, including access to mental health support and flexible working arrangements.

Training and Support

- **Winter preparedness training**: Offer specific training sessions on managing winter-related health issues, such as respiratory illnesses and flu.
- **Leadership support**: Strengthen support for clinical leaders to ensure they can manage their teams effectively during high-pressure periods.

Winter Preparedness

Public Health Initiatives

Vaccination Campaigns

- **Flu Vaccinations**: Intensify the annual flu vaccination campaign, with a particular focus on high-risk groups, including staff.

Public Awareness Campaigns

- **Health education**: Launch public awareness campaigns to educate the public on managing common winter illnesses at home and when to seek professional care.
- **Cold weather advice**: Provide guidance on staying warm and preventing cold-related illnesses, particularly targeting the elderly and vulnerable.

Winter Preparedness

Contingency Planning

Surge Planning

- **Flexibility in operations**: Develop plans to flexibly allocate resources, including staff, beds, and equipment, based on real-time demand.

Collaboration with Partners

- **Coordination with local authorities**: Work closely with local councils, social care providers, and voluntary organisations to ensure a joined-up approach to care.
- **Partnership with private sector**: Explore partnerships with other healthcare providers to manage overflow in cases of extreme demand.

Winter Preparedness

Monitoring and Evaluation

Real-Time Data Monitoring

- **Dashboard utilisation**: Utilise real-time monitoring dashboards for tracking hospital admissions, bed occupancy, staffing levels, and supply usage, via a capacity manager at PLACE
- **Regular Reviews**: Conduct daily or weekly reviews of key performance indicators (KPIs) for quality, safety and operational performance to quickly identify and address emerging issues.

Post-Winter Review

- **Evaluation**: At the end of the winter period, conduct a comprehensive review of the plan's effectiveness, including feedback from staff and patients.
- **Continuous improvement**: Use the findings from the review to inform planning for the following winter, ensuring a cycle of continuous improvement.

What we want to do:

- Additional support for paediatric UECC
- Additional support in medicine and UECC
- Additional transport
- Surge capacity for paediatrics
- Protecting elective orthopaedic ward
- Extended opening hours for pharmacy
- Extended opening hours for surgical SDEC
- Additional capacity in IRR Senior support to ward areas
- Dedicated exec support to departments and care groups- quick early escalation and decision making
- No additional training first 2 weeks in Jan
- Corporate support
- Dedicated slots in imaging for SDEC
- Tea trolleys for staff well being
- Asks to ICB and Place for senior support- clinician time
- Meetings stepped down
- NHS responders
- Fire service
- Meal times matter
- Reconditioning
- Review visiting for urgent and emergency care to manage over crowding in the waiting rooms
- Increase capacity for UECC by utilising fracture clinic out of hours
- Rollout of digital support
- Consistent SMOS actions prepared on an evening
- Consistent nurse staffing rep
- Refresh of on call responsibility
- Annual leave around Christmas
- Further planned in reach from community into the acute trust

Bed capacity - What we will do

- Review demand and capacity in operational plan submission (increase in attendances in 23/24 by 10 % in comparison to the previous year)
- Bed reconfiguration- move of medical bed base to support flex capacity and shared risk across the trust
- B6 – SDEC will not have capacity for inpatients
- Protecting electives- ensuring MEOC is utilised fully
- Orthopaedic ring-fenced ward
- Spot purchase in community with support from community teams

TRFT Winter Plan

- Allocation for winter in our 24/25 financial plan £950K
- Schemes reduced to December to May to manage spend (April and May will come out of next years allocation)
- Areas focussed on acute and community (hospital avoidance and discharge, dealing with increased demand)
- IPC requested £200K worth of testing kits this has not been included in the Winter plan- this is to be further updated when guidance has been issued nationally
- Vaccination programme has been included at a cost of £82K
- Through comprehensive check and challenge a number of schemes were not supported, additional re-enablers to support discharge from hospital, additional trusted assessor. To explore at place for community support, additional bank holiday opening hours for PC.

Winter Spend

- Twilight medical cover for medicine
- Additional junior doctor cover for medicine and SDEC
- Extension of weekend consultant cover
- Additional escalation beds
- Additional waiting room support for UECC in Jan
- Extended opening hours for ASU
- Flex beds on orthopaedics
- Additional RSCN
- Additional TOCH nurse to support discharge
- Increased capacity in IRR
- Flu/COVID vaccination programme
- Sunday opening hours of CRU
- Additional support overnight in UECC
- **Current plan – £1.2 million Including additional support for UECC overnight with porters, medics and nursing staff to support sustained increase in demand (250K)**
- **Current budget- £950K**

Scheme Title	Period	Total Planned 24-25 only £
Twilight Medical Cover	Dec-May 25	144,357
Junior Cover	Dec-May 25	116,986
Extension of weekend consultant cover	Dec-May 25	37,163
Extension of Beds - Ward B5	Dec-May 25	232,100
Extended hours opening for "RAT" Beds on AMU - Maximum claim 1 RN 1 HCA Midnight to 8am Max Claim £3,060 per week (1 x RN 1 x HCA) Nov-Mar	Dec-May 25	82,500
UECC - ED Medical Support	Dec-May 25	97,081
UECC Portering / Transfer Team	Dec-May 25	39,372
UECC - RN	Dec-May 25	47,439
UECC - House Keeper	Jan-25	8,250
ASU		55,080
		13,019
Rockingham		80,784
Additional RSCN	Nov 24-May 25	92,078
Additional Pharmacy cover	Oct 24-May 25	44,847
Additional TOC support		20,879
Community Therapist		
Rapid response support team	Dec-Jun	40,934
Flu/Winter Vaccinations		82,000
Community Ready Unit	Dec-Jun	25,528
		1,260,396

What is different to last year?

- Early movement of SDEC to be protected from inpatient beds
- Co-location of Integrated Discharge Team with Transfer of Care Hub
- Community in reach to Urgent care pathways with a pull approach
- Close working with the ambulance service to reduce hospital conveyance
- Trusted assessors for care homes
- 7 day opening of the community ready unit (CRU)
- Flexibility in teams/ budgets to support patient movement
- Early action to step down planned meetings and release capacity early
- No planned training
- Robust bank holiday cover
- Enhanced support to teams ahead of winter
- Reduced finance to support significant additional pressures

• Place winter plan

- Allocations
  - £500K winter funding
  - Discharge funding supporting social care schemes
- Proposals being worked through by ICB on behalf of PLACE
- Social care – enablement and additional homecare
- Trusted assessor for care homes
- Voluntary sector – transfer of care hub, social prescriber, Age UK
- Place escalation wheel
- ARI hubs- to be opened early
- Mental health support for patients that are in ED
- Additional transport

Ask of our partners

- Early start of ARI hubs
- Increased access to primary care
- Robust Christmas and New Year cover across place
- Early actions which are at OPEL level 3 to improve the position across the PLACE
- Response to rapid discharge if Duty to rescue protocol implemented at the front door
- Discharge thresholds adapted to meet need of system pressures
- Flexibility in use of community bed base and care packages at home
- Rapid access to CHC assessments
- Mental health patients not boarding in ED whilst waiting for a placement
- Reducing demand at the front door helping our population make the right choices
- Rapid response to system pressures
- Clear cations to manage demand
- Reduced demand on teams to attend meetings and update reports
- Clear understanding of capacity in the system- place escalation wheel
- Support with repatriations- OOA patients waiting social care input from another place
- Manage patients in the most appropriate place as a system
- Shared understanding of the risk across the system

Previous Winters

Elective Admissions

Elective By Month							
	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	2661	3120	2993	2427	2792	2596	2756
2019/20	2736	2966	2656	2478	2665	2560	2120
2020/21	2088	2117	2156	2088	1947	2096	2452
2021/22	2534	2318	2311	2081	1915	2102	2390
2022/23	2395	2449	2775	2222	2639	2718	2896
2023/24	2357	2467	2696	2251	2598	2578	2604

Attendances

Row Labels	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5849	6110	6111	6214	6811	6016	6575
2019/20	6977	7123	7303	7225	7112	6452	5413
2020/21	7206	6607	6130	6215	5675	5635	7343
2021/22	8100	8043	7766	7542	7204	7094	8066
2022/23	7350	7818	8010	8117	7207	6840	7802
2023/24	7811	8114	8189	8328	8316	7953	8946

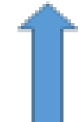
NEL admissions

Non-Elective By Month excluding inpatient Observations							
	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1820	1916	1892	1936	2068	1887	2048
2019/20	1851	1935	1826	1920	1958	1727	1683
2020/21	1930	1872	1784	1714	1753	1715	1939
2021/22	1916	1814	1778	1838	1718	1736	1756
2022/23	1659	1803	1815	1833	1873	1735	1962
2023/24	1971	2045	2064	2060	2089	1981	2220

Non-Elective Observations							
	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	268	309	296	277	326	346	533
2019/20	429	493	447	418	448	407	321
2020/21	827	676	633	600	517	653	669
2021/22	865	865	869	822	806	863	885
2022/23	1010	993	973	1015	1001	992	1269
2023/24	997	1091	1084	930	734	875	1039

UECC Performance

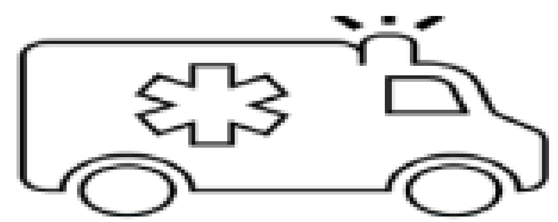
Number of Attendance in UECC	
22/23	23/24
92,148	96,842



Up by 4694 attendance this financial year that's a 5% increase overall this year.

Number of 4-hour breaches in UECC	
22/23	23/24
50,651	39,506

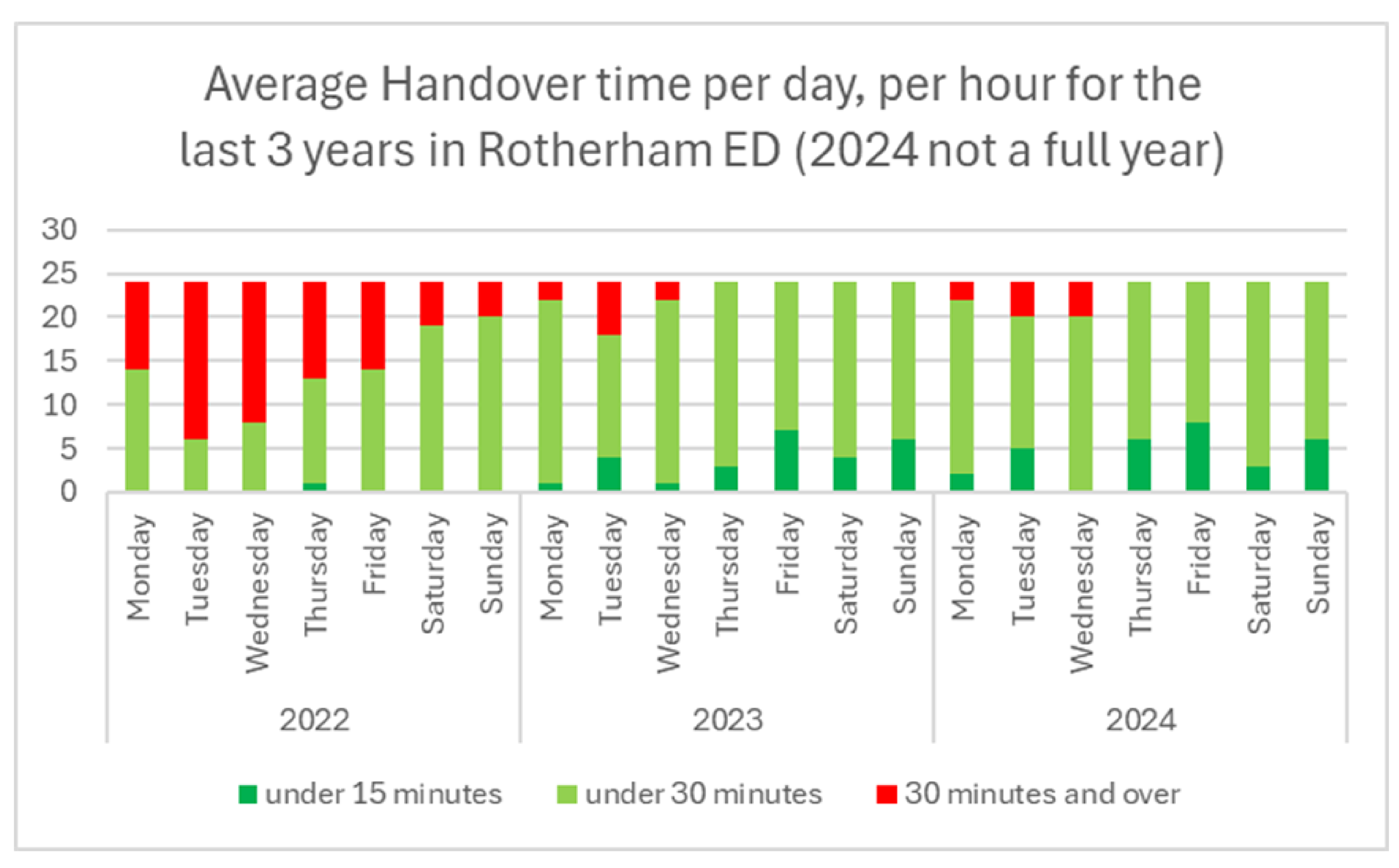
The number of 4-hour breaches has reduced by 11,145 as the trust implements the 4 hour access standard



Number of Ambulance Handovers - Over 30 Mins	
22/23	23/24
5748	3880

Despite the increase in attendances our Ambulance Handovers within 30 mins has improved

Ambulance handovers



Performance against National Targets and high impact interventions

The Rotherham NHS Foundation Trust

	Daily Average Hours Lost from Ambulance Handovers						
	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	10.8	10.8	10.8	10.8	10.8	10.8	10.8
Actual	4.2	9.6	6.7	12.0	24.4	20.1	12.0

General & Acute (G&A) Bed Occupancy – based on KH03 data 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	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Actual	90.0%	89.0%	90.6%	90.0%	91.3%	88.7%	89.5%	89.0%	89.0%	93.3%	91.0%	91.3%

	Number of Patients with No Right to Reside						
	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	56	56	56	56	62	60	54
Actual	44	66	51	46	94	87	47

Staff Well being

- Early action to support teams at times of operational pressures
- Managing flexibility to enable teams to have a work/home life balance
- Well being services
- Mental health support
- Supportive leadership
- Staff recognition
- Listening events
- Management of movement of staff to reduce number of times this happens
- Full trust approach to supporting additional beds
- Substantive workforce to staff additional beds

Recommendations

- Funding gap for Winter 2024/25- balance of patient safety and over spend to manage operational demand
- Governance around spending and authorisation- ability to respond and adapt quickly based on demand and pressures
- Flex and surge beds to be introduced to support demand into winter with substantive staffing
- Early movement of SDEC to support the model in preparation for capital scheme
- Further work to explore how we support staff to remain well in the winter and stay at work
- Non- care group support to areas to support staff well being and operational pressures

- This winter plan aims to ensure the NHS is prepared to manage the increased demand during the winter months while maintaining high standards of patient care and staff welfare. By focusing on resource management, patient care pathways, staffing, public health initiatives, and contingency planning, the NHS can continue to provide resilient and responsive healthcare throughout the winter season.

- This plan should be reviewed and adapted regularly based on emerging trends, new guidance, and feedback from all stakeholders involved.

Public Board of Directors' Meeting
8th November 2024

Agenda item	P174/24
Report	**2024 – 2028 Digital Strategy**
Executive Leads	James Rawlinson, Director of Health Informatics
Link with the BAF	B1, B7, B8
How does this paper support Trust Values	Effective digital systems support the organisation and its patients in providing joined up high quality and safe care together.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The Trust continues to be recognised as one of the most digital mature in the region, with the 2024 Digital Maturity assessment giving an average 'score' of 2.88. This updated Digital Strategy has been in production for over 12 months, with adaptions being made to reflect our own organisation strategic updates and objectives, the ever changing technology landscape (especially AI) and changes to digital strategies regionally and nationally. This strategy sets a vision: *To provide excellent digital experience for our workforce and the communities we serve. Driving the highest standards of intuitive digital co-design and delivering exceptionally reliable solutions and insights.* *We will be '#TRFTProud2bDigital"* Listening to our staff, the strategy has 6 themes, which will guide everything we do:

Transformational and operational changes are grouped around enablers of:

- Digital systems
- Technology
- Information
- People and Governance

Enablers		2024	2025	2026	2027	2028
Digital systems	Care plans and Assessments					
	Clinical Digital Support					
	Digital Recruitment and Onboarding					
	eConsent					
	EPR Future					
	EPR Replacement					
	EPR Optimisation					
	In Hospital Wearables and sensing					
	Medical device Integration					
	Patient Digital front door					
	Shared Records					
	Shared LIMS, PACS, Maternity					
Technology	Smart Hospital inc Inventory Management					
	Voice Recognition					
	AI Back Office inc Intranet refresh					
	Cloud Migration and N365					
	Gigabit Internet					
	Pager Replacement					
	Tech refresh programme					
Information	Virtual Desktop and SSO					
	AI supported data Analysis					
	Clinical 'command centre'					
	Data Strategy					
	Discrete Simulation					
	Faster Data Flows					
	Predictive Analytics					
	Sustainable Coding					
People and Governance	Clinical Leadership					
	Data Essential Programme					
	Shared Services					

Specific areas and risks to highlight are:

1. EPR changes – earliest 2027 and will be governed somewhat by external funding
2. Recognise the impact and evolving nature of AI and changing regulatory environment
3. Clinical input and leadership, especially in nursing, is not without cost and requires additional investment.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Strategy has been reviewed by our Digital Transformation committee and supported at October 2024 Finance and Performance Committee.
Board powers to make this decision	

Who, What and When (what action is required, who is the lead and when should it be completed?)	This Board of Directors are asked to approve this updated digital strategy and delegate to Finance and Performance committee delivery of the strategy
Recommendations	Approve the strategy and acknowledge further investment (unquantified at this time) required.
Appendices	none

NHS
The Rotherham
NHS Foundation Trust
The Rotherham NHS Foundation Trust
Digital Strategy
2024/28

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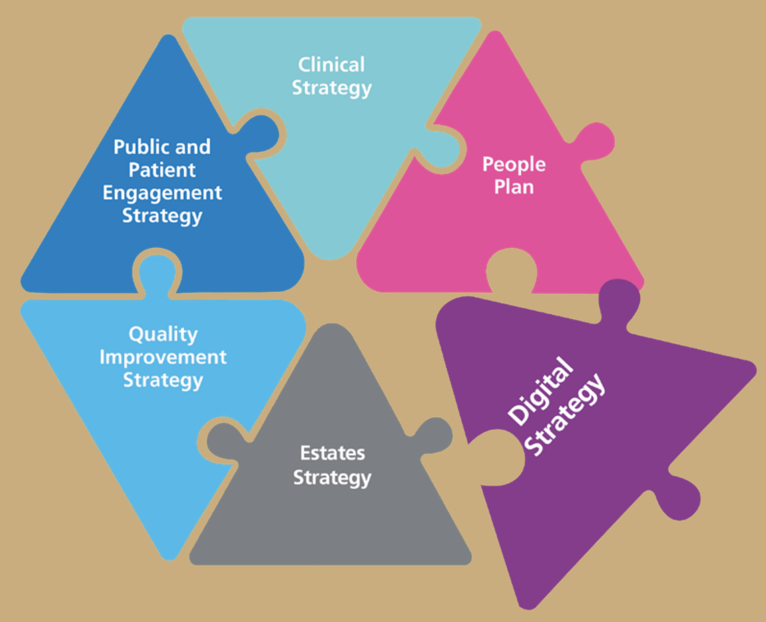
Foreward

Welcome to our "TRFTProud2bDigital"

These are exciting times for Rotherham FT and the NHS as we continue on our journey towards 2028, with a proven track record of digital excellence at both regional and national levels.

To ensure our future success, we must wholeheartedly embrace the digital challenge. While I acknowledge the significant technological improvements we have made in recent years, we still have a long way to go and our ability to deliver exceptional clinical services hinges on establishing a high quality digital infrastructure and empowering our digitally skilled workforce. Each individual and department should have the confidence and proficiency to seize the opportunities presented by digital technology and have seamless access to high-quality digital tools that enhance their work.



Collaboration and partnership with local and regional organisations play a pivotal role in our strategy. By forging strong alliances, we can leverage shared expertise and resources to create a leading digital environment that benefits everyone. We actively seek close engagement with our partners, working hand in hand to drive innovation and find creative solutions to healthcare challenges. Together, we aim to establish a robust ecosystem of collaboration that propels our collective progress towards outstanding patient care, while maintaining our positioning as trailblazers in the region's healthcare landscape.

As we refresh our strategy and redefine our commitment to digital excellence, we aim to capitalize on our strategic strengths while addressing our underlying weaknesses. Through collaboration and partnership, we can tap into the diverse perspectives and knowledge of our local and regional counterparts.

However, publishing this strategy marks just the beginning of a new phase characterized by close engagement and collaborative work. Achieving our ambitious vision requires a collective effort from all of us, including our valued partners and collaborators.

Introduction

Digital, Data and Technology are key enablers to the support the Trusts organisational strategy ‘Our new Journey Together – together to excellence’, which sets out the ambition of the Trust and provides a direction of travel for the organisation through what is a challenging and changing local, regional and national landscape.

In a society that is continually adopting and embracing technology, the NHS must not remain stagnant. Our vision outlines our commitment to incorporating digital solutions into every patient interaction, through clinical leadership, we aim to enhance the quality of care and improve the overall experience for our patients, while supporting our workforce with safe and efficient tools.

Our journey towards digital excellence involves eliminating transactional friction, implementing empowering modern technologies such as AI, aligning technology with specific roles, and ensuring high-quality data is readily available during care delivery. Furthermore, we emphasize the digitization of patient interactions and the automation of associated processes, facilitating the sharing of data across the healthcare system. Lastly, we will leverage our growing wealth of data and insights to provide decision-makers at all levels of the Trust with insightful self-service business intelligence.

This document sets out this enabling Digital, Data and Technology (DDaT) strategy over the next 5 years (2024 – 2028), taking into consideration our journey so far alongside regional and national ambitions[1]

NHS Providers define digital as:
“Applying the culture, processes, operating models & technologies of the internet era to respond to people’s raised expectations”

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A digital strategy is therefore as much about business transformation as it is adopting modern technology, with the ultimate aims of:

- Empowering and enabling all parts of our organisation to deliver efficient, safe, high-quality care
- Helping people and their families access services easily and manage their own health and wellbeing
- Improving wider population health and choices
- Improving the working environment for our workforce .

[1]Appendix 1 and 2

Vision

To provide excellent digital experience for our workforce and the communities we serve. Driving the highest standards of intuitive digital co-design and delivering exceptionally reliable solutions and insights. We will be '#TRFTProud2bDigital".

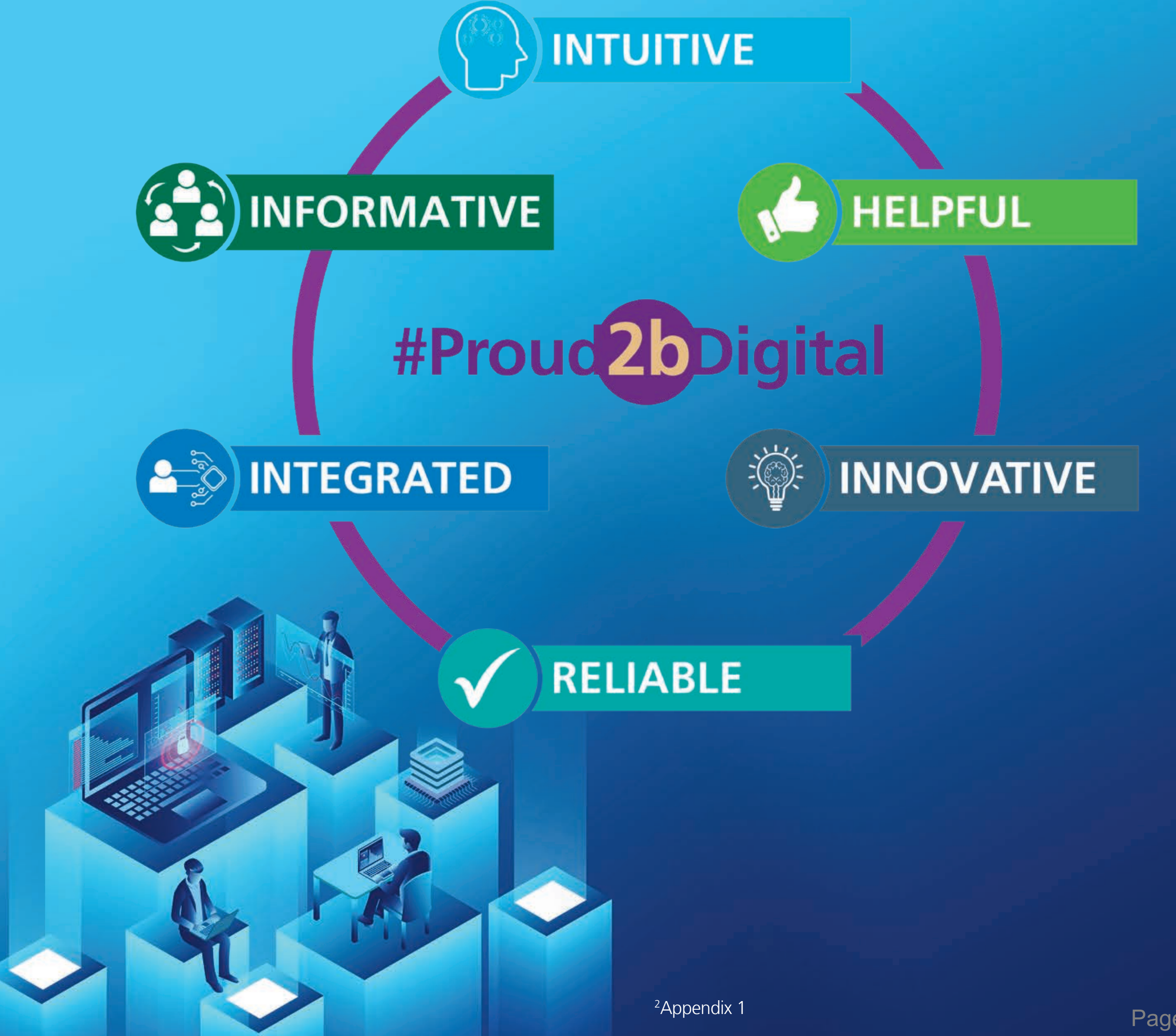
We will encourage, foster and develop a culture of "digital first", investing in co-designing digital change, and be at the heart of organisational transformation and improvement. We will deliver high performing customer-centric, digital environments where people will want to work with digital tools, that don't slow us down, intuitively supporting and guiding the work we do.

The NHS England Digital Maturity Assessment process will be used to measure our progress of this strategy and enable to us to compare our progress nationally and regionally. In addition, we will look to instigate a process of obtain regular usability and customer service feedback using global best practices, such as KLAS or NPS.

Our Digital Ambitions

During 2022 and 2023 we ran several online user workshops across the Trust in order to listen and understand our workforce's real-life aims and digital goals. Everyone recognised the digital journey the organisation has been on, and the significant level of digital adoption already embedded across the organisation, but also acknowledged there is lots still to do. We received over 300 responses of feedback that have been grouped into the following ambitions centred around our vision.

We also reviewed the Trust 2022 Strategy, the Rotherham Health and Care place plan 2023 – 2025 and the current South Yorkshire and Bassetlaw Integrated Care System Digital strategy[2]



[2]Appendix 1

INTUITIVE

Our digital systems and tools need to be intuitive and instinctive to use, with the minimal number of clicks and data input to get the job done. Information about our patients needs to be readily available to our clinical teams from wherever and whichever organisation created it.

We will look to further enhance our clinical input into all our digital programmes, embedding and skilling teams in the principles of co-design. We'll also consider where we can leverage emerging technologies such as AI-driven speech recognition, or machine learning with chatbots to drive our digital interactions for both our workforce and patients.

We will also prioritize digital patient inclusion as an integral part of intuitive ambition. Recognizing the importance of equitable access to healthcare services, we will aim to ensure that all patients can benefit from our digital initiatives., we will actively seek input and feedback of groups such as the Rotherham Digital Inclusion forum, to tailor our digital solutions to their needs. By considering factors such as accessibility, language diversity, and digital literacy, we will strive to bridge the digital divide and create intuitive inclusive digital platforms that empower patients to actively participate in their healthcare journey.

HELPFUL

Our digital tools need to support and alleviate the mental burden, not add to it. Ideally, they will have embedded clinical decision support aiding our workforce and guiding them through a specific process.

Our non-clinical processes are often overly complex to navigate and understand, often relying on antiquated systems or ways of working, making telephone calls to obtain updates, walking the estate looking for kit or manually copying information from sheets of paper into electronic systems.

Patients and their carers increasingly want to digitally interact with our services and contribute to their own health record in a safe and secure manner and be kept updated about their own care, so they can choose well.

INNOVATIVE

Within the Trust there is a powerful desire to continue to be digitally innovative and leverage our digital capabilities as a positive force for change. We will look to establish digital innovation capability where teams can bring transformative ideas and problems and after a process of prioritisation, work with digital experts to co-design scalable solutions.

RELIABLE

As our reliance and dependency on digital environment has grown, we recognise our whole digital portfolio, from systems, infrastructure and data needs to be exceptionally reliable and secure, and work seamlessly wherever and whoever we are. This will mean systematically and routinely investing in our infrastructure, transforming how we deliver applications, with embedded Single Sign-On (SSO), and put in place processes that routinely measure meaningful end-user metrics.

In addition, being a relatively small organisation, we'll need to accelerate our 'cloud-first' journey, outsourcing infrastructure management to global specialists, and invest training and culture of our digital support services to provide more self-services, self-healing systems an excellent and responsive customer service.

INTEGRATED

Compared to other NHS organisation we do have substantial levels of integration between our internal and external clinical systems, which has raised our user's expectation and there is more to do. Staff, at times, must access several different systems to be able to obtain a total picture of a patient's care, and as we move to increased integrated and partnership working across the ICS (Integrated Care System), the expectation and demand on interoperable systems will rightly increase, and we will positively consider EPR alignment across the ICS as a way of achieving deep digital integration.

In addition, as we accelerate the adoption of smart medical machines across the estate or in patients' homes, we need to ensure the data they produce is fully and automatically interoperable with our EPRs (Electronic Patient Record).

This Integration challenge also applies to our non-clinical systems and process, with staff also telling us they have multiple solutions to navigate, with duplication of information or antiquated 'word' forms that are cumbersome to complete.

We will be unwavering in our digital integration strategy, and follow national standards, which may mean hard choices in not progressing potential opportunities where there is a lack of integration capability.

INFORMATIVE

We generate a tremendous amount of data daily as a by-product of the digital systems we use,and this is only going to increase exponentially. Whilst we've made significant strides in providing high quality data and information back into the organisation, access to this information is generally limited to a few individuals and teams and there is increasing appetite clinical and non-clinic teams to obtain their own insights and support clinical research.

We will build upon our self-service data strategy, make more of our data transparent to those in and out of our organisation and explore establishment of our own internal Trusted Research Environment.

What does this mean?

Our organisation and our values, is all about people and communities. People in terms of our workforce, those accessing our services and the communities and families that wrap around and provide support.

Yasar has a young family, lives in Swinton at the edge of town near Mexborough. He's the main carer for his elderly mother who still live in Brinsworth, who has home help services. Yasar has Type I diabetes managed well with a CGM.

Yasars story

Yasar is playing football and has a very serious knee injury. Using the NHSApp his coach can see our UECC is the 'quietest' across South Yorkshire. Upon arrival, he 'taps' in his phone to be booked in, and the Yorkshire and Humber Care Record produces an AI generated clinical summary of Yasars history for the triage nurse, picking up his diabetes, CGM history and allergies or hospital appointments / GP Appointments.

Some x-rays are taken, with AI giving a diagnosis in 30 seconds. Whilst not serious, he's given a digital prescription for painkillers, to be picked at any Pharmacy, and an internal referral is made to our community physio team. In the NHS App Yasar, can see all his notes, and also receives updated from community physio who would like to book a virtual video consultation.

Using video Yasar, meets the physio team, who can see his full hospital, GP and community records and send over via the NHS App some exercises for him to carry out and how to update the NHSApp with his progress. Physio teams use voice recognition to update SystmOne.

AI, and pain surveys can see his pain is not getting better, and automatically invite Yasar to schedule a hospital appointment with an Orthopaedic surgeon – again Yasar can see through the NHSApp when the referral has been received, triaged and booked, and whilst waiting keeps in touch about his condition.

Upon arrival at the hospital, Yasar taps to check in and is instantly sent a link to where the clinic is, and how long roughly he'll be waiting. He see the consultant, who uses voice to interact with the EPR who decides he needs an operation and start the 1st phase of electronic consent. Whilst waiting for his operation, Yasar is given options about where he can have his operation and decides to select MEOC, and using a chatbot type interface is give some dates as to when he'd like be seen – all the time having access to videos of his procedure and what to expect.

At MEOC he receives amazing care, his wife is automatically kept informed of his progress and the clinical team can see, electronically, all the information about him. At the end of the operation, his surgeon films a quick video as to how it went

and what to expect next. Yasar is discharged onto a virtual ward who occasionally check in by video.

Yasars Mum, Sadai, has CPD and home help and is on a frailty virtual ward.

The AI enabled falls sensors knows Sadia is at home, but detects something abnormal in her day to day activity, and telephone calls Sadai home with no response, after which an automatic notification is sent to IRR who can see her vitals are active. Real-time nurse tracking shows a District nurse is already in the area, he's auto re-scheduled and given details of how to access Sadai's property and send sent links to her care plans (his previous appointment is auto notified that there will be a delay).

Sadai is not well and an ambulance is called. As Yasar his is the prime carer as recorded on Sadai care plan he is auto notified, along with contact details of the district nurse who re-assures him. YAS crews can also see Sadia care plans and Yasar can see which A&E Sadai is taken to. A transfer of care document is created, along with a detailed AI advanced clerking summary.

Sadai receives amazing timely intervention, staff use RTLS find equipment, are auto notified of test results, but she does require some overnight care – as Sadai moves through the hospital Yasar is kept updated.

Unfortunately Sadai needs transferring to Northern General – clinical teams make one 'order' and automatically, PTS are scheduled, then porters, NGH can see a pre-registration before arrival. Upon admittance at NGH, clinical teams can see all Sadai information.

After specialised care at NGH, Sadia is re-patriated back TRFT (Yasar continues to be informed), and ultimately discharged back to the frailty virtual ward

Adoption of this strategy, over the next 3 years will impact the following people in the following ways.

Our patients, families, communities

The COVID-19 pandemic has proven there is societal willingness (and now expectation) for patients to digitally interact with healthcare services. In Rotherham we want this to continue, as enabling digital interactions allows us to provide personalised care and at the same time freeing up much needed capacity for those who are unable to access these digital services.

By 2028, patients will be in control and be informed electronically about their care and transact with us fully electronically 24x7. They will be able to:

- Updating their own care plans, or inviting carers to interact with us on their behalf.
- Traditional hospital services will increasingly be provided directly into people's homes with home intuitive home monitoring solutions, linked to virtual ward capability
- If patients do need to come to hospital, it will feel like a modern digital organisation, we'll provide digital tools, that will guide them before they arrive, so they know what to expect, when and where and after leaving we'll digitally keep in touch to make sure they are well.
- If things change, we'll let them know in near real-time, and why and importantly inform the people they would like us to.
- We will always be open and transparent with our patients and their carers and use digital apps to keep them informed in all stages of their care, and if they wish you digital technology to communicate directly with us.
- In addition, the communities we serve will be able to know in real time how we're performing across several domains, for them to be empowered to make their own informed choices.

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Those who directly provide and support care delivery

Over the next 4 years, we will:

- Have transitioned to a modern EPR, that is intuitive to use and maintains deeply integrated across all our major care pathways with clinical decision support capability.
- Clinicians will be updating patients records in real time in some places using their own voice.
- Ideally this platform will be like our partners, but if this not possible, we will ensure the very highest levels of integration so that we can instantly access and share information.
- Being an integrated organisation, with the input of a dedicated clinical digital team, we will have determined which elements of our EPR(s) need to be fully and automatically integrated, so that staff no longer have to access multiple systems with different user interfaces.
- All our diagnostic machines will be fully integrated into our digital systems and no-one will be manually taking readings from one machine to type into another.
- If clinical teams want or need to access the data they're contributing to; they'll be able to self-serve or use AI technology to extract high quality datasets.

Partners, and wider health and care systems

Across the ICS and beyond our digital systems will positively support pathway re-design, integration and partnerships, to a level that patients will not be concerned with traditional organisational boundaries and facilitating (not hindering) skills and resources to move with the patient across the ICS, and by positively considering EPR alignment across the ICS our clinical teams will benefit from seamlessly being able to access and share information.

All our partners and local communities will also be able to see our performance in real-time, we'll be openly sharing our data and information so we can make shared decisions in real-time.

Our collegues and how we work

By 2027, we will have moved to modern office platforms enabled by AI, reducing reliance on excel spreadsheets on shared drives or cumbersome MS word 'forms', to manage our processes.

Our staff Intranet, will be transformed to a modern platform, with the ability for collegues to access information and receive updates that matter to them. By 2028, we will have fully deployed a GenerativeAI organisational chatbot, that is available 24x7 to answer queries, search policies and interact with the organisational knowledge. New starters will have had a modern and seamless onboarding processes, and we would have re-designed interactions with all our back-office services such as IT Service desk to be 100% electronic and intuitive and helpful using AI where applicable.

The technology and infrastructure we use on a daily basis will work reliably 24x7, be fit for purpose and operate any location with integrated Single Sign On technology and we will use the latest technology and regional and national systems to ensure we are Cyber safe and able to operate safely if there are any issues.

Interactions within the organisation TRFT will feel 'easy', communications will be responsive and we will know what's going on with a specific process without having to 'chase people up'. We will be able to intuitively find 'things' in real time and stock will automatically order and replenish itself. We will continue to support and skill up the Trust QI programme.

Digital professionals

By 2028, we'll have re-branded the Health Informatics directorate to the Digital, Data and Technology (DDaT) directorate, making it clearer what we are responsible for. The directorate will have a reputation for being professional, responsive and customer focused and would have achieve Level 2 of Health Informatics accreditation, demonstrating our commient to digital change delivered by professionals. Our staff will continued to encourage in self-development and other digital professionals will have 'heard' of TRFT and will want to come to work for us.

Whilst we currently have good levels of clinical engagement, we continue to lack dedicated medicine, community and nursing leadership that can support us in driving through change, co-designing new services and helping make those hard choices.

By 2028, we'll have a dedicated and properly funded digital clinical team that everyone in the organisation knows, they will be experts in digital improvement and will integrate and communicate with the rest of the organisation. This team will run the new Digital Innovations Unit and build a network of digital ambassadors with links into the Trusts QI programme.

Objectives

This section shows the tangible changes we will undertake over the next five years to breathe life into our vision and manifest our visionary aspirations.

It is constructed from 4 digital enablers across 3 pillars of change.

It sets out the broader programme of work to achieve our vision over the term of the strategy. These pillars and enablers will also serve as the ongoing reference point for future decision making.

Appendix 2 – provides further details on each of the objectives in the table below.

	PILLARS		
	Basics Getting the fundamentals right and ensuring reliability	**Improve** Building on the basics, and leveraging existing investments and capabilities	**Transform** Changes that enable us to change how we deliver care
Enablers			
Digital systems	Voice Recognition Paper light eConsent Nursing assessment Smart Hospital Inventory management	Systems and Machine Integration Shared records Clinical Decision support End-to-End Recruitment and onboarding	Digital Front Door EPR Future Virtual Wards In zhospital wearables Back Office experience
Technology	Cyber Secure Guaranteed tech refresh programme SSO Telecommunications	Cloud first Seamless connectivity everywhere Collaboration	Self-healing and self service VDI Gigabit Internet Cloud migration
Information	Clinical Coding Data Quality Mandate External Returns/Data Flows	Predicative analytics Clinical 'command centre' Info easily accessible at the point of need.	Population Health Data Transparency Internal TRE
Our People and Governance	Funded clinical leadership Digital Governance and prioritisation. User co-design	Data Essential Programme QI Patient digital engagement Ongoing professional development	Embed Digital in all our business planning process Un waving digital First culture Digital innovation Unit

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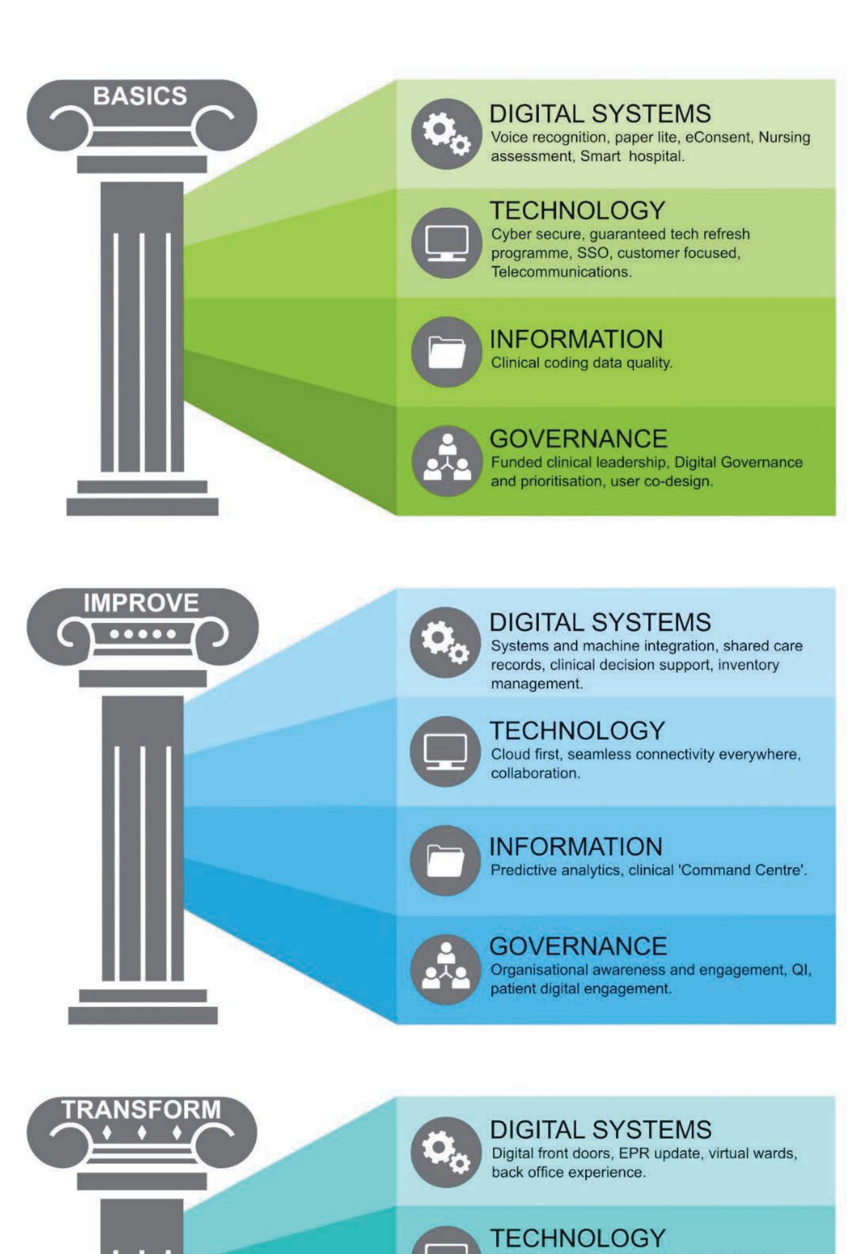
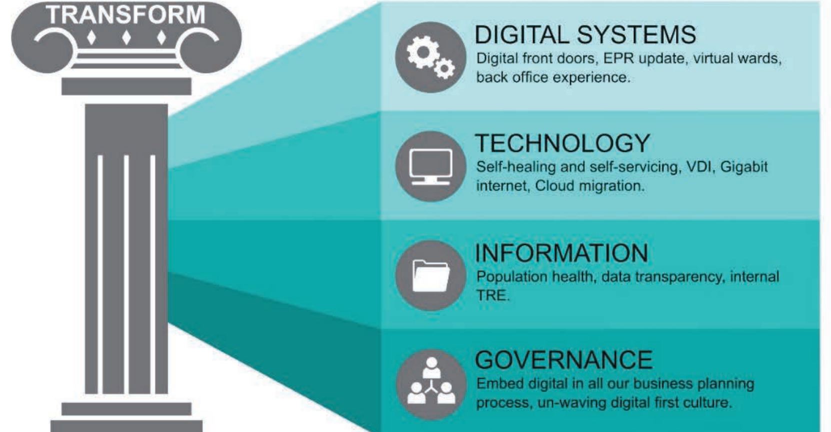

BASICS
DIGITAL SYSTEMS
Voice recognition, paper lite, eConsent, Nursing assessment, Smart hospital.
TECHNOLOGY
Cyber secure, guaranteed tech refresh programme, SSO, customer focused, Telecommunications.
INFORMATION
Clinical coding data quality.
GOVERNANCE
Funded clinical leadership, Digital Governance and prioritisation, user co-design.
IMPROVE
DIGITAL SYSTEMS
Systems and machine integration, shared care records, clinical decision support, inventory management.
TECHNOLOGY
Cloud first, seamless connectivity everywhere, collaboration.
INFORMATION
Predictive analytics, clinical 'Command Centre'.
GOVERNANCE
Organisational awareness and engagement, QI, patient digital engagement.


TRANSFORM
DIGITAL SYSTEMS
Digital front doors, EPR update, virtual wards, back office experience.
TECHNOLOGY
Self-healing and self-servicing, VDI, Gigabit internet, Cloud migration.
INFORMATION
Population health, data transparency, internal TRE.
GOVERNANCE
Embed digital in all our business planning process, un-waving digital first culture.

Strategic timeline

Enablers		2024	2025	2026	2027	2028
Digital systems	Care plans and Assessments					
	Clinical Digital Support					
	Digital Recruitment and Onboarding					
	eConsent					
	EPR Future					
	EPR Replacement					
	EPR Optimisation					
	In Hospital Wearables and sensing					
	Medical device Integration					
	Patient Digital front door					
	Shared Records					
	Shared LIMS, PACS, Maternity					
Technology	Smart Hospital inc Inventory Management					
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	Discrete Simulation					
	Faster Data Flows					
	Predictive Analytics					
	Sustainable Coding					
People and Governance	Clinical Leadership					
	Data Essential Programme					
	Shared Services					

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Enterprise Architecture

Enterprise Architecture aims to provide a a blueprint for how we will achieve the objective of this digital strategy, aligning our DDaT systems and processes with the NHS Long Term Plan for digitally enabled care. Enterprise Architecture (EA) serves as a critical framework for aligning our information technology strategies with our overarching organizational goals and clinical objectives. This comprehensive approach is essential for managing the inherent complexity of our healthcare systems, driving our digital transformation, and ensuring that our DDaT capabilities effectively support the delivery of high-quality patient care. The purpose of EA in our context extends beyond mere technology management; it is a strategic tool that bridges the gap between our clinical needs and technological solutions.

The scope of our EA is comprehensive, encompassing business architecture, data architecture, application architecture, and technology architecture. Our business architecture component maps our clinical and operational processes, organizational structures, and service delivery models, including patient pathways and clinical workflows. Our data architecture focuses on our approach to data management, governance, quality, and analytics, supporting initiatives like population health management and personalized medicine. Our application architecture details our portfolio of clinical systems, diagnostic tools, and support applications, while our technology architecture outlines our DDaT infrastructure, including networks, servers, and end-user devices, as well as our approaches to cloud computing and cybersecurity.

Adopting EA is considered good practice in healthcare DDaT for several reasons. It improves our decision-making by providing a holistic view of our DDaT landscape, enhances our agility in responding to changing requirements, and supports better resource allocation. Our EA also plays a crucial role in ensuring our compliance with NHS standards and regulations, maintaining public trust, and meeting our statutory obligations.

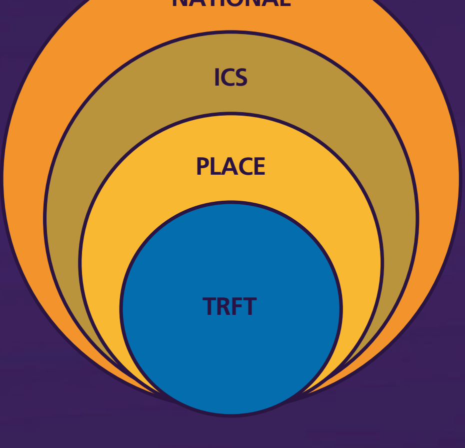
Moreover, it provides us with the framework for managing our digital transformation.

Our Full EA document is available **HERE**

Appendix 1 – Strategic context

TRFT

In 2022 the Trust took the decision to refresh its organisational strategy. The new strategy, 'Our new journey, together' sets out the ambition of the Trust over the coming five years and provides a clear direction of travel for the organisation through what is a challenging and changing local, regional and national landscape.



The strategy sets our vision for the Trust and our values. These are outlined below:

VISION:

We will always ACT in the right way and be PROUD to provide exceptional healthcare to the communities of Rotherham

VALUES:

Ambitious, Caring, Together (ACT).
To support he delivery of this vision the Strategy sets out five strategic ambitions. These are:

Proud

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

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

Our partners
We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care

Us
We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work

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

The Trust is and continues to work to embed and deliver the ambitions set out within the strategy. A key pillar to this is the alignment of other strategies to this overarching Trust strategy, including Digital.

South Yorkshire and Bassetlaw Integrated Care System

Digital Transformation Strategy 2021-2024

OUR VISION

Using data and digital transformation for the benefit of all SYB citizens and staff, to improve health and wellbeing, reduce health inequalities and deliver excellent services

OUR MISSIONS / CAPABILITIES

Digital Citizen

Empower citizens with the digital tools and skills to manage their health and care effectively.

- citizen digital inclusion and literacy
- common digital citizen offer
- condition specific digital citizen offer
- AI to support citizens

Data Intelligence

Use data and tools to create intelligence and insight to address the health inequalities of the SYB population

- population health intelligence platform
- system-wide intelligence cell
- information governance
- decision support and AI

Workforce

Provide the digital tools and skillsets for staff to work safely and effectively, building a digitally literate, resilient, and capable workforce

- whole workforce digital skills and literacy
- elearning and collaboration tools
- integration with Citizen Offer
- agile / remote working
- automation and AI tools

Integrated Care

Digitally transform services and improve data sharing to better integrate care, improve efficiencies and enhance people's care

- digital standards and IG
- data-rich clinical and social care systems
- regional diagnostic systems / networks
- an integrated shared patient record
- data standards

UNDERPINNING CAPABILITIES

Infrastructure

- Networks
- Hardware
- Cybersecurity
- Cloud computing

Change Management

- Leadership and governance
- Digital Maturity Benchmarking
- Communication / engagement
- Communities of Interest
- Quality improvement & Benefits

Innovation

- Innovation Management
- Learning networks
- Rotherham Digital Aspirant Programme

Standards | ***"Think Big, Start Small, Scale Fast"*** | **Principles**

6 Enabling Workstreams

6.1 Digitally Enabling Our System

The Rotherham Place Partnership Digital Group has been operating for many years, it has representation from all key partners and has supported the development of strong working partnerships between the digital teams across Rotherham, which helps to drive forward our joined up digital initiatives. Our first place-wide digital strategy was co-produced in 2019, it supported us in our bid for funding from the national Digital Aspirant Programme (DAP) in 2020, which in turn supported the significant acceleration in delivery of the strategy over the period 2020 – 2022. Our inclusive partnership approach to working together enabled us to use the DAP funds to support the delivery of digital transformation across the place including in health, care, and voluntary services.

In 2022 we updated and refreshed our place digital strategy, acknowledging that much has changed for the health and social care organisations in the place because of the Covid-19 pandemic. This unprecedented period of demand for public services dramatically changed the preconceptions of both citizens and the health and social care workforce about how those services should be provided, with a surge to digital and remote delivery. We need to take stock of the ongoing ramifications of the pandemic, updated strategy elaborates on the following five overarching objectives. We will:

1. ensure that place partners build integrated digitally supported care pathways in a way that involves the wider health community (e.g., community pharmacy and ambulance), puts citizens and their needs at the centre of service design, and gives staff the skills they need to manage these services effectively.
2. keep digital innovation at the heart of our service commissioning and delivery planning.
3. continue to work towards ever closer alignment of our individual organisations' digital programmes and increase the information that is shared for patient care.
4. continue be full partners in the development of NHS South Yorkshire's digital strategy and plans and contribute to ICS wide initiatives.
5. continue to leverage the power of our collective data to design and commission services to meet the needs of the population.

These objectives are then augmented by specific actions set out in four themed sections, which reflect on Rotherham's ambitions in those areas, the challenges experienced, and the steps required to achieve them: The themes and associated actions are detailed in the following sections:

1. **Digital infrastructure**
Acknowledging that many new digital technologies have been implemented across Rotherham to support the Place-wide Covid-19 response, we commit to a review programme that will consolidate and optimise them and develop and document use cases and standard operating procedures, we will:
• ensure that all digital solutions implemented are fully compliant with mandated standards and staff are fully trained to use them.
• Build on the implementation of remote patient monitoring technologies in Rotherham, we will develop service models that harness the potential to support patients in their own homes, intervene when patients' health deteriorates, and reduce unnecessary face-to-face attendance.
• ensure that care homes and PODAC providers have robust and secure digital infrastructure, and access to key systems, building on the pharmacy integration work started between TRFT and community pharmacies to implement the NHS Discharge Medicines Service.
• continue our programme of reviewing and improving GP network performance.
• support our NHS partners and care homes to meet required bandwidth capacities
	2. **Shared care records** - we will:
	• assess the long-term role of the Rotherham Health app in the context of:
	  ○ the 2022-23 Priorities and Operation Planning Guidance requirement to raise NHS app registrations to 60% of GP adult lists size.
	  ○ potential to secure NHS Digital's support for integration of the Rotherham Health app into the NHS app.
	• review, and if required develop and communicate a set of use cases for the Rotherham Health Record.
	• work with partners across the ICS and Yorkshire and Humber region to build the availability of data and number of people using the Yorkshire Humber Care Record.
	will continue with work to improve the datasets available in Rotherham Health Record.

3. **The digital citizen** - we will: • review the impact of the Covid-19 pandemic on the digital maturity of the voluntary sector, recognising the significant contribution that the sector makes to the lives of Rotherham citizens. • when we procure or design digital tools for public use, we will engage citizens or citizen groups in co-design and testing, to ensure ease of use is built in. • continue to work with GP surgeries to align their website to those of their PCN. • continue to develop Gismo as a tool to signpost citizens to voluntary organisations, by increasing its functionality and driving higher usage. • support the work of the Digital Inclusion Team and look for opportunities to share learning across the place partners.	4. **Intelligence and analytics** - we will: • continue to develop the sustainable analytical resources that we need to support the delivery of population health management across the Place, from data analysis tools techniques to skilled analysts and general data skills in the workforce. • contribute to better population health management at ICS-level by developing and improving data links with health and social care organisations outside Rotherham. • create information products in collaboration with all of the ICP partners, ensuring that they provide insights from which commissioning and service redesign decisions can be made. • maintain a forward view of innovative data analysis techniques and technologies, e.g., artificial intelligence and machine learning.

The table below show some of the key ongoing projects from our digital strategy mapped to the strategic aims for the Rotherham Place that are detailed in this plan:

Prevention and Health Inequalities	Ensuring the Best Start in Life	Enjoying the Best possible Mental Health and Wellbeing	Enabling people to Live Well for Longer	Improving care for Life-limiting illnesses and End of Life Care	Transforming Healthcare Delivery
Dedicated digital inclusion programme underway in Rotherham Closely linked with work to reduce health inequalities and response to cost of living crisis • Flexible digital support arrangements planned to complement formal digital skills courses already available • Established strong links with communications teams to improve how we shared information and guidance with our local populations • Partnership with local colleges and voluntary groups are under discussion • Plans for access to devices, mobile data packages, free wi-fi sites. Training and support in development Work to support deliver of the proactive (anticipatory) care programme is ongoing. Initiatives include: • Providing appropriate digital solution to support the identification of people for anticipator care support • Providing the MDT with the necessary information to fully support proactive care delivery in a joined-up way • Enabling the sharing of care plans with the patient and across the MDT	• Supporting the development of a joined up digital offer for the Family Hubs that will be developed in Rotherham • Integration of data from RMBC Children and Young Peoples Service (CYPS) into the Rotherham health Record, starting with inclusion of a SEND data set • Onboarding staff from CYPS as users of the Rotherham Health Record	• Working with place partners to ensure digital is embedded within mental health transformation projects • Supporting community mental health reporting requirements (MHDS specification) for ARRS identifiable activity • Scoping the use of eReferrals for mental health services • Development of the Community Mental health Transformation Hubs • Reconciliation of SMY registers across the place • Development of the Bluebox devises for outreach SMI health checks	• Further development of the Rotherham Health App functionality to provide people with the information and tools to support management of their long-term condition • Widening use of the Rotherham Health App functionality through integration that will enable direct access via the App	• Digital transformation for Enhanced Health in Care Homes: • Rolling out secure access to the Rotherham Health Record in care homes to improve information sharing between settings • Enabling key documentation to be uploaded to the Rotherham Health Record, enabling detailed plans and information to be shared more effectively across care settings • Working with the ICB wide programme to increase the uptake of digital care record systems and falls detection systems in our care homes	Primary care digital plan for FY 23/24 developed to continue optimised use of core systems and tools to support primary care colleagues to: • Improve access and personalised care • Increasing and optimising capacity • Addressing variation and encouraging good practice • Improving communications with the public Urgent, Emergency and Community Care: Virtual Wards – understanding gaps in information sharing across the end to end pathway to help ensure patients get the best outcomes and can avoid unnecessary hospital (re) admissions and get the care they require in their usual place of residence Improving information sharing – linking our place shared records with the wider Regional record (Yorkshire and Humber Care Record)

National

What good looks like

In August 2021, NHSx, (now subsumed into NHSE), published its strategic framework for delivering digital transformation across our health and social care services.

The What Good Looks Like (WGLL) framework draws on local learning. It builds on proven good practice to supply clear guidance for health and care leaders to digitise, connect and transform services safely and securely.

Well led

Articulating a need to develop clear digital strategies and align these across Integrated Care Systems.

Ensure smart foundations

Ensuring digital, data and infrastructure operating environments are reliable, modern, secure, sustainable, and resilient.

Safe practice

Maintain robust cyber security practices as well as routinely review system-wide security, sustainability, and resilience.

Support people

To build digital tools and systems that are fit-for-purpose and support staff to do their jobs well.

Empower citizens

Ensuring citizens can access and contribute to their healthcare information, taking an active role in their health and wellbeing.

Improve care

Embedding digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing.

Healthy populations

Using longitudinal data to design and deliver improvements to population health and wellbeing, making best use of collective resources; with insights from data used to improve outcomes and address health inequalities.

NHS Minimum Digital Foundations (MDF)

Building on the WGLL framework, the Minimum Digital Foundations has been published, and is a key stepping stone to delivering the extent of WGLL, in support of the LTP. The MDF identifies eight elements of maturity relating to the digitisation of care records, specifically: Records and Assessments, Transfers of Care, Diagnostics Management, Medicines Management, Decision Support, Remote and Assistive Care, Asset and Resource Optimisation, Business and Clinical Intelligence. Across each of these categories, the MDF has been split in to three areas related to:

Foundational elements: The foundational capabilities set the bar for a minimum level of digital maturity for the levelling up agenda and there is a well-established market offering (although organisations should use this as a base to deliver transformation and future innovation).

Transformational elements: Where some example implementations are present in selected organisations, but this is not widespread. There is an emerging and scalable market offering for these functionalities and this is what all advanced Trusts should aim to achieve.

Innovation elements: such technologies have yet to be proven at scale but hold promise. Such areas should be included in future development plans of digitally mature organisations, with support from the market to develop such solutions, including developments to support future national requirements

Digital Maturity Assessment

The Digital Maturity Assessment (DMA) is a tool developed by NHS England to help providers and integrated care systems across England understand their level of digital maturity. The DMA is based on the What Good Looks Like Framework, which identifies seven dimensions of digital maturity:

- Leadership and governance
- People and skills
- Information and data
- Technology
- Products and services
- Patient experience

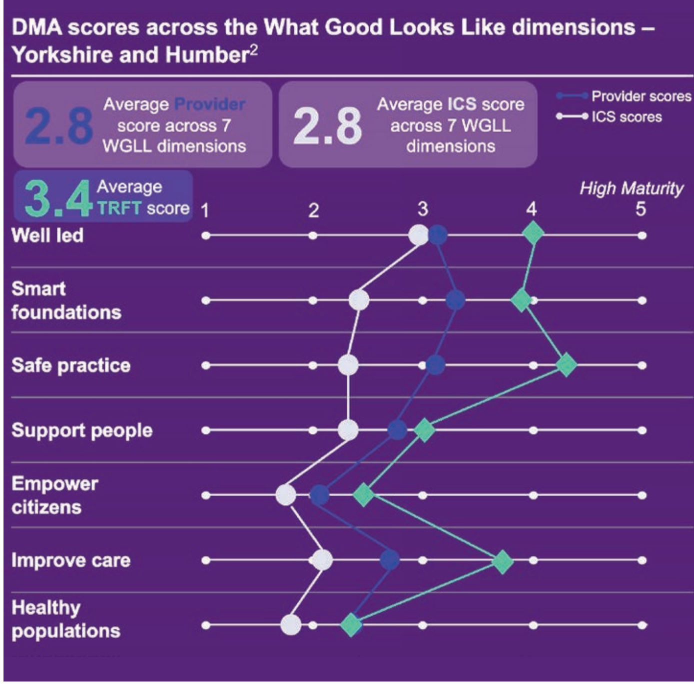
The DMA consists of 50 questions that assess each of these dimensions. Providers and integrated care systems can use the DMA to identify their strengths and gaps in digital maturity, and to develop a plan to improve their performance.

The DMA was first launched in 2015, and a new version was launched in July 2022. The new version of the DMA includes a number of improvements, including:

- A focus on outcomes, rather than just processes
- A more comprehensive assessment of the seven dimensions of digital maturity
- A more user-friendly interface

The DMA is an important tool for helping the NHS to improve its digital maturity. By understanding their level of digital maturity, providers and integrated care systems can identify areas for improvement and develop a plan to make better use of technology to improve patient care.

The below pictogram, shows TRFT average score across each of the What good looks like DMA domains, relative to all providers in Yorkshire and Humber and the three ICS's in Yorkshire and Humber. The Y&H average provider analysis, mirrors exactly the Y&H analysis, with a national average score of 2.8.



DMA, whilst a crude and developing tool, demonstrates TRFT continues to be reasonably mature compared to other healthcare organisations national and regionally. Particular strengths are in in safe practice especially clinical safety, led by Dr Mark Ryan and Smart Foundations, reflecting our extensive use of a fully integrated EPR system and investments in Wifi and End User Devices over the last 3 years.

The DMA is an important tool for helping the NHS improve its digital maturity. By understanding their level of digital maturity, providers and integrated care systems can identify areas for improvement and develop a plan to make better use of technology to improve patient care.

Appendix 2 – Programme Definitions

Programme Definition

Programme	Ambition
Back Office experience	Digitise high volume back office process such as onboarding, recruitment, IT support, payroll, communications
Clinical 'command centre'	Adapt our command centre and processes and analytics to view managed critical quality and safety metrics
Clinical Coding	Achieve 95% flex targets and maintain very high levels of depth and quality
Clinical Decision support	Digital tools to guide clinicians through care pathways
Cloud first	New systems and upgrades to placed in the 'cloud' providing resilience, reliability and scaleability, and supporting carbon energy targets – unless there is compelling reasons not to do so.
Cloud migration	Migrate existing on premises system to the public cloud, improving reliability, scalability, access and support carbon energy targets
Cyber Secure	Protect and secure our systems and services from cyber incidents
Data Literacy	
Data Transparency	Provide public access to our operational and summative clinical information
Digital Front Doors	Patient and families being able to digital access and interact with our services. e.g. Appointment management, preferences, Personal care plans
Digital Governance and prioritisation.	Develop a mechanism, along with senior leaders to support prioritisation
eConsent	Digital tools to capture consent and pre-operative information
Embed Digital in all our business planning process	
EPR update	Review and migrate to a modern and intuitive patient record system that improves functionality and usability
Funded clinical leadership	Substantially fund a clinical digital improvement team, skilled and trained in co-design
Gigabit Internet	Update all our community data connections to minimum of 1GB, ensuring all our staff benefit from high speed access
Guaranteed tech refresh programme	Refresh end user devices and IT Infrastructure, periodically and systematically, so no-one, especially our patient facing clinicians has to make do with out dated and unreliable technology.
Internal TRE	Abstract the data from our clinical systems so that our clinicians and researchers can securely and easily directly access

Programme	Ambition
Inventory management	Electronic automated stock control, reducing admin burden and waste
Nursing assessments and care plans	Assessments and plans to be digital, reduce duplication, shared across health and care and patients able to contribute and view
Organisational awareness and engagement	
Paper light	Remove the use of paper where possible throughout our clinical and non-clinical process. (NB: mass scanning of historic clinical records is not included)
Patient digital engagement	
Population Health	Use the data and intelligence we have about our local population to target interventions and address health inequalities
Predicative analytics	Use our data to predict
QI	
Self-healing and self service	Deploy technology that self-heals and proactively manages itself, reducing need to 'contact' IT and things are not working
Shared records	Connect Community, Hospital, Primary and social care records across the ICS and beyond.
Smart Hospital	Fabric of our estate has capability to track and locate 'things'.
SSO	Implement Single-Sign on technology, with access cards, across all our digital estate
Systems and Machine Integration	Connect medical devices directly into electronic patient records, enabling near instantaneous viewing, alerts, sharing and eradicate manual data entry and charting
Telecommunications	Upgrade telecommunications infrastructure to improve reliability, directory management and support voice recognition enabling quicker contact
Un waving digital First culture	
User co-design	Skill all our digital professionals in co-design
VDI	Virtual Desktop technology, initially within our UECC to enable very very fast access to clinical systems
Virtual Wards	Effectively and safely provide care for patients in their own homes
Voice Recognition	Use natural language speech to input and control our electronic patient record systems

Appendix 3 – Contributors and feedback

During 2022, we held a number of online workshops with NHS Providers, Digital experts, Digital Transformation Committee and Trust Senior leaders. During these workshops, we posed a number of questions around thoughts and views on our current digital offer, and in the future how they would foresee a future digital NHS.

It is the year 2027, what 5 words would you use to describe the our digital offer 20

futuristic indispensable patient centred
interlinked Secure Inclusive seemless
interoperable
real time interop innovative Efficient
personalised seamless
minima CLICKS simple reliable Fast understanding
future proof resilient interactive easy to use

- innovative
  Votes: 6
- Inclusive
  Votes: 4
- efficient
  Votes: 3
- Reliable
  Votes: 3
- Accessible
  Votes: 3
- Fast
  Votes: 3

It is the year 2027, what 5 words would you use to describe the our NHS digital offer 9

Personal targeted care Instant Clinical Ownership
Focused Simple Suitable Streamlined Embedded
Rreliable
collaborative
Linked up mature Reliable inspiring Modern
Digital single EPR
user friendly progressive Integrated
responsive to cosutomers Predicted illness
Fully integrated Inactive

NAME	TITLE
Ben Gray	Assistant Director: Strategy, Planning and Delivery
Lisa Fox	Associate Director of Information Services
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Abigail Starr	Clinical Lead Therapist / Speech Therapy (Adult)
Rod Kersh	Community Physician
Steven How	Consultant – Emergency Medicine
Mark Smith	Consultant Anaesthetist
Mark Ryan	Consultant Anaesthetist
Richard Slater	Consultant Surgeon, CCIO
Kristy Barnfield	Continence Service Lead Nurse
Jo Butler	Digital Midwife
Kevin Grice	Digital Programme Manager
James Rawlinson	Director of Health Informatics
Elizabeth Wardle	Head of Business Intelligence Analytics
David Simm	Head of Business Intelligence and Data Warehouse
Martin Clarke	Head of Coding and Data Quality
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Derek Stowe	Head of Information Governance & DPO
Rhona McCleery	Information Governance Manager
Sam Ramsden	Interim Head of EPR
Christine Hazlehurst	IT Customer Service & RA Manager
Christopher Birks	IT Integration & Development Manager
Ian Watson	IT Support Service Manager
Wendy Herman	IT Training & Identity and Access Management Manager
Shahzan Zafar	Lead Pharmacist EPMA
Katherine Crooks	NHS Providers, Administrator
Amelia Old	NHS Providers, Administrator
Louise Stopford	NHS Providers, Programme Lead
Angela Ford	Patient Access Service Operational & Performance Manager & Clinical Operations Lead
Cate McLaurin	Public Digital, Director
Connie van Zanten	Public Digital, Principal Lead
Steven Cheung	Radiology Systems Manager/ Department of Clinical Radiology
Claire Hudson	Service Manager, Therapies, Dietetics and Community

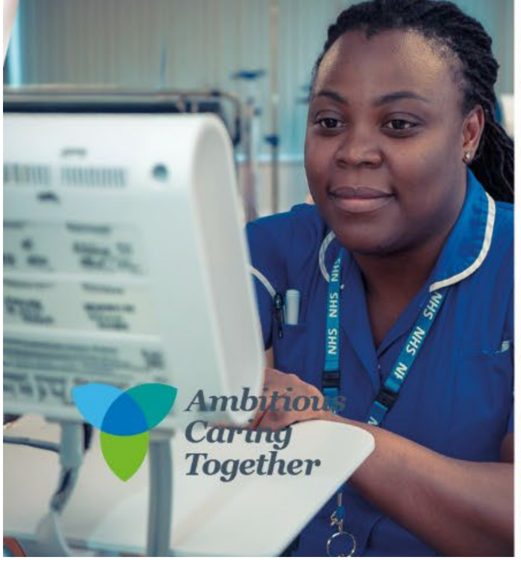
Board of Directors' Meeting
8 November 2024

Agenda item	P175/24
Report	**Quality Improvement Strategy**
Executive Lead	Helen Dobson – Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and experience for our patients.
How does this paper support Trust Values	This strategy is bringing together empowerment for our staff to undertake improvement work, by building capability and working towards a culture of continuous improvement. The strategy aims to put patients at the forefront of work, working together across the organisation and owing the work being done by teams who deliver care.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Quality Improvement (Qi) Strategy has been developed from the gap analysis of both the Health Foundation and NHS Impact self assessments of the organisation's progress in terms of Qi. The ambitiousness of the strategy reflects where the organisation is on this Qi journey. There are three main elements: 1. Building capacity and capability 2. Creating a culture of continuous improvement 3. Co-production with users of our services The strategy aligns with the overall Trust strategy and the People and Culture strategy. The Quality Strategy is currently being developed and the Qi Strategy will support this. It is therefore acknowledged that further amendments to the Qi strategy may be required once the overarching Quality Strategy is completed.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Strategy has gone for consultation to Patient Safety Committee, Clinical Effectiveness Committee and Quality Committee
Board powers to make this decision	The Board of Directors are responsible for approving Trust wide strategies.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Board is asked to review and recommend the strategy for launch

Recommendations	It is recommended that: The strategy is approved for launch
Appendices	No Appendices

The Rotherham NHS Foundation Trust

Quality Improvement Strategy 2024/28



NHS
Improvement Learning
South Yorkshire
Your roadmap to
Quality Improvement
FINISH
START
1 PROBLEM
Clearly identifying what you intended to improve is fundamental to your project's success
2 PEOPLE
Involving the right people and seeking their diverse perspectives early in a project, helps you gain essential buy-in.
3 UNDERSTAND
Following a systematic process deepens understanding of the whole system and its issues. Ensuring effective, sustainable change is achieved.
4 AIM
Developing a clear aim statement will give your project the focus it needs, by aligning the whole teams' improvement efforts.
5 MEASURE
Robust measurement strategies are vital for unbiased assessment of current performance and the impact of any changes.
6 CHANGES
Change ideas informed by best practice, high-quality evidence, and a deep knowledge of the processes within your system, maximises improvement potential.
7 TEST
The iterative process of PDSA cycles supports the rapid learning and refinement from any real-time tests of change.
8 IMPLEMENT
Ensure the improvement plan is effectively executed and sustainable. Gradually integrate it into standard practice with a clear strategy for long-term sustainability.
9 EVALUATE
Ensure the change process meets its objectives. Continuously monitor to sustain original aims and benefits. Document lessons learned for future use

Welcome to our Quality Improvement strategy. As a Trust we are on a journey to excellence with quality improvement being a significant element of this.

This strategy aligns to our overall Trust strategy and our People and Culture strategy, linking to our values (ambitious, caring, and together) and our strategic ambitions, whilst recognising that as an organisation we are in the early stages of our quality improvement journey.

Quality improvement (Qi) in healthcare is based on the principle of organisations and staff continuously trying to improve how they work and the quality of care outcomes for patients. This requires an iterative approach to change, continuous testing and measurement by empowering frontline teams. (Ross and Naylor 2017)

In order to provide outstanding services, it is crucial that colleagues in our organisation are capable and supported to lead innovative and fast paced service change. These improvements are developed through re-starting, re-designing or developing new processes, pathways and services.

To that end, it is proposed that the Trust takes a strategic and systematic approach to quality improvement (QI), particularly with a view to achieving key improvement aims described in the Trust's 2023 – 2028 strategy:

This means making quality improvement the core of our every day, encouraging our staff to make changes by removing bureaucracy wherever we can and celebrating their achievements (TRFT Our new journey together 2022-27).

As part of our operational plan we aim to empower our teams to deliver improvements using Qi to provide outstanding care for our patients and services for our people.

National context

Following a national improvement review, NHS England have further created a proposed approach for Improvement for all Trusts with a Qi model in place. NHS Impact sets out five elements outlined which, along with the Health Foundation Organisational Checklist (Woodhead 2015) have formed the baseline assessment for TRFT, the gap analysis and areas for improvement of these has formed a base on which to build the Qi strategy for the next five years with the overarching long

term aim of becoming a learning organisation using continuous improvement as part of our culture..

Impact

Already, our 2023 staff survey results are demonstrating more people are involved in improvements in their area which will have an impact on staff and patent experience, seeking continuous improvement of work and services on our journey to excellence (People and Culture strategy 2024 – 2027). With our newly co-created Improvement Learning South Yorkshire (ILSY) improvement training, we aim to showcase improvement activity from across the Trust.

The ambition of enabling our staff to undertake Qi activity is that we want to become the employer of choice by being recognised as enabling staff to improve patient care continually. The key impact of becoming a learning organisation using continuous improvement is reflected in our staff survey and patient feedback results, our staff need to be supported and enabled to safely test new ideas and not be afraid to retry safely if needed. By involving patients and users of our services in Qi we strive to co-produce our improvement activity and shape our improvement journey through lived experience and feedback.

Implementing our strategy and measuring success

Strategic ambition	Building blocks (self-assessment)	Actions	Measurement of success
1. Building capacity and capability All staff are confident to undertake a small piece of improvement work and have support from line managers to make small tests of change	1.1 Qi training at all levels QI 1 day and QI Practitioner (ILSY) available to all staff.	Qi training is available to all levels of staff. Qi training is included in induction, preceptorship and leadership development	• 60 staff per annum attend Qi 1 day training • 70 QI practitioners per annum • Qi 1 day giving staff knowledge of basic tools and permission to seek support to start improvement work • 90% of QI Practitioner projects shared within 6 months of theory training • Staff of all levels invited to attend QI courses at both levels • Staff are coached to use improvement tools, methodology and language • We offer two places per cohort for users of our services to participate in improvement training

	1.2 Online data and resources Resources and data are available for staff online and in the library to support improvement work	Staff use resources and data including Power Bi and Datix as well as literature for evidence to develop improvement work linked to identified PSIRF improvement themes	• 20 Pebbles and rocks submitted via the Hub and supported by Qi team • Hub page and library resources available to all staff • 50% of national clinical audits will have QI activity registered that specifically aims to improve compliance with evidence based standards of care to improve patient outcomes • 90% of Qi Practitioners register improvement work on AMaT and utilise the tools available within that to shape improvement work within 3 months of course • Qi work relating to Patient Safety Improvement Framework (PSIRF) initiated by clinical teams from Datix themes
	1.3 Coaching support for improvement work	Coaching style is used to support	• Staff undertaking improvement work are coached through the process by the Qi

		development of individual and group improvement work	team or a local QI Practitioner reflected in different sources; pebbles and rocks registered, the exemplar accreditation Qi evidence and staff trained. • QI Practitioners supported to maintain and continue developing improvement skills • 50% QI Practitioners attend regular action learning sets • All staff with leadership responsibilities utilise Qi coaching on a daily basis through huddles and supporting Qi activity locally
2 Creating a culture of continuous improvement Staff are supported to make small changes (Qi pebbles), and support is available	2.1 Qi embedded within all job descriptions Set the expectation through new joiners to the trust that all staff should have a common understanding of improvement	Qi is introduced as a concept and training offer made at induction All preceptees will undertake Qi training and present back a	• Qi features in induction and preceptorship programme • 70 new Qi Practitioners trained per year • 20 pebbles and rocks registered annually • 50 people/teams supported to use Qi

for staff having undertake Qi training to develop their Qi knowledge and skills to undertake further improvement work		piece of work at the end of the preceptorship year	• Outcomes of Qi work shared at celebration events annually • Leadership engagement with Qi for all levels of staff to undertake improvement work
	2.2 Support and resilience Support is available regularly for QI Practitioners and when individuals or teams start improvement work	Support for Qi Practitioners available regularly via action learning Individuals and teams offered coaching support to develop Qi work locally	• Qi Practitioner action learning sets available bimonthly to discuss issues • Offer of deep dive into improvement tools and how to use them available as group support • Coaching support offered to help projects progress to completion with measureable outcomes • Improvement activity is supported every day by leaders using improvement coaching tools
	2.2 Qi work and outcomes measured	Training is measured on throughput as well as changes made	• Qi team to support 90% of improvement work following on from training

	All improvement work is monitored for outcomes	following the programme. All Qi Practitioner attendees are expected to undertake a piece of improvement work	• All improvement work will be monitored and followed up with support offered where needed • Care Groups use Exemplar Accreditation to showcase Qi activity being undertaken 5 Gold accreditations awarded by 2027 • Staff survey results reflect the increase in capability of staff undertaking improvement work locally
3 Co-production of improvement with users of our services Demonstrate the impact of coproducing improvements with people who use services as an	3.1 Empower teams delivering services and care to test improvement work Our leaders empower teams across the organisation to use Qi concepts to make small improvements	Have a clear leadership development strategy outlining capability requirements and access to training, including improvement training	• Leading improvement education support available within the trust and via NHS Impact for our leaders • Offer 8 users of our services formal Qi training per annum • Staff are given permission to make small tests using Qi concepts, in the form of pebbles and rocks

integral part of daily work. Our leaders are encouraged and support to develop themselves and their staff to lead improvement work		Our leaders create an environment for all staff to use Qi concepts to make small improvements	• Data is available to all staff to shape improvement work with users of our services • Engage with NHS Impact leadership offer for defined staff • Supporting local Qi work and using improvement language when doing this to embed the concepts • Our leaders support staff to develop small tests of change to try in a safe to fail environment
	3.2 Engage with people who have lived experience of our services to design what matters to them We engage with our services users to co-produce improvement	Users of our services are invited to co-produce improvement work as partners	• Our teams have a good understanding of what matters most to them and the opportunity to work with people using our services to shape improvements • We work in partnership with users of our services to co-produce improvement outcomes with them

	where changes directly affect them		

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The Rotherham NHS Foundation Trust People and Culture Strategy 2024 – 2027 People and Culture Strategy 2024 - 2027 (xrothgen.nhs.uk)

Board of Directors' Meeting
8 November 2024

Agenda item	P176/24
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D8: We will not be able to sustain services in line with national and system requirements because of a potential deficit in 2024/25 leading to further financial instability.
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 September 2024 (Month 6 2024/25): ○ A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management. ○ The Trust was notified in September that it would receive £5,718K of national deficit funding. The overall impact is the requirement to improve the 2024/25 planned deficit from £6,302K to £584K

	• Section 2 – Income & Expenditure Account for September 2024 (Month 6 2024/25: o Financial results for September 2024. - A control total deficit to plan of £555K in month and £2,180K year to date; - NHS England measures the Trust's I&E performance against its control total having adjusted for depreciation on donated assets, impairments and accounting for Private Finance Initiatives under IFRS 16 – Leases (total of £393K). • Section 3 – Income and Expenditure Account Forecast Out-Turn o A forecast out-turn deficit to the planned control total, for the year ending 31st March 2025, of £12,591K. o At this point the Trust will be reporting externally to the ICB and NHSE that it will be delivering its planned deficit as actions are being taken to recover this position, and the use of reserves will enable the Trust to deliver its plan. • Section 4 – Capital Expenditure for September 2024 (Month 6 2024/25) o Results for September 2024 show expenditure of £865K in month and £2,996K year to date against a budget of £4,124K, an under-spend of £1,128K (27%). Schemes are progressing and it is expected that the Trust will spend its full capital allocation. o Financial plans and monthly profiles have been revised and updated in line with budget holder expectations. • Section 5 – Cash Flow 2024/25 o A cash flow graph showing actual cash movements between April 2023 and September 2024. A month-end cash value as at 30th September 2024 of £6,383K, which is £1,014K adverse to 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 on 29th October 2024. • CIP performance was discussed at the Efficiency Board meeting held on 9th October 2024 and it was discussed at the Financial Recovery Meeting on 10th October 2024. • Capital expenditure was reviewed at the Capital Monitoring Group held on 21st October 2024. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 30th October 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			Year to date			Forecast	Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	FV £000s
I&E Performance (Actual)	3,531	2,972	(559)	(369)	(2,573)	(2,204)	(12,616)	(13,198)
I&E Performance (Control Total)	3,592	3,037	(555)	0	(2,180)	(2,180)	(12,591)	(13,176)
Capital Expenditure	912	865	47	4,124	2,996	1,128	0	0
Cash Balance	(2,975)	(3,444)	(469)	7,397	6,383	(1,014)	0	0

1.2 The Trust has over-spent against its I&E control total in September 2024 by £555K and year to date by £2,180K. NHS England measures the Trust's I&E performance against its control total having adjusted for depreciation on donated assets, impairments and accounting for Private Finance Initiatives under IFRS 16 - Leases.

1.3 These figures include an under performance on elective recovery activity of £1,417K year to date, it is expected that this will be recovered through additional targeted schemes and from a review to provide assurance that the coding of activity is appropriately recorded and captured.

1.4 The Trust was notified of deficit funding of £5,718K in September 2024, which improves the overall planned deficit for 2024/25 from £6,302K to £584K. Deficit funding has been phased into the plan from September 2024.

1.5 Capital expenditure is behind plan in month and year to date, with cumulative spend of £2,996k against a budget of £4,124K. Approval to spend capital funding, across the Trust's priorities, has been agreed and the forecast is to fully deliver against plan. The capital programme is continuing to be monitored by the Capital Monitoring Group chaired by the Director of Finance.

1.6 The cash position at the end of September 2024 remains strong at £6,383K but is adverse to plan by £1,014K.

2. Income & Expenditure Account for September 2024 (Month 6 2024/25)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered a deficit to plan in September 2024 of £555K and £2,180K year to date.

Summary Income and Expenditure Position	Annual plan	Month			Year to date			2024/2025
		Plan	Actual	Variance	Plan	Actual	Variance	Monthly Trend /
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	Variance
Clinical Income	340,247	31,969	32,063	94	171,837	172,765	928	
Other Operating Income	23,433	2,062	2,183	121	12,327	13,348	1,020	
Pay	(230,358)	(19,320)	(20,769)	(1,449)	(116,504)	(123,733)	(7,230)	
Non Pay	(101,171)	(9,200)	(9,778)	(578)	(55,935)	(59,466)	(3,531)	
Non Operating Costs	(5,040)	(330)	(324)	5	(2,207)	(1,905)	301	
Reserves	(29,059)	(1,650)	(403)	1,247	(9,888)	(3,581)	6,307	
Retained Surplus/ (Deficit)	**(1,949)**	**3,531**	**2,972**	**(559)**	**(369)**	**(2,573)**	**(2,204)**	
Adjustments	1,365	61	65	4	369	393	24	
Control Total Surplus/ (Deficit)	**(584)**	**3,592**	**3,037**	**(555)**	**(0)**	**(2,180)**	**(2,180)**	

2.2 Clinical Income is ahead of plan year to date due to the true up position on the 2023/24 ERF and income associated with the consultants pay reform. These figures include an adverse year to date position on ERF in 2024/25 of £1,417K. The overall ERF target for South Yorkshire ICB and the Trust is 103% of 19/20's activity (priced at current tariff), for variable activity the plan is based on 2023/24 outturn uplifted for 2024/25 tariff.

2.3 Other Operating Income is ahead of plan in month and year to date with increased income from staff recharges (£581K), which will be an offset to the pay over-spend, and increased research, education and training income (£483K).

2.4 Pay costs are over-spending by £7,230K year to date. Bank and agency expenditure is not currently being maintained within the gross establishment budget, and contributing to this is £1,915K under-delivery against the planned cost improvements.

2.5 Non Pay costs are over-spending by £3,531K year to date. The overspend is largely related to Drugs and Clinical Supplies £3,066K, Premises £239K, and under-delivery against cost improvement plans of £690K which are offset by under-spends for clinical negligence £231K.

2.6 The positive performance in Non-Operating Costs is due to interest receivable on cash balances being better than planned.

2.7 £6,307K has already been released from Reserves year to date, this is to cover the under-delivery of CIP, additional capacity over and above funded bed capacity and Industrial Action impact on ERF.

3 <u>Forecast Out-Turn Performance to 31st March 2025</u>

3.1 The table below shows the forecast out-turn position for the financial year 2024/25. The Trust is forecasting to deliver a £12,591K deficit to plan.

Summary Income and Expenditure Position	Annual plan	Forecast outturn (Full Year)	Forecast Variance (Full Year)	Actual Variance (YTD)	Forecast Variance	Total Variance	2024/2025 Monthly Trend / Variance
	£000s	£000s	£000s	£000s	£000s	£000s	
Clinical Income	340,247	342,293	2,046	928	1,118	2,046	
Other Operating Income	23,433	25,842	2,410	1,020	1,389	2,410	
Pay	(230,358)	(246,852)	(16,494)	(7,230)	(9,265)	(16,494)	
Non Pay	(101,171)	(108,538)	(7,367)	(3,531)	(3,836)	(7,367)	
Non Operating Costs	(5,040)	(4,558)	482	301	181	482	
Reserves	(29,059)	(22,752)	6,307	6,307	0	6,307	
Retained Surplus/ (Deficit)	**(1,949)**	**(14,565)**	**(12,616)**	**(2,204)**	**(10,412)**	**(12,616)**	
Adjustments	1,365	1,390	25	24	(1)	25	
Control Total Surplus/ (Deficit)	**(584)**	**(13,175)**	**(12,591)**	**(2,180)**	**(10,414)**	**(12,591)**	

3.2 Within Clinical Income, the estimated ERF YTD under delivery against divisional targets is reflected of £1,417K. No further under or over delivery of ERF is forecast. Additional income is forecast from other variable activities, it also includes the true up of 2023/24's ERF and variable income, and income relating to the consultants pay reform which was notified of post plan submission.

3.3 Other Operating Income is forecasting increases in income from research, development, education & training (£1,075K) and staff recharges (£1,439K). 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 but this does include, as yet, undelivered annual CIP budget of £4,633K and premium agency costs of £4,350K.

3.5 Non Pay costs are similarly showing a significant deterioration in performance linked to continued increasing costs most notably within premises £957K, undelivered CIPs £2,419K, and drugs and clinical supplies £5,347K, which are partly offset by forecast underspends in clinical negligence £450K.

3.6 Non-Operating Costs reflect increased income from interest receivable on money deposited with Government banking services.

3.7 The Trust will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE. It assumes that with appropriate management action and the use of reserves, these will enable the Trust to deliver its overall plan by 31st March 2025, a year end deficit of £584K. This position assumes that the Elective Recovery Fund and Efficiency targets will be met, costs will be funded for periods of Industrial Action of £604K and actions are taken with regards additional capacity.

3.9 Cost reduction and CIP delivery are key to improving the forecast outturn position, and are required to be proactively managed across all services, and for action plans to be implemented. This remains a significant risk to the Trust delivering against its overall plan. This was addressed at July's efficiency Board with Care Groups and Corporate Services leads. Financial Recovery Meetings are being held monthly with Senior Leaders and Executive Directors to address the financial and operational challenges, and to identify solutions.

4. Capital Programme

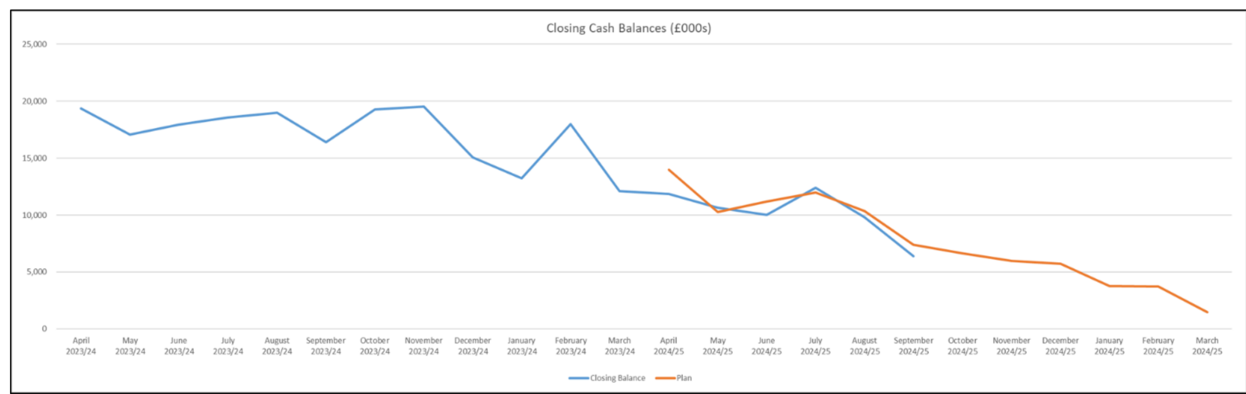
4.1 During September 2024 the Trust incurred capital expenditure of £865K, and year to date it is £2,996K. Schemes are progressing and it is expected that the Trust will spend its full capital allocation of £11,180K.

Capital Expenditure	Month			Year to date			Forecast	Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	Forecast Variance £000s
Estates Strategy	289	231	58	1,405	1,160	245	0	0
Estates Maintenance	410	35	375	1,369	538	831	0	0
Information Technology	150	386	(236)	1,070	858	212	0	0
Medical & Other Equipment	63	213	(150)	413	440	(27)	0	0
Other	0	0	0	(133)	0	(133)	0	0
TOTAL	912	865	47	4,124	2,996	1,128	**0**	**0**

4.2 Financial plans and monthly profiles have been revised and updated in line with budget holder expectations.

5. Cash Management

5.1 The cash position at the end of September remains strong at £6,383K but is adverse to plan by £1,014K. This has allowed the Trust to earn interest on its daily cash balances of £442K year to date.



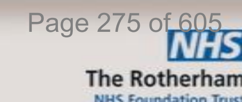
Steve Hackett
Director of Finance
14 October 2024

Finance & Performance Committee Meeting -- October 2024

Agenda item	FPC/134/24
Report	**Integrated Performance Report – September**
Executive Lead	Michael Wright, Managing Director
Link with the BAF	D5, D6
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	The Finance & Performance Integrated Performance Report (IPR) consolidates the essential monthly data for the organisation across both the Finance and Operational domains. The primary focus is on utilising Statistical Process Control (SPC) charts to provide impact-focused commentary. This report maintains the use of RAG ratings for metrics based on national standards or local targets, incorporating Operational Plan or regional trajectory metrics as appropriate. Benchmarking comparisons have been included as agreed, although it is important to note that these are often subject to a time lag due to the publication dates of national data.
Due Diligence	This paper is presented to the Finance & Performance Committee before presentation to the Board. Relevant Executive Directors have approved the national submissions contained within this report, and been sighted on relevant performance metrics through the weekly Executive Team Performance Report.
Board powers to make this decision	The paper is provided for assurance only.
Who, What and When	The paper is to provide assurance to Committee members around the Financial and Operational performance of the Trust. No decision or action is requested.
Recommendations	It is recommended that the Committee note the contents of this report.
Appendices	Integrated Performance Report – September 2024

Board of Directors Meeting

Integrated Performance Report - September 2024



Performance Matrix Summary

The Rotherham NHS Foundation Trust

Assurance

Variation	Pass	Hit or Miss	Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • Stillbirth rate • Turnover (12 month rolling)	**GOOD: CELEBRATE AND UNDERSTAND** • Readmissions • OP to PIFU • DM01 • FDS • Mean LoS (Non-Elective)	**CONCERNING: CELEBRATE BUT TAKE ACTION** • 1:1 Care in Labour • 65+ weeks • 4 Hour Performance • Clinic Utilisation • Did Not Attend
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • SHMI • MAST – Job Specific	**STATIC: INVESTIGATE AND UNDERSTAND** • VTE Risk Assessments • Care Hours per Patient Day • Combined Positivity Score • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Patient Falls (Moderate and above) • Pressure Ulcers (Cat 3 and above) – Acute • Medication Incidents (Moderate and above) – Acute and Community • C. diff infections • Waiting List Size • 31 Day Treatment Standard • 62 Day Treatment Standard • >12 hours in A&E • Bed Occupancy • LoS >21 Days • Date of Discharge = Discharge Ready Date • A&E Attendances from Care Homes • Patients on Virtual Ward • Urgent 2 Hour Response • Model Hospital Day Case Rate • First Outpatients (%Plan) • Inpatients (%Plan) • Daycases (%Plan) • LoS >7 Days • Mean LoS Elective • Vacancy Rate (total)	**CONCERNING: INVESTIGATE & TAKE ACTION** • Breast milk first feed • RTT • Ambulance Handovers >30min • Average time to be Seen • Criteria to Reside is No • Admissions from Care Homes • Capped Theatres Utilisation • Discharged <5pm • Sickness Rates (12 month rolling) • Sickness Rates • Appraisal Rates (12 month rolling) Appraisal Rates
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • MAST - Core	**CONCERNING:INVESTIGATE & TAKE ACTION** • Pressure Ulcers (Cat 3 and above) – Community • Overdue Followups • 12 hour Trolley Waits	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** 52+ weeks

Performance Matrix Summary - Quality

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • Stillbirth rate	**GOOD: CELEBRATE AND UNDERSTAND** • Readmissions	**CONCERNING: CELEBRATE BUT TAKE ACTION** • 1:1 Care in Labour
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • SHMI	**STATIC: INVESTIGATE AND UNDERSTAND** • VTE Risk Assessments • Care Hours per Patient Day • Combined Positivity Score • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Patient Falls (Moderate and above) • Pressure Ulcers (Cat 3 and above) – Acute • Medication Incidents (Moderate and above) – Acute and Community • C. diff infections	**CONCERNING: INVESTIGATE & TAKE ACTION** • Breast milk first feed
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION** • Pressure Ulcers (Cat 3 and above) – Community	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

How to read the ICONs in this report:

Have we achieved in month?

Are we consistently passing(P)/failing (F) or is it hit and miss (?)

Are we significantly Improving /deteriorating or is there no significant change?

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	-	30,402	Feb-24	-	-			C
Number of 52+ Weeks	200	678	Feb-24					VC
Number of 65+ Weeks	37	74	Feb-24					S

Quality

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
SHMI	"As expected"	"As expected" (103.7)	May-24	N/A			-	S
Readmissions (%)	-	5.9	Aug-24	-	-			G
VTE Risk Assessments (%)	95.0	94.4	Sep-24					S
Care Hours per Patient Day	7.3	7.1	Sep-24					S
Combined Positivity Score (%)	95.0	95.6	Sep-24				-	S
Complaints (per 10k Contacts)	8.0	14.7	Sep-24				-	S
Patient Safety Incident Investigations	3	6	Aug-24				-	S
Patients Falls (Moderate and Above per 1000 bed days)	0.19	0.17	Sep-24				-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 1000 bed days - Acute	0.77	1.48	Sep-24				-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 100 contacts - Community	0.06	0.11	Sep-24				-	C
Medication Incidents - Moderate and Above per 1000 bed days – Acute	0.05	0.09	Sep-24				-	S
Medication Incidents - Moderate and Above per 100 contacts - Community	0.00	0.00	Sep-24				-	S
C. difficile Infections	<4	4	Aug-24					S

*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

SHMI: Summary Hospital-Level Mortality Indicator

Data, Context and Explanation

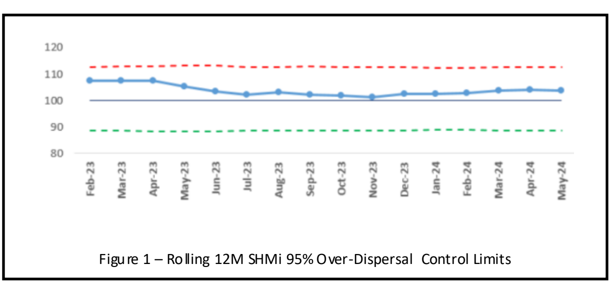


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

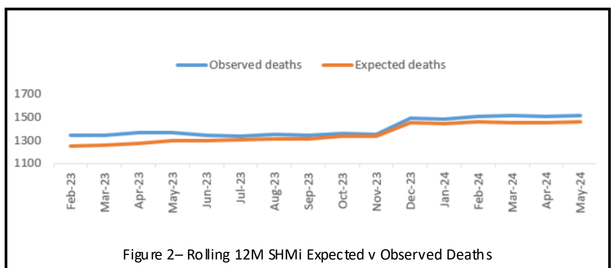


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

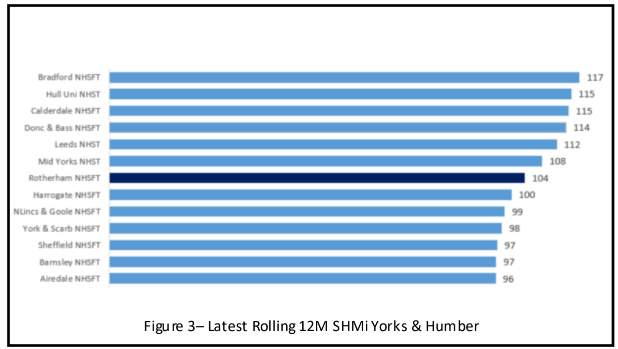


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

TRFT's SHMI remains in the 'As Expected Band'

Covid activity was added back into the SHMI data Dec 2023

- The SHMI reports on mortality at trust level across the NHS in England using a standard methodology. It is produced and published monthly as a National Statistic by NHS Digital
- The SHMI is the ratio between the observed number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated
- The SHMI acts as a 'smoke alarm' to prompt Trusts to consider investigating areas of potential area of concern where more deaths are observed than expected
- Approximately 50% of England's Trusts will be above 100 and 50% below
- There are 3 SHMI banding, As Expected, Higher or Lower. TRFT's SHMI has consistently been As Expected, since July 2021
- SHMI Bandings are calculated for the Trust overall and 10 diagnostic groups

Metric	Current	Target	Exec Owner	Organisational Lead
Latest Rolling 12 Month SHMI -May 24	103.7	-	Jo Beahan	John Taylor
Expected Deaths	1460	-		
Observed Deaths	1515	-		
Trust Banding	Expected	-		

What actions are planned?

- To highlight when SHMI values are in the higher than expected band (95% Over-dispersion Control Limit)
- The Trust Mortality Group will decide on any required investigations/reviews based on the Investigation Pyramid
- This may lead to changes/improvements in practice

What is the expected impact?

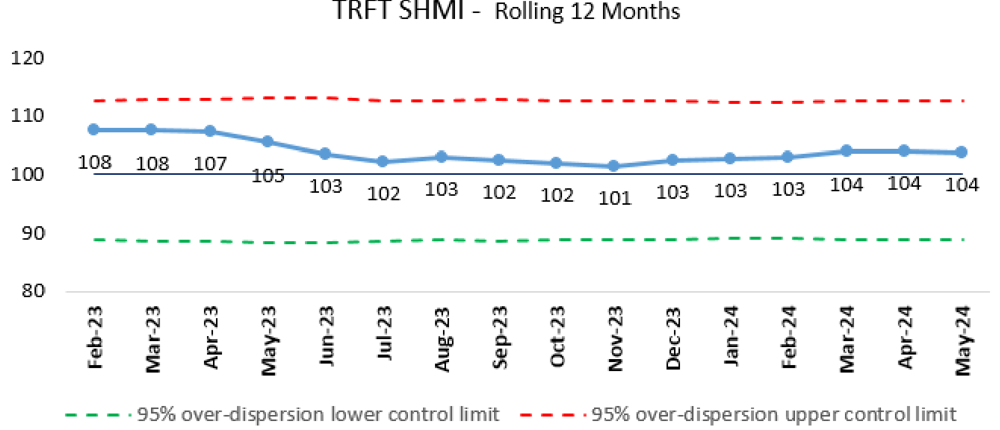
- Investigations or reviews resulting from SHMI investigations will give the Trust Assurance when there are significantly more deaths observed than expected
- Intelligence from SHMi investigations/reviews may lead to changes/improvements in practice

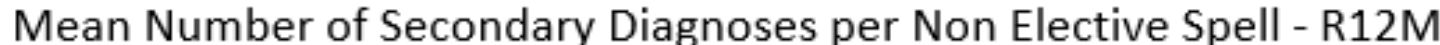
Potential risks to improvement?

- The SHMI isn't monitored and reported on routinely & correctly
- The Trust Mortality Group's response to areas of concern isn't robust and the correct investigations aren't requested/completed
- That intelligence from any investigations/reviews isn't acted upon

SHMI: Summary Hospital-Level Mortality Indicator - Update

SHMI Update

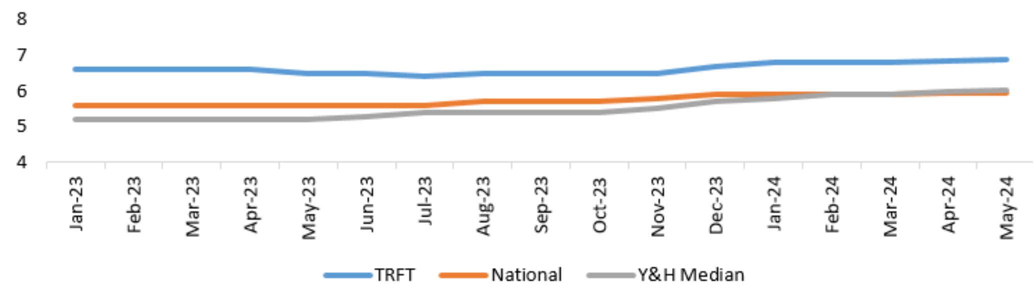




This chart shows that TRFT has consistency been in the As Expected band. The trend pattern shows Common Cause Variation, within this band.

Interpretation Guidance NHS England June 2024

'Where a trust has an 'as expected' SHMI, it is inappropriate to conclude that their SHMI is lower or higher than the national baseline, even if the number of observed deaths is smaller or larger than the number of expected deaths. This is because the trust has been placed in the 'as expected' range because any variation from the number of expected deaths is not statistically significant



The depth of co-morbidity coding is important for the SHMI because its effects the calculated expected risk of death % for each inpatient admission.

This chart shows that TRFT's depth of coding for non elective spells has been consistently higher than the National figure and the Yorkshire & Humber median.

TRFT's higher rate is either down to TRFT's casemix having a higher prevalence of co-morbidities or better capture of these co-morbidities.

SHMI: Coding & Alerts

SHMI - Diagnostic Group Alerts

Acute Myocardial Infarction – VLAD (Variable Life-Adjusted Display) Alert March 2024

This alert was triggered by a higher number of deaths than expected in March 2024. Usually at TRFT there are between 0-5 deaths per month in this group. In March 2024 there were 7.

This alert was discussed at the September Trust Mortality Group meeting. A decision was made to request that Cardiology complete a brief review of the deaths and to request SJRs for 5 of the 7 deaths.

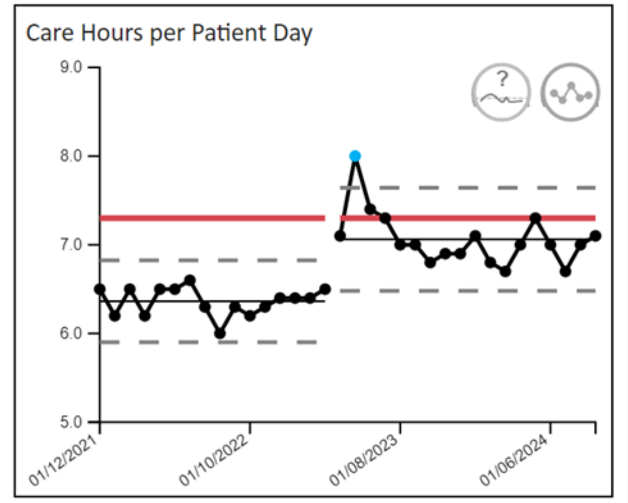
Cardiology have fed back they have looked at the cases and haven't judged any of the deaths to have been preventable. One SJR has been returned, although issues were identified with the care, the death was judged to have 'Definitely Not Preventable'. The remaining SJRs will be viewed upon completion.

SHMI Changes – Methodology, Process or Specification

No new changes

Subtheme: Care hours per patient day

Data, Context and Explanation



- Care Hours Per Patient Day (CHPPD) is the formal, principal measure of workforce deployment in ward-based settings.

- CHPPD forms an integral part of a ward/unit/trust review and oversight of quality and performance indicators to inform quality of care, patient outcomes, people productivity and financial sustainably.

- CHPPD should be used alongside clinical quality and safety outcome measures to understand and reduce unwarranted variation, and support delivery of high quality, efficient patient care.

- Focus on percentage of fill rate against funded establishment.

- Fill rates are within 5% of planned for HCSW day and RN nights. Fill rates are under 5% planned for RN days but there are more support staff around to support safety. Fill rates are over 5% of planned for HCSW nights.

Metric	Value	Target	Exec Lead	Ops Lead
Care Hours per Patient Day	7.1	7.3	Helen Dobson	Cindy Storer

What actions are planned?

- Continued roll out of the Exemplar Accreditation programme. This programme is underpinned by Quality dashboards
- Recruitment of 90 Newly Registered Nurses in September/ October 2024
- Fill rates against planned establishments scrutinised and noted to be lower for RN in the day where more support staff are available.

What is the expected impact?

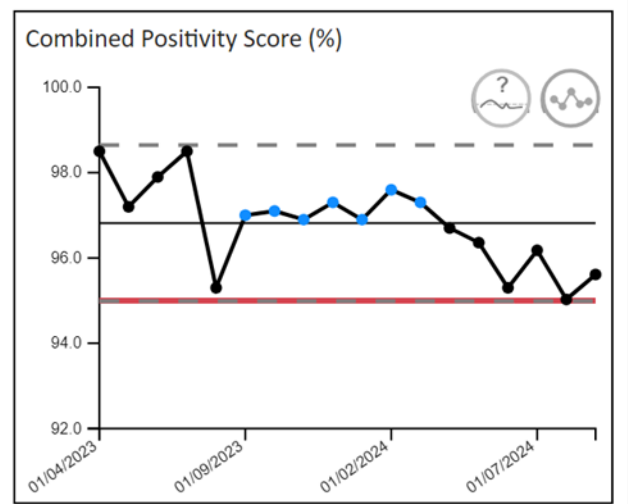
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.

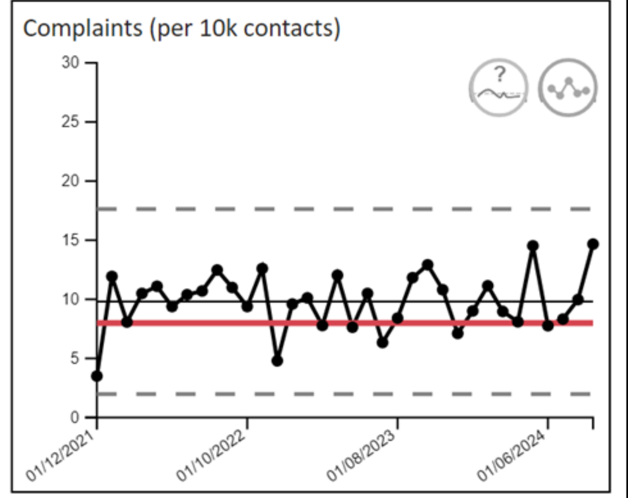
Potential risks to improvement?

- Needing to open additional beds using existing establishments and temporary NHS staff
- Roster KPI not being met
- Turnover of Nurses, Midwives and HCSW

Subtheme: Patient Experience

Data, Context and Explanation





- The Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
- The FFT asks people if they would recommend the services they have used. Our Combined Positivity Score is consistently meeting our target of 95% of Patient saying they would recommend our services.
- Patients can complain about any aspect of NHS care, treatment or service and this is written into the NHS Constitution.
- The number of complaints continues to be monitored. There has been a consistent rate of written complaints per month over the last three years., despite the rising numbers of patients being seen.

Metric	Value	Target	Exec Lead	Ops Lead
Combined Positivity Score (%)	95.6	95.0	Helen Dobson	Cindy Storer
Complaints (per 10k contacts)	14.7	8.0	Helen Dobson	Cindy Storer

What actions are planned?

- Front line resolution through the new PALS resulting in positive compliments
- Training through new Monopoly board continues
- Purple Butterfly resources boxed launched to support personalised care at the end of life
- Carers promise launched to support those with caring responsibilities

What is the expected impact?

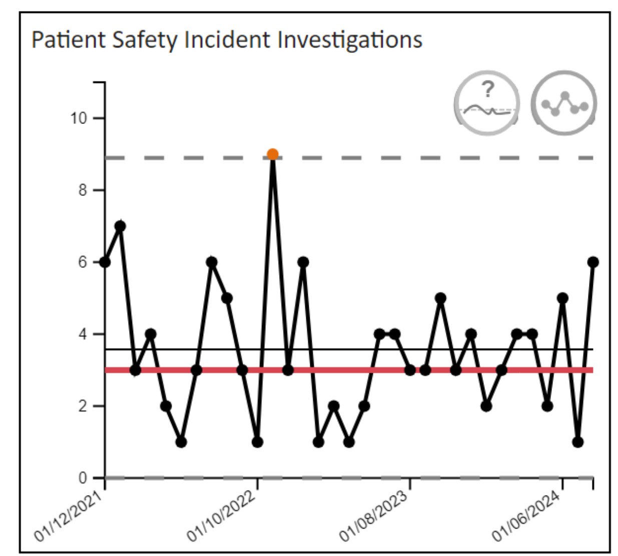
- FFT Continued Positivity score above 95
- The PALS service aims to promote local resolutions to concerns earlier in the process leading to a reduction in formal complaints per 10k contacts

Potential risks to improvement?

- None – all patient experience improvement plans now delivered for 2024/5

Subtheme: Care Incidents (1)

Data, Context and Explanation



Patients Falls (Moderate and Above) per 1000 bed days

- Patient Safety Incident Investigations are completed when a patient has been involved in a moderate harm incident and significant learning identified. Number of PSI remain consistent per month.

- The number of patient falls at moderate harm is remaining consistent at present, at times achieving the 0.19 per 1000 bed days target, including this month although this will not be the case every month.

Metric	Value	Target	Exec Lead	Ops Lead
Patient Safety Incident Investigations	6	3	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.17	0.19	Helen Dobson	Victoria Hazeldine

What actions are planned?

- A Falls Prevention Lead is proposed for the Trust to help reduce the total number of all falls and moderate harm falls through Qi projects and education
- The Patient Safety Incident Response Plan has been updated and will be published by December 2024

What is the expected impact?

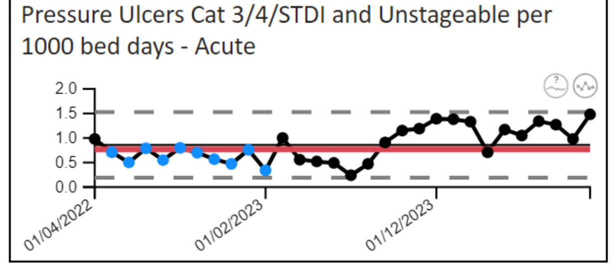
- Stabilisation of PSII's with adequate evidence of shared learning
- Reduction in the total number of falls
- Clear guidance on the use of PSII's against alternative investigation methodology

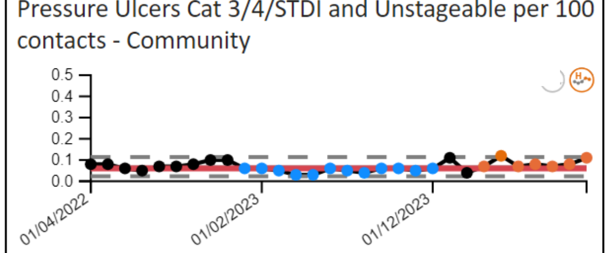
Potential risks to improvement?

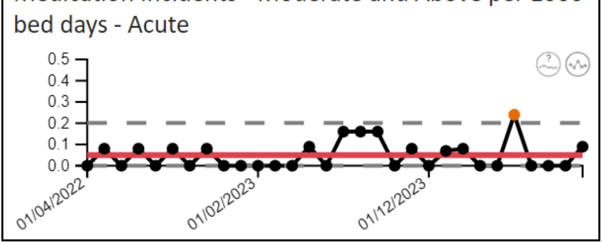
- Increase in the number of patients admitted to acute Trust with complex health problems and additional bed capacity, resulting in reduced nursing and medical ratios
- The lack of a falls lead practitioner to complete work across acute and community to ensure the Trust is compliant with NAIF and Qi initiatives

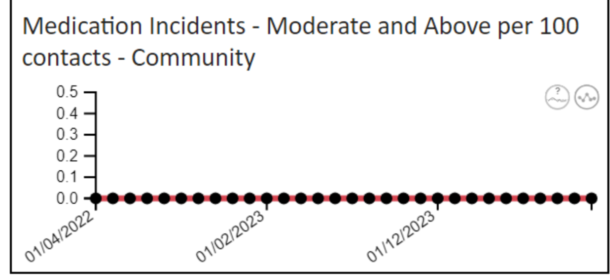
Subtheme: Care Incidents (2)

Data, Context and Explanation









- Medication incidents that are reported through the Datix system can occur for a number of reasons. Over the last 18 months, the Trust has consistently seen just shy 100 incidents reported per month. The aim for 2024/25 is to reduce that down to average of 90 per month (10% reduction)
- Pressure ulcers (PU) remain a concern and are considered, the main, an avoidable harm associated with healthcare delivery. Treating pressure damage costs the NHS more than £3.8 million every day and causes both physiological & psychological harm. The rate of PU in Acute remains in common cause, however in Community the PU rate has shown a deterioration with an increased rate of PU.

Metric	Value	Target	Exec Lead	Ops Lead
Pressure Ulcers Cat 3/4/STDI and Unstagea...	1.48	0.77	Helen Dobson	Victoria Hazeldine
Pressure Ulcers Cat 3/4/STDI and Unstagea...	0.11	0.06	Helen Dobson	Victoria Hazeldine
Medication Incidents - Moderate and Abov...	0.09	0.05	Jo Beahan	Victoria Hazeldine
Medication Incidents - Moderate and Abov...	0.00	0.00	Jo Beahan	Victoria Hazeldine

What actions are planned?

- The metric for medication incidents has now been set for moderate harms and above. This has taken into account the past 2 years data to provide a reasonable target score.
- Pressure ulcers data has been split into Acute (1000 bed days) and Community (1000 contacts). The target has been set using 2 years worth of data to define a reasonable mean

What is the expected impact?

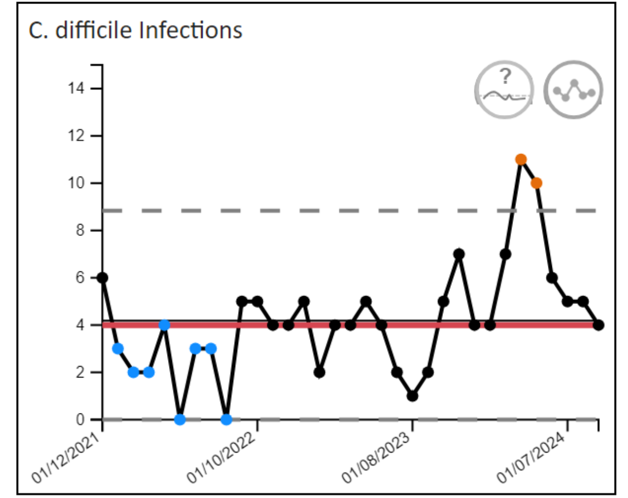
- Reduction in the number of moderate and above medication incidents.
- Reduction in the number of CAT 3/4/SDTI and unstageable pressure ulcers
- Clearer understanding of where the highest area of risk in between community and acute

Potential risks to improvement?

- Increase in the number of patients admitted to acute Trust with complex health problems and additional bed capacity, resulting in reduced nursing and medical ratios

Subtheme: Infection Prevention & Control

Data, Context and Explanation



- Clostridium difficile (C. diff) is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It can usually be treated with a different type of antibiotic.
- The first two months of 24/25 showed significantly higher than expected rates. This is also in line with increased national rates of C. diff.
- Learning from harm is reviewed monthly at Harm Free Care panels and the emerging themes linked to antimicrobial stewardship and prescribing practices. Action are in place to address (see planned action box). It is noticeable that, at present, we will continue to see infections higher than target.
- Nationally there is a trend for increasing rates of C. diff with a renewed focus on AMR. Rates per 100,000 bed days from UKHSA have been published for Q1 highlighting the Trust as an outlier for that period.

Metric	Value	Target	Exec Lead	Ops Lead
C. difficile Infections	4	4	Helen Dobson	Jen Hilton

What actions are planned?

- Harm Free panel continues with continued themes on antibiotic prescribing identified.
- National Standards of Healthcare Cleanliness (2021) have been re-launched.
- New microbiologist appointed and start date anticipated November – the second person will start in February to cover 1 wte.
- Antimicrobial stewardship through prescribing for co-amoxiclav

What is the expected impact?

- A Reduction in case of C. diff and associated per 100,000 bed day rate

Potential risks to improvement?

- Intermittent microbiology support to lead strategically across the Trust, support proactive ward rounds and input into Trust Harm Free Care Panel. Now appointed to but wont start until November 2024

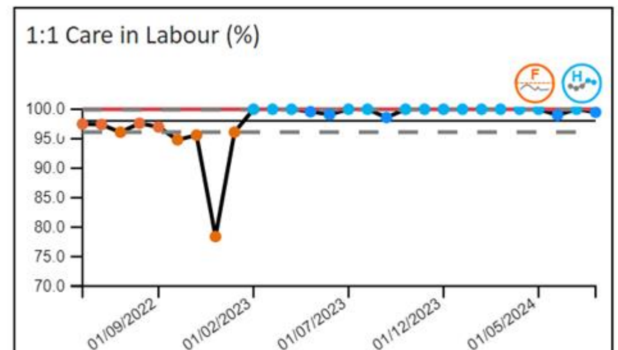
Maternity

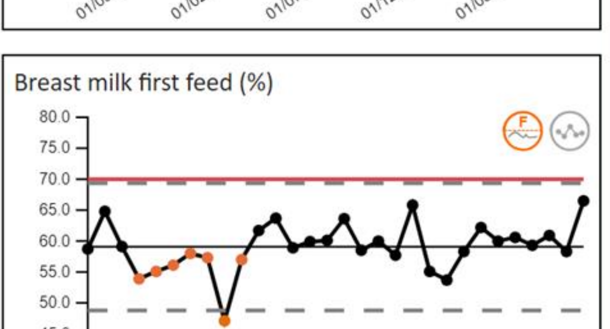
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	99.5	Aug-24		F	H	-	C
Breast milk first feed (%)	70.0	66.5	Sep-24		F			C
Stillbirth rate (per 1000 births)	4.66	2.4	Sep-24		P	L	-	VG

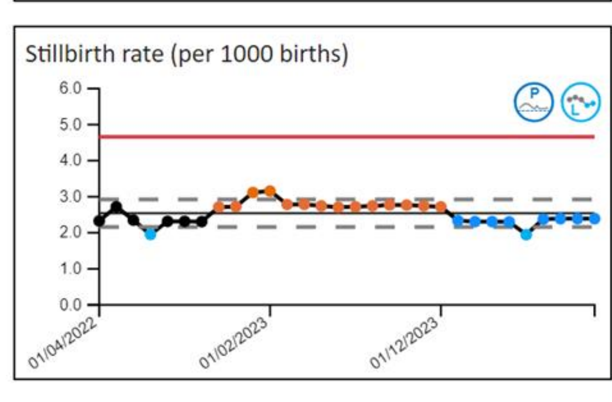
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Maternity

Data, Context and Explanation







- 1:1 care in labour remains at a high performance level, This data is monitored through the Maternity Birth Rate plus Acuity tool to provide assurance for Maternity incentive scheme. Performance on the tool is 100% for August.
- Breast Milk First Feed % continues to be below the Trust target, with an average of 60.9 % against a Trust target of 66%.
- Work is ongoing to educate and support families regarding the benefits of breast milk. TRFT Maternity services are working with partners to support this supporting the Unicef Baby Friendly (BFI) infant feeding standards.
- Still Birth Rates remain consistently lower than the NHS England ambition, of a rate of 2.4 per 1000 births at TRFT. Excluding medical termination of pregnancy (MTOP) and fetal abnormality the rate is 2.39 per 1000 births.

Metric	Value	Target	Exec Lead	Ops Lead
1:1 Care in Labour (%)	99.5	100.0	Helen Dobson	Sarah Petty
Breast milk first feed (%)	66.5	70.0	Helen Dobson	Sarah Petty
Stillbirth rate (per 1000 births)	2.4	4.66	Helen Dobson	Sarah Petty

What actions are planned?

- 1:1 care in labour is a standard for CNST, birth rate plus data is monitored through maternity and neonatal safety paper to monitor compliance. This is to ensure that all women in labour on labour ward receive 1:1 care.
- Breast milk first feed: Unicef Baby Friendly action plan to achieve standards for BFI, working in collaboration with RMBC and 0-19. Actions have included High standards of parent information and education on breast feeding, working with partners in Family hubs to improve infant feeding support.
- Stillbirth rate: Continuous improvement with the Saving Babies Lives care bundle version 3 implementation – TRFT currently at 93% compliance.

What is the expected impact?

- Performance to be maintained following safe staffing /escalation policy for TRFT.
- Achieving BFI accreditation ensures that TRFT meet the required standards to support infant feeding standards across the service. The Three year delivery plan recommends that this is achieved by March 27
- The LMNS assurance visit in September 2024 highlighted compliance at 97% for TRFT.

Potential risks to improvement?

- Maintain birth rate plus establishment setting requirements and backfilling maternity leave and gaps above headroom supports safe staffing on every shift
- Infrastructure and support to gain BFI including training. To maintain partnership working with RMBC.
- The recent withdrawal of public health funding for smoking in pregnancy service could impact service delivery and impact on the delivery of the Saving babies lives care bundle

Performance Matrix Summary – Finance and Performance

	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Variation: Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE**	**GOOD: CELEBRATE AND UNDERSTAND OP to PIFU** • OP to PIFU • DM01 • FDS • Mean LoS (Non-Elective)	**CONCERNING: CELEBRATE BUT TAKE ACTION** • 65+ weeks • 4 Hour Performance • Clinic Utilisation • Did Not Attend
Variation: Common Cause	**GOOD: CELEBRATE AND UNDERSTAND**	**STATIC: INVESTIGATE AND UNDERSTAND** • Waiting List Size • 31 Day Treatment Standard • 62 Day Treatment Standard • >12 hours in A&E • Bed Occupancy • LoS >21 Days • Date of Discharge = Discharge Ready Date • A&E Attendances from Care Homes • Patients on Virtual Ward • Urgent 2 Hour Response • Model Hospital Day Case Rate • First Outpatients (%Plan) • Inpatients (%Plan) • Daycases (%Plan) • LoS >7 Days • Mean LoS Elective	**CONCERNING: INVESTIGATE & TAKE ACTION** • RTT • Ambulance Handovers >30min • Average time to be Seen • Criteria to Reside is No • Admissions from Care Homes • Capped Theatres Utilisation • Discharged <5pm
Variation: Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION** • Overdue Followups • 12 hour Trolley Waits	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • 52+ weeks

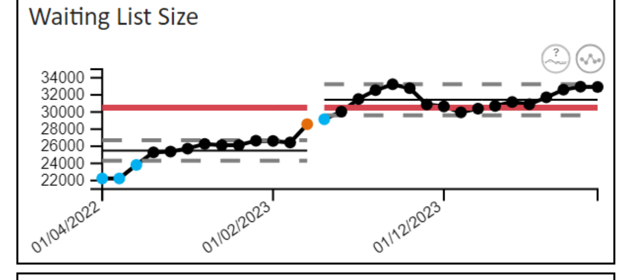
Elective Care and Cancer

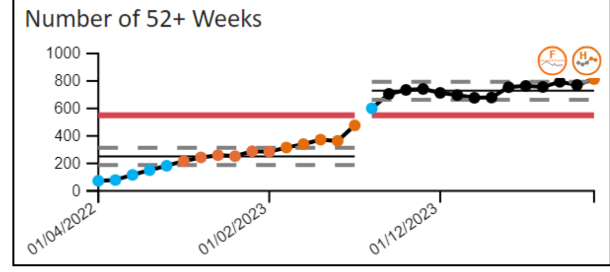
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	30,500	32,920	Sep-24					S
Number of 52+ Weeks	550	814	Sep-24		F	H		VC
Number of 65+ Weeks	0	0	Sep-24		F	L		CI
Referral To Treatment (%)	92.0	62.0	Sep-24		F			C
OP Activity moved or Discharged to PIFU (%)	2.5	2.9	Sep-24		?	H		G
Overdue Follow-ups	-	16,240	Sep-24	-	-	H	-	C
DM01 (%)	1.0	0.5	Sep-24		?	L		G
Faster Diagnosis Standard (%)	77.0	80.4	Aug-24		?	H		G
31 Day Treatment Standard (%)	96.0	96.8	Aug-24		?			S
62 Day Treatment Standard (%)	70.0	80.5	Aug-24		?			S

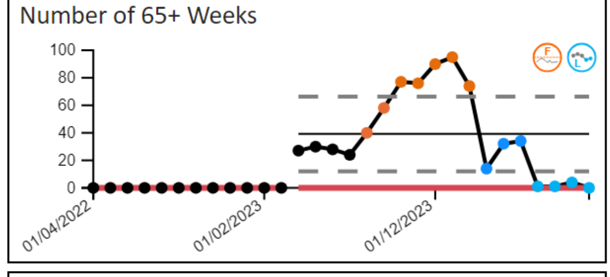
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

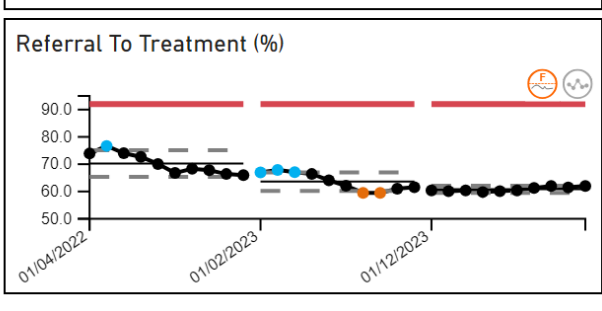
Subtheme: Long Waiters

Data, Context and Explanation









- The number of patients on our RRT waiting list continues to be within normal variation, although has been above plan for the last three months. This growth is naturally impacting on the ability to reduce the number of patients waiting over 52 weeks.
- The Trust has committed to reducing the number of patients waiting over 52 weeks by 50% by March 2025. Whilst there has been a further reduction in month, from 771 in August to 733 this month, this is normal variation, indicative that next month could fall within a similar range.
- For 2024/25, the national planning guidance set an objective for 0 patients to still be waiting over 65 weeks for their treatment by the end of Sept-24. The Trust committed to deliver this target by July-24.
- We continue to see significant improvements in our run rate and achieved 0 breaches in Sept-24. We will now focus on sustaining this position moving forwards.
- A transformation programme focusing on increased theatre and outpatient productivity, linked to GIRFT Further Faster is in place. This work aims to see us reach our Trust ambition to achieve RTT performance of 92% in a minimum of 5 specialties. Respiratory has now achieved compliance with the RTT standard.

Metric	Value	Target	Exec Lead	Ops Lead
Waiting List Size	32,920	30,500	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks	814	550	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	0	0	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	62.0	92.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Continuation of additional clinics in Gastroenterology throughout October 2024 to support patients to receive their first outpatient appointment, improving the RTT position.
•Continuation of additional clinics in Cardiology throughout October 2024 to support patients to receive their first outpatient appointment, improving the RTT position.
•Outsourcing of 256 orthopaedic patients in October 2024 to ensure they receive their treatment in a timely manner, improving the RTT position.

What is the expected impact?

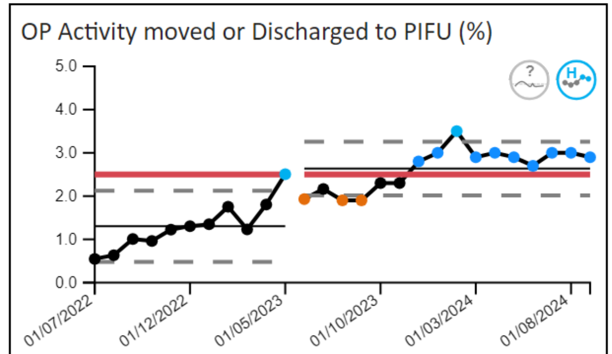
•Improved RTT position in Gastroenterology by January 2025, supporting the Trust to achieve RTT status by March 2025.
Improved RTT position in Cardiology by January 2025, supporting the Trust to achieve RTT status by March 2025.
•Sustained achievement of zero patients waiting longer than 65 weeks for surgery in T&O from September 2024 onwards and a reduction in the number of patients waiting longer than 52 weeks by March 2025.

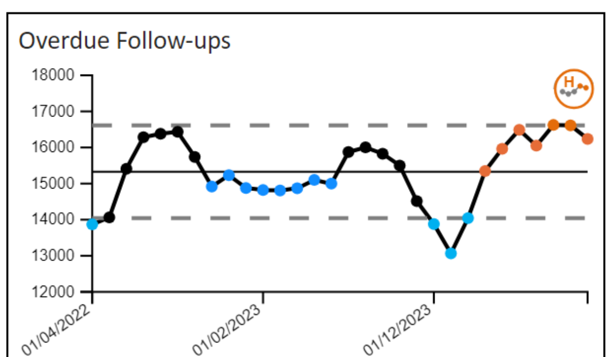
Potential risks to improvement?

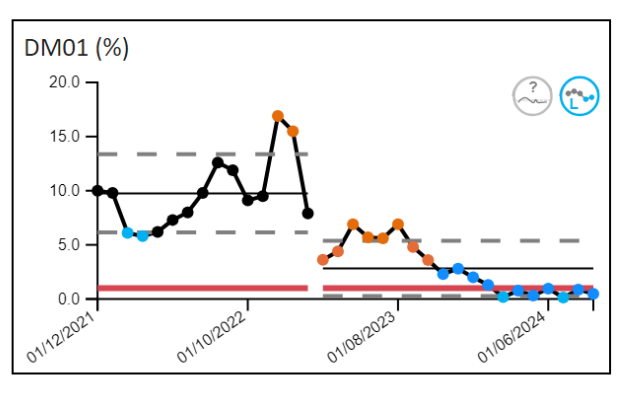
- Clinician agreement and availability to undertake additional sessions as required to support the outpatient and elective activity.
- Potential impact of any future industrial action affecting availability of doctors or nurses.
- Availability of financial resource to support additional activity.
- Risk of identification of long waits through enhanced validation of waiting list.

Subtheme: Diagnostics & Follow-ups

Data, Context and Explanation







•The 2024/25 national planning guidance set an objective to continue to implement outpatient transformation approaches, including patient-initiated follow-up (PIFU).

•The Trust therefore set the objective to ensure 1.5% of patients waiting for an outpatient follow-up appointment is moved or discharged to PIFU, by Mar-25. We have seen significant improvement in this area since Dec-23.

•The last quarter, has seen the number overdue follow ups fall outside of the upper limits, this means the number exceed the anticipated 'normal' run rate, with notable increases seen in Ophthalmology, Respiratory, Dermatology, ENT and Rheumatology.

•The 2024/25 national planning guidance also set an objective to increase the % of patients that receive a diagnostic test within 6 weeks to 95%.

•As the Trust is consistently achieving this standard, we have set an internal stretch ambition to maintain performance at 99% for 24/25. The Trust has maintained this achievement since Mar-24.

Metric	Value	Target	Exec Lead	Ops Lead
OP Activity moved or Discharged to PIFU (%)	2.9	2.5	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	16,240	-	Sally Kilgariff	Andrea Squires
DM01 (%)	0.5	1.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Additional outpatient clinics in place throughout October 2024 to ensure Respiratory patients receive their follow-up appointment in a timely manner.
•Continuation of additional Ophthalmology weekend clinics in October 2024, which will ensure patients waiting for an overdue follow-up appointment are prioritised affectively.
•Delivery of mutual aid via Montagu CDC to increase Endoscopy provision continues to ensure the Trust maintains compliance with DM01 standards following the change to reporting requirements at the end of September 2024.
•Demand & Capacity Planning continues to be progressed for 2025/26.

What is the expected impact?

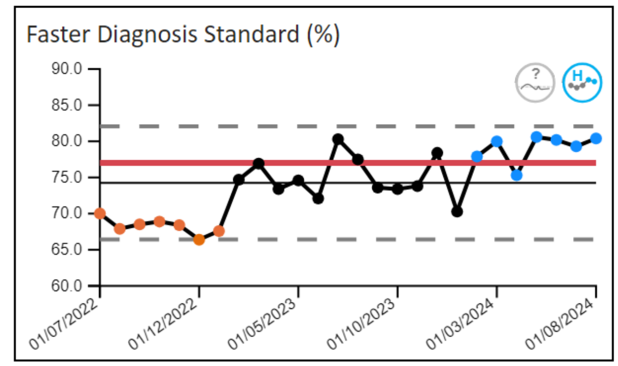
•Patients overdue a follow-up appointment will have confirmed that they still want/need a follow-up appointment by the end of September 2024 and plans will be in place to increase capacity where required by October 2024.
•Endoscopy will continue to achieve the DM01 standard following changes to guidance regarding surveillance patients in October 2024.
•Services will identify gaps in service provision and develop 'closing the gap' plans to support 2025/26 planning cycle.

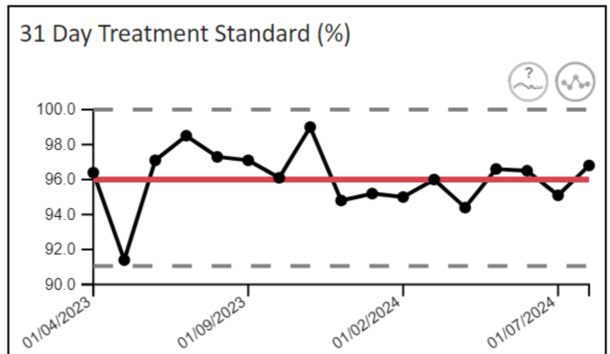
Potential risks to improvement?

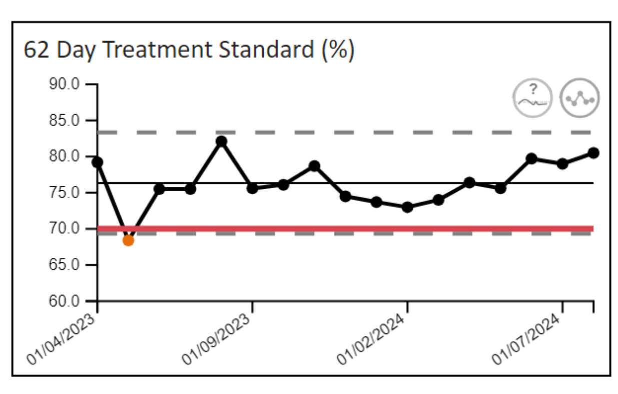
- Addition of overdue surveillance patients in endoscopy to DM01 from September 2024 may impact on DM01 performance.
- Reliance on additional activity to support endoscopy capacity continues which if unavailable may impact the ability to achieve the DM01 standard from September 2024 onwards.
- Availability of financial resource to support additional activity.
- Impact of the transfer of long waits in DM01 as part of any mutual aid agreements across the system.

Subtheme: Cancer

Data, Context and Explanation







- In 2024/25, the national planning guidance set an objective to improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025. 5 out of the last 6 months have achieved the national target, with an average of 76% since Feb 23 and we continue to work towards consistently achieving this standard and have set a further ambition to improve performance to 80% by March 2025.

- The 31-day standard continues to show normal variation patterns. There are actions to improve this.

- The national planning guidance also sets the objective to improve the 62-day Referral-to-Treatment performance to 70% by Mar-25. As the Trust is consistently achieving this standard, we have set a further ambition to improve performance to 77% by March 2025. The trust continues to meet this target, and current variation/process indicates that it is extremely unlikely that performance will fall below target levels, however it is not impossible

Metric	Value	Target	Exec Lead	Ops Lead
Faster Diagnosis Standard (%)	80.4	77.0	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	96.8	96.0	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	80.5	70.0	Sally Kilgariff	Andrea Squires

What actions are planned?

- Plan our second Patient Focus Group on 03/12/24 to gain a greater understanding of our patients needs and improve quality of cancer care.
- Finalise the pancreatic GIRFT return and audit clinical leadership.
- Development of our first stand-alone Cancer Access Policy by November 2024.
- Finalise the UGI (28 day) and Gynaecology (62 day) Improvement Plans by October 2024.

What is the expected impact?

- Improve the Faster Diagnosis Standard in Lower GI further from 65.1% to above 70% by March 2025.
- Improve the Faster Diagnosis Standard in Upper GI further from 65.8% to above 70% by March 2025.
- Reduce the number of patients waiting longer than 62 days for treatment following diagnosis of cancer in gynaecology.
- Improve the National Patient Experience Survey responses further for 2024.

Potential risks to improvement?

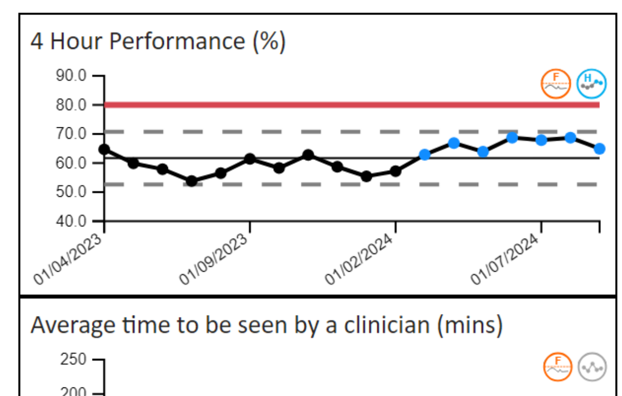
- Reliance on additional activity to support endoscopy capacity continues which if unavailable may impact the ability to achieve the FDS and 62 Day standard in Lower GI.
- Workforce challenges in both Lower GI and Urology continue to impact cancer pathway progression and improvement work with consultant vacancies and sickness absence.

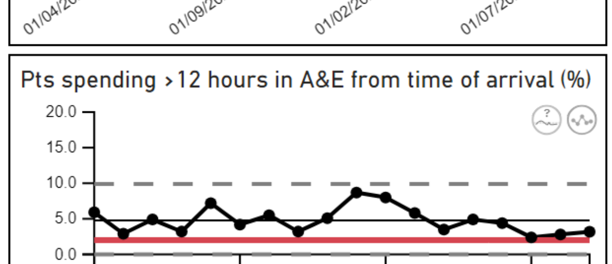
Non-elective and Flow

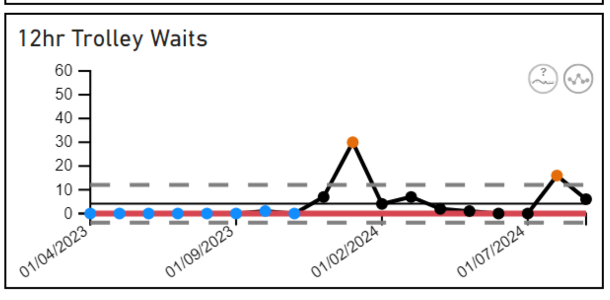
Metric	Trust Target	Latest Data	Period	Achieved in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	80.0	65.0	Sep-24		F	H		CI
Ambulance Handover Times >30 mins (%)	0.0	13.1	Sep-24		F			C
Average time to be seen by a clinician (mins)	60.0	123.3	Sep-24		F		-	C
Patients spending >12 hours in A&E from time of arrival (%)	2.0	3.2	Sep-24		?			S
12hr Trolley Waits	0	6	Sep-24		?		-	S
Bed Occupancy (%)	92.0	91.9	Sep-24		?			S
Length of Stay over 21 Days	64	55	Sep-24		?		-	S
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	82.9	Jul-24		?		-	S
Criteria to Reside is No (%)	10.0	19.2	Sep-24		F		-	C

*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Data, Context and Explanation







•In 2024/25, the national planning guidance set an objective for all Trusts to achieve the 4 hour performance standard of 78% by March 2025. While performance falls below this standard, there is sustained improvement in this area, which is now performing at a stable average of 67%.

Average time to see a clinician remains in a natural variation pattern. Variability in demand continues to further challenge further improvements however there has been improvement in the long waiting times overnight.

•The number of patients spending more than 12 hours in the department is a key national focus. The last few months have seen a month on month increase.

•The Trust has set a standard to achieve zero trolley waits in line with national guidance, this has been achieved recently in a number of months, this is not the case over the last two months due to challenges around patient flow across the trust footprint.

Metric	Value	Target	Exec Lead	Ops Lead
4 Hour Performance (%)	65.0	80.0	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	123.3	60.0	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	3.2	2.0	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	6	0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Work continues to develop SDEC Pathways and improve efficiency within SDEC's
- Data quality and visibility of SDEC Dashboard
- Continued focus sessions on Radiology through the month of October to improve patient flow with further developments of Dashboards to improve visibility
- Review of options to improve fill rate of Minor Injuries rota
- Additional validation by senior operational team

What is the expected impact?

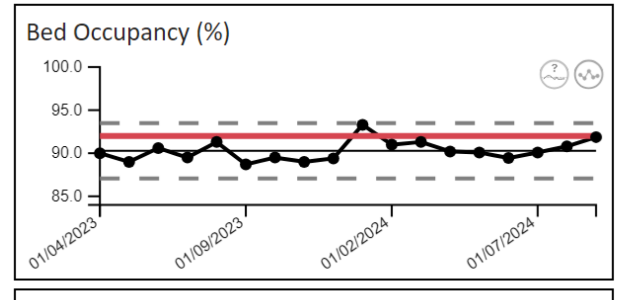
•Non-admitted performance for Primary Care, Minor Injuries and SDEC will continue to improve
•Visibility of all SDEC area via the new dashboard, to improve flow and support SDECs to remain open even at times of high demand
•Improvement in the total time patients spend in the department
•0 12 hour trolley Waits
•Improved time to be seen by a clinician

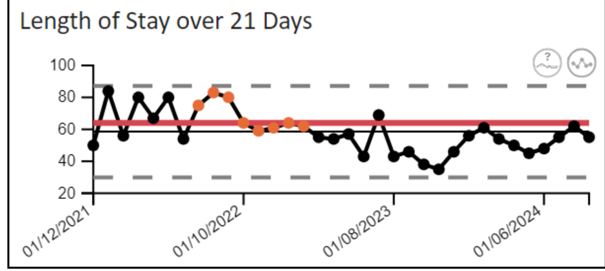
Potential risks to improvement?

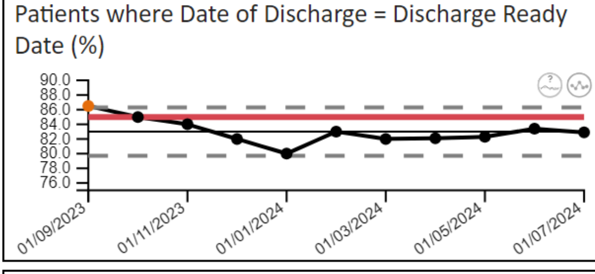
• Significant increased in demand will significantly impact the Trust ability to achieve the 4 hour performance standards.

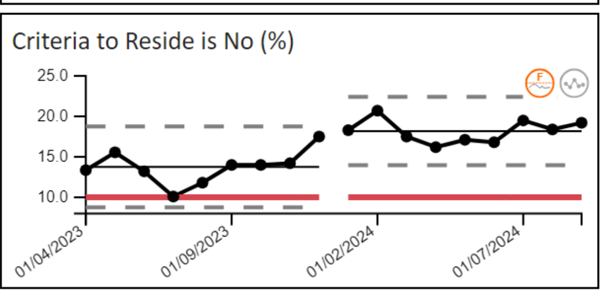
Subtheme: Inpatient Flow

Data, Context and Explanation









- This includes both core bed capacity as well as escalation capacity in line with national definition.
- 92% is recognised as optimum bed occupancy. Recent months have fallen below this, however throughout September we have been at the higher end of the target. It should be expected that we would see values fluctuate between 87% and 94% based on current patterns and Winter pressures.
- Length of stay >21 days remains in line with natural variation and achieving the target for the month
- Date of Discharge = Discharge Ready holds steady below target at around 83%.
- Criteria to Reside continues to fluctuate, showing natural variation between 22% and 14%, consistently not achieving the target of below 10%. Due to challenges experienced across all discharge pathways, more focused work is planned to take place to achieve the Trust standard of 10%.

Metric	Value	Target	Exec Lead	Ops Lead
Bed Occupancy (%)	91.9	92.0	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	55	64	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	82.9	85.0	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	19.2	10.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Roll out of discharge tracker across the trust
- Length of Stay meetings changed and more focus on patients not known to IDT
- Focus on criteria to reside and internal delays
- Clear repatriation policy at place and in the trust
- Board round standardisation across medical wards

What is the expected impact?

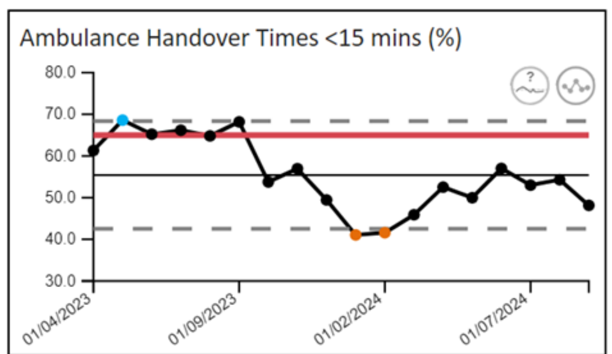
- Patients discharged on discharge ready date will reach target
- Continued reduction in patients in hospital over 21 days
- Reduction in those patients that have been an inpatient over 7 days
- Reduction in numbers of patients that are Out of Areas and an increased LOS
- Reduction in internal delays for patients waiting discharge

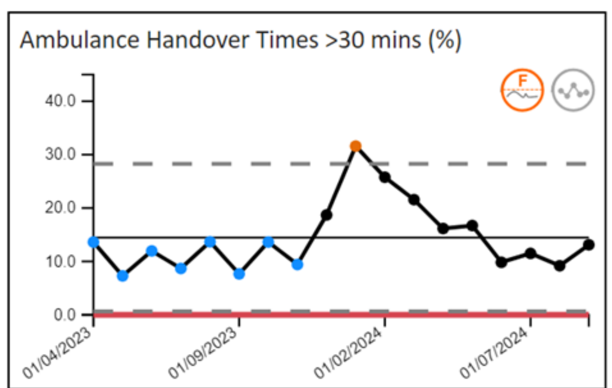
Potential risks to improvement?

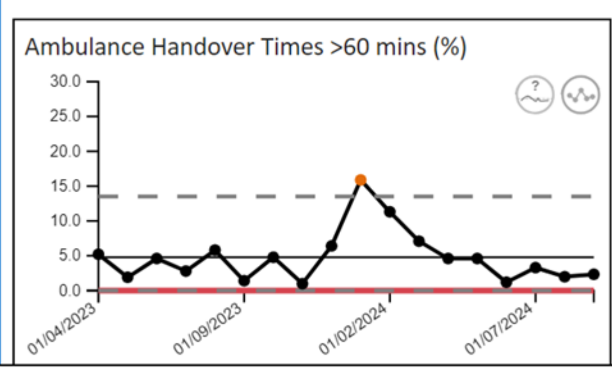
- Increase demand through UECC sustained
- De-escalation of inpatient beds not possible due to ongoing pressures
- Increased demands fails to reduce bed occupancy and additional beds will need to remain open

Subtheme: Emergency Care - Ambulance

Data, Context and Explanation







- The Operational Planning Guidance set an objective to achieve an average of 30 minutes to handover by March 2025.
- Achievement of this standard is dependent on compliance with two other standards; patients wait less than 15 minutes for handover and patients must not wait over 60 minutes for handover.
- The Trust compliance with Ambulance handover times <15 minutes remains below the standard of 65% and continues to perform in line with natural variation.
- For handover times >30mins, average times appear to be falling but we are not yet seeing sustained, significant improvement.
- Similarly, Ambulance handover times >60 did not meet the standard of 0.0%. Current performance levels indicate that we should expect an average of 5%, while some months will achieve 0%, that process is not currently sustainable.
- YAS has identified the Trust as benchmarking positively.

Metric	Value	Target	Exec Lead	Ops Lead
Ambulance Handover Times <15 mins (%)	48.1	65.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >30 mins (%)	13.1	0.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	2.3	0.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Ongoing focused work with the Yorkshire Ambulance Service to analyse and improve data validation will continue to ensure accurate reporting of TRFT ambulance data nationally by Q3 of 2024.
- YAS and the Trust particular Community and UECC are working together on Project Chronos
- Key focus on ambulance handover by Operational managers and Nursing workforce
- Text Messages will alert Operational Managers to delays with Ambulance Handovers

What is the expected impact?

•There will be an improvement in ambulance handover times and TRFT sustained high levels of performance

•Project Chronos will support reduction in conveyance to ensure all pathways in and out of hospital are utilised

Potential risks to improvement?

• A possible increase in ambulance attendances or batching of ambulances
•Ongoing demands for UEC services
•Peaks in demands for services
•Flow within the Trust/organisation and Place
• A possible increase in IPC during the winter which will require off load direct to cubicles

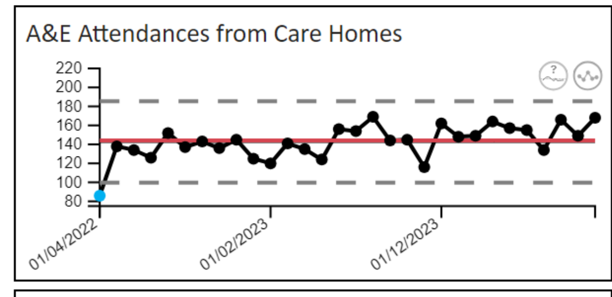
Community

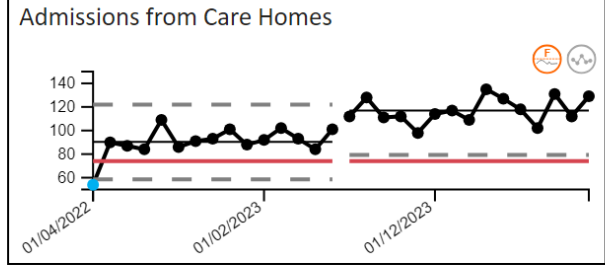
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	144	168	Sep-24				-	S
Admissions from Care Homes	74	129	Sep-24		F		-	C
Number of Patients on Virtual Ward	80	65	Sep-24				-	S
Urgent 2 Hour Community Response (%)	70.0	72.0	Jul-24				-	S

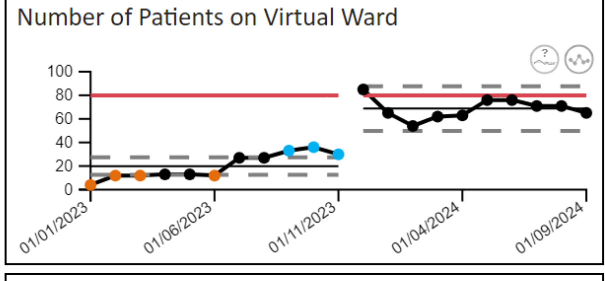
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

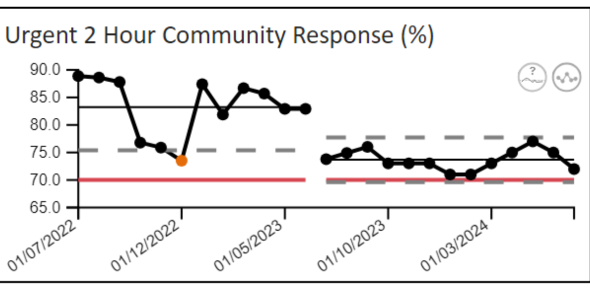
Subtheme: Community

Data, Context and Explanation









- Last month 168 patients attended UECC from Care Homes across Rotherham against the Trust standard of 144. The ICB have provided non recurrent funding for the recruitment of 2 Trusted Assessor for Care Homes. Both appointments commenced in post in August. They will be supporting training requirement in care homes as well as working alongside Trust colleagues to reduce attendances, admissions and LOS. It will take some time to see the impact of their posts.
- Admissions from Care Homes remain in line with natural variation. The community unplanned team in-reach into UECC to prevent any unnecessary admissions. The Trusted Assessor are also reviewing how they can impact admissions.
- The number of patients on Virtual Ward remain within normal variation at an average of 65 patients being cared for against a Trust standard of 80. Occupancy reached a peak of 86 on the 1 September. Capacity was impacted by sickness in month.
- The National standard for the 2 hour urgent community response is 70% of appropriate referrals. The trust is consistently meeting this target, however the variation pattern predicts it wouldn't be entirely unexpected if one month fell short of the target.

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances from Care Homes	168	144	Sally Kilgariff	Penny Fisher
Admissions from Care Homes	129	74	Sally Kilgariff	Penny Fisher
Number of Patients on Virtual Ward	65	80	Sally Kilgariff	Penny Fisher
Urgent 2 Hour Community Response (%)	72.0	70.0	Sally Kilgariff	Penny Fisher

What actions are planned?

- Embed the new role of Trusted Assessors and monitor impact.
- Development of a Virtual Ward Heart Failure pathway is ongoing.
- Introduction of a virtual ward assessment tool to assess the intensity of care required based on patient acuity is underway.
- Ongoing review of specialist planned nursing activity to identify any UCR activity, including a review of the Directory of Service and Data quality.

What is the expected impact?

- Reduce conveyance from Care Homes to UECC and admission from Care Homes
- Increased offer to patients and increased referrals to Virtual Ward, thereby increasing our Virtual Ward bed utilisation.
- Improved Categorisation of patients into three general acuity levels
- Continue to increase patient volumes and improved systems and processes, along with staff well-being.

Potential risks to improvement?

- Resource availability may impact on the ability to deliver improvement work.
- Workforce retention and wellbeing may impact on the ability to deliver improvement work

Productivity Priorities

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%)	85.0	77.0	Sep-24	✗	F	H	-	CI
Capped Theatres Utilisation (%)	85.0	77.5	Sep-24	✗	F			C
Model Hospital Daycase Rate (%)	85.0	83.0	Jun-24	✗	?			S
Did Not Attend (%)	7.0	8.2	Sep-24	✗	F	L		CI
First Outpatients (% of Plan)	100.0	103.0	Sep-24	✓	?		-	S
Inpatients (% of Plan)	100.0	88.0	Sep-24	✗	?		-	S
Daycases (% of Plan)	100.0	101.0	Sep-24	✓	?		-	S
Length of Stay over 7 days	-	200	Sep-24	-	-		-	S
Mean Length of Stay (Non-elective)	-	5.1	Sep-24	-	-	L		GI
Mean Length of Stay (Elective excluding Daycases)	-	2.2	Sep-24	-	-			S
Discharged before 5pm (%)	70.0	61.3	Sep-24	✗	F		-	C

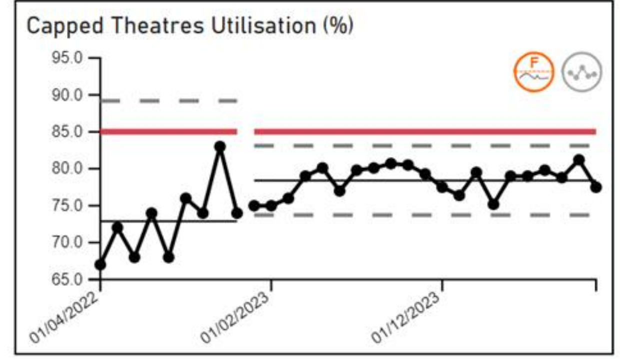
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

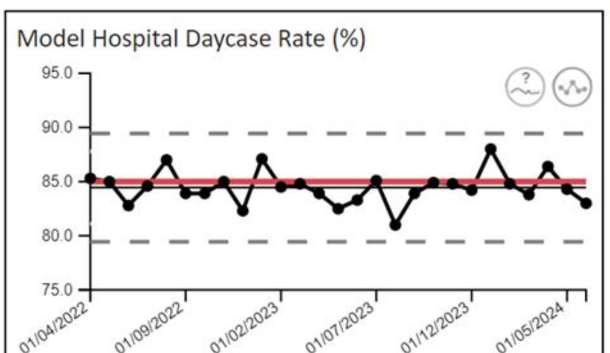
Plan is 19/20 + 3% i.e. *103% of 19/20*, therefore 100% achievement against Plan is 103% of 19/20

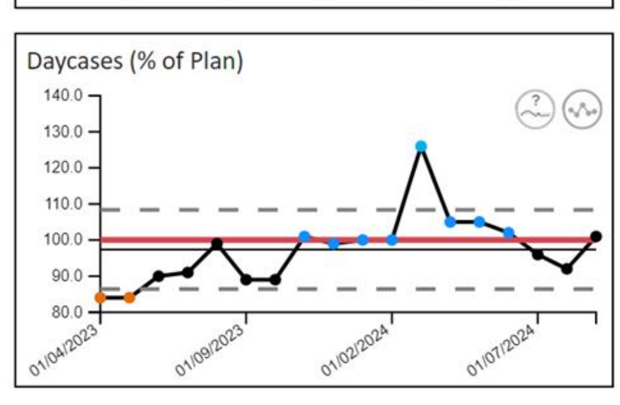
NHS The Rotherham NHS Foundation Trust

Subtheme: Theatres

Data, Context and Explanation







- National planning guidance has set a trajectory of 85% capped theatre utilisation (operating time of planned theatre sessions).
- Trust Capped Theatre Utilisation is consistent, with current utilisation at 77.5% against the 85% standard.
- The Trust MH Day Case rate remained stable at 83% against the 85% standard
- Day case activity achieved the target at 101% against Trust plan. Work continues to improve the day case activity further across a variety of targeted specialties.

Metric	Value	Target	Exec Lead	Ops Lead
Capped Theatres Utilisation (%)	77.5	85.0	Sally Kilgariff	Jodie Roberts
Model Hospital Daycase Rate (%)	83.0	85.0	Sally Kilgariff	Jodie Roberts
Daycases (% of Plan)	101.0	100.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increased pre-op assessment sessions have been agreed to support scheduling and utilisation following 6-4-2 principles and ensuring we are booking out to 6 weeks from September 2024.
- Increased focus on T&O day cases
- Enhanced analysis of work that has been transferred to MEOC
- Validation of patients that are not fit for surgery
- Trial of increased number of patients per list in Ophthalmology

What is the expected impact?

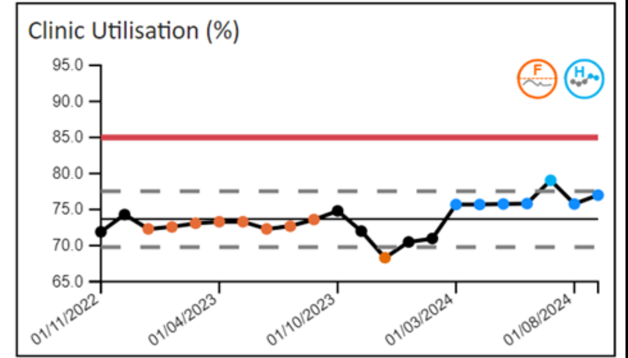
- Improvement in theatre utilisation
- Improved overall scheduling
- Increase in use of day cases theatres from T&O
- Increased day case rate in Ophthalmology
- Improvement in forward view and reducing on the day cancellations.
- Improved booking out to 6 weeks
- Positive impact on data quality

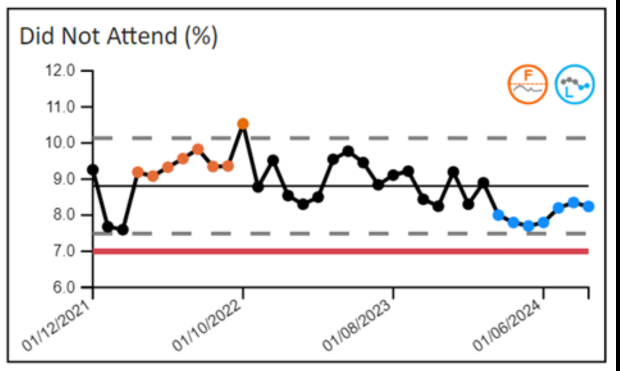
Potential risks to improvement?

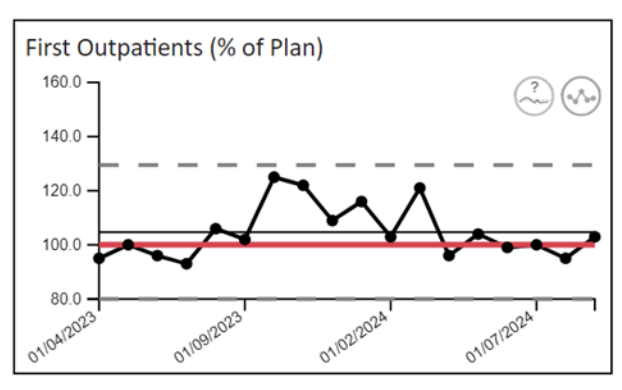
- Anaesthetic rotas may continue to impact on the ability to run theatre activity which significantly impacts on T&O
- Capacity to deliver pre-op assessment may impact on patients available and fit for surgery
- High levels of staff absence impacting on lists been used
- Theatre staffing remains a concern

Subtheme: Outpatients

Data, Context and Explanation







- Clinic Utilisation is key to productivity and underutilised clinics is a key focus for the Trust this year. The last 7 months have shown an 4% improvement step change, with some work still to do to achieve the standard of 85%.
- Trust DNA rates have shown sustained reductions over the last 7 months, holding steady around 8%, with more to do to get to the 7% target. Work is focused on meeting the needs of our local population when attending for outpatient appointments to improve attendance via digital reminders and targeted patient engagement.
- Outpatient productivity provides the organisation with the opportunity to increase activity levels and improve outcomes for patients, this month it has performed to plan.
- The Further Faster programme (GIRFT) supports each speciality in addressing their own specific productivity challenges in relation to outpatients in line with the GIRFT handbooks.

Metric	Value	Target	Exec Lead	Ops Lead
Clinic Utilisation (%)	77.0	85.0	Sally Kilgariff	Jodie Roberts
Did Not Attend (%)	8.2	7.0	Sally Kilgariff	Jodie Roberts
First Outpatients (% of Plan)	103.0	100.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increased capacity to deliver first outpatient appointments across numerous specialities to support activity levels are on-going. Funded via ERF.
- Ongoing work with the contact centre and specialities continues to ensure cancellations are backfilled timely to improve utilisation further through 2024/25.
- Review Utilisation capacity and understand un-booked slots.
- Review data on discharged at first appointment to understand where triage may have biggest impact.
- Text reminders is being piloted with time frame changing from 7 and 2 days to 10 and 1 day

What is the expected impact?

- Increase in clinic utilisation by 5% by Q3 2024/25.
- Reduction in patients that DNA to 7% by Q4 2024/25
- Increase in outpatient activity by 2% by Q3 2024/25.

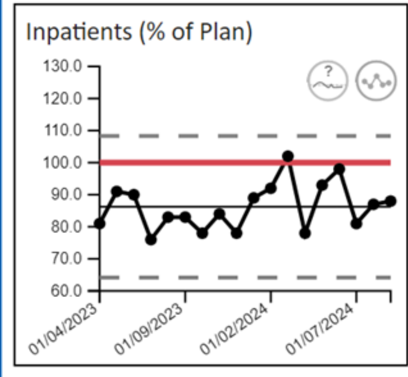
Potential risks to improvement?

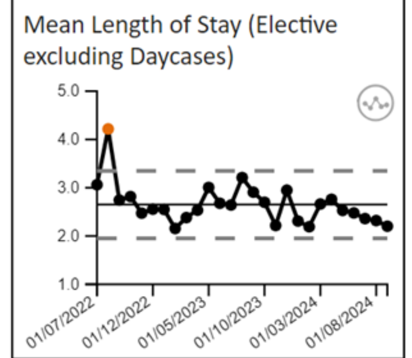
- Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
- Patient availability may impact on the ability to improve clinic utilisation, particularly short notice backfilled appointments.
- GP collective action and impact on referrals to specialities and use of advice and guidance

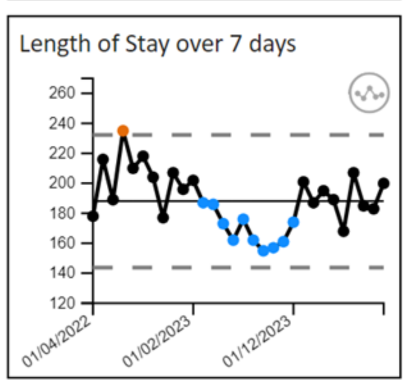
Subtheme: Inpatients

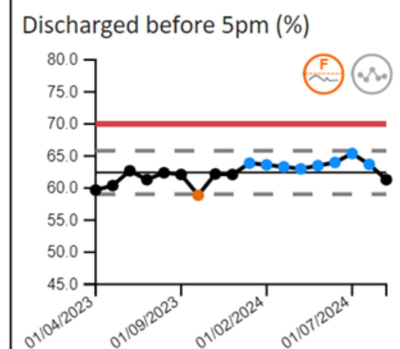
Metric	Value	Target	Exec Lead	Ops Lead
Inpatients (% of Plan)	88.0	100.0	Sally Kilgariff	Jodie Roberts
Length of Stay over 7 days	200	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	5.1	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	2.2	-	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	61.3	70.0	Sally Kilgariff	Jodie Roberts

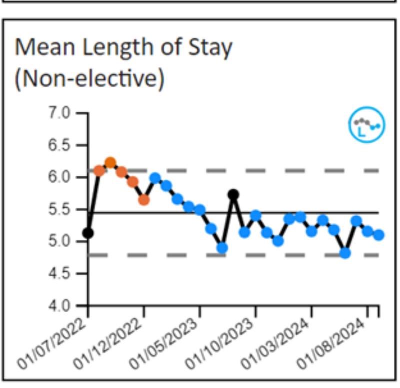
Data, Context and Explanation











- The % of elective inpatients was 88% against the Trust plan.
- Mean length of stay for **elective** patients is showing a continued downward trend. Focused work to decreasing length of stay on surgical wards is imperative to support the elective recovery programme.
- Mean length of stay for **Non-elective** patients has remained stable under 5.5 days over the last 12-18 months.
- Average Length of stay for any patient, over 7 days has remained static . Work continues to focus on getting patients to the right place and follow the home first approach.
- Patients discharged before 5pm was showing sustained improvement, although the current month has dipped. Work continues to focus on improving discharge rates earlier in the day. With a new discharge tracker implemented across the trust.

What actions are planned?

- Increase daily numbers through the discharge lounge by 5 further patients.
- Ongoing LLOS reviews focusing on patients not known to IDT
- Focus on Internal delays to reduce non value adding activity
- Focus on LOS in surgical specialities
- Focus on patients waiting over 7 days to reduce LOS overall
- Opening of Community Ready Unit on Sundays through Winter to support earlier discharges
- Option to change transport times to support earlier discharges on a weekend

What is the expected impact?

- Increase number of patients discharged before 5pm to 70% by Q3 2024.
- Reduction of 7 day LOS patients by 10%
- Reduction in average LOS in elective patients
- Discharges earlier in the day supported by CRU opening on a Sunday and earlier transport

Potential risks to improvement?

- Increased complexity of patients and a reliance on out of hospital care
- Increased number of beds open to deal with demand and thorough discharge planning ahead of time, with no additional resource to support both internally and externally
- Ability for the CRU to manage significant increase in numbers and transport to support earlier discharge (peaks and troughs in demand)

Activity

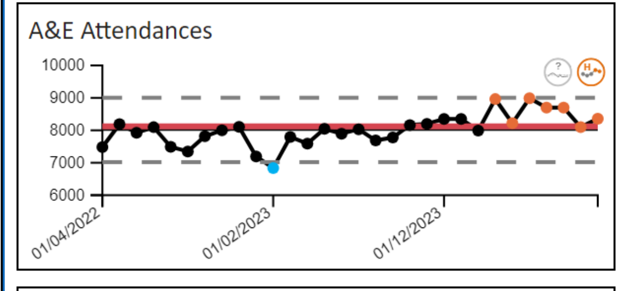
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances [Block]	8,124	8,359	Sep-24				-	C
Inpatient Observations – INOs/SDEC [Block]	-	2,031	Sep-24	-	-		-	G
Non-Elective Inpatients [Block]	-	2,585	Sep-24	-	-		-	C
Outpatients Follow Up - Attendances [Block]	14,699	15,605	Sep-24				-	S
Daycases [ERF]	1,999	2,012	Sep-24				-	S
Inpatients - Electives [ERF]	352	309	Sep-24				-	S
Outpatients New - Attendances [ERF]	6,049	6,254	Sep-24				-	S
Outpatient Procedures - New and Follow Up [ERF]	4,767	4,486	Sep-24				-	S
Referrals [Outpatient Demand]	-	8,082	Sep-24	-	-		-	S
2ww Referrals [Outpatient Demand]	-	1,073	Sep-24	-	-		-	S

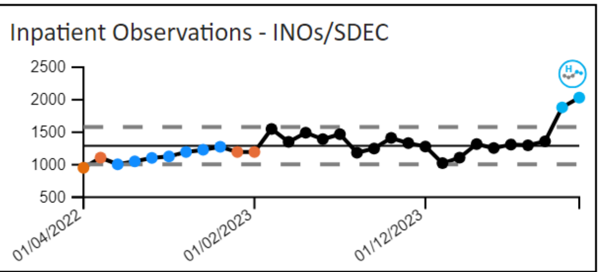
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Block

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances	8,359	8,124	Sally Kilgariff	Jodie Roberts
Inpatient Observations - INOs/SDEC	2,031	-	Sally Kilgariff	Jodie Roberts
NE Inpatients (exc obs)	2,585	-	Sally Kilgariff	Jodie Roberts
Outpatients Follow Up - Attendances	15,605	14,699	Sally Kilgariff	Jodie Roberts

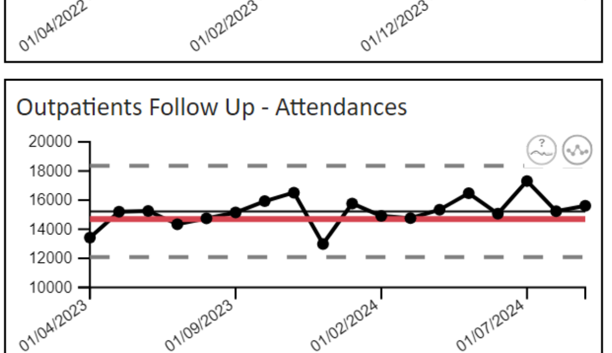
Data, Context and Explanation





NE Inpatients (exc obs)

5000
4500
4000
3500
3000
2500
2000
01/04/2022
01/02/2023
01/12/2023



- Key activity lines on block contract are based on 23/24 M10 forecast outturn (block funding will not directly reflect activity)
- Block contracts do not allow additional income generation where activity lines are over performing
- A&E attendances are above plan both in-month and year-to-date.
- Non-Elective admissions have seen a significant reduction in-month due to introduction of SDEC recording in the A&E data set
- Outpatient Follow-ups continue to significantly over perform both in-month (and year-to-date)
- The Trust has significant follow-up backlogs therefore over performance is expect to continue/increase whilst we look to clear these.

What actions are planned?

- Reconciliation of SDEC activity against Non-Elective under performance
- Review of un-coded A&E attendances
- Continue to monitor follow-up performance and benchmark new to follow-up ratios at specialty level
- Identify any areas of correlation between non-elective pressures and reduction in elective procedures (impacting ERF)

What is the expected impact?

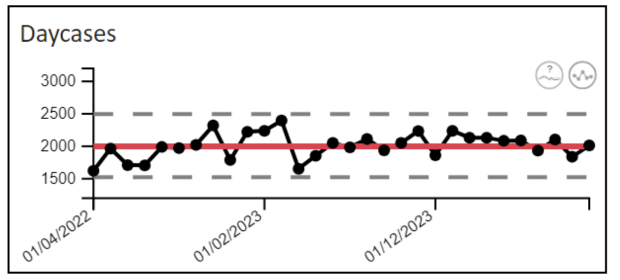
- Confirm SDEC/NEL activity is accurately being reflect in the data submission/contract monitoring. Fully understand the impact of EDS4.
- Ensure accurate record keeping for A&E attendances (should the contract mechanism change in the future this could potentially impact any re-basing)
- Identify areas of above national/peer average new to follow-up ratios and initiate further review to understand why.

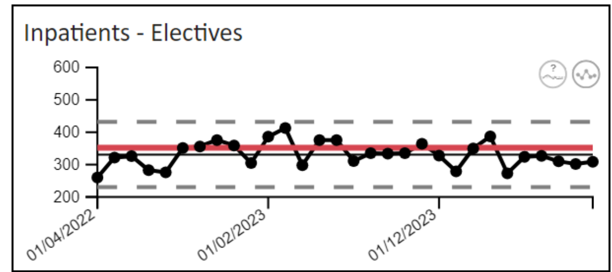
Potential risks to improvement?

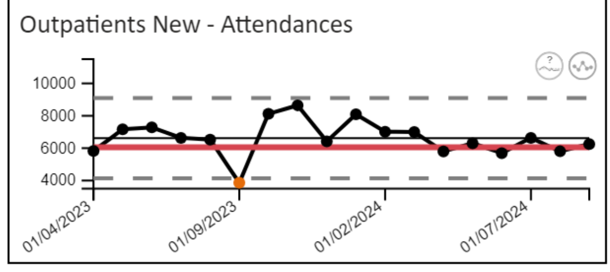
- Despite being on block, all key lines require scrutiny to ensure the Trust a) understands how this is impacting on financial performance b) we maintain an accurate position to safeguard changes to future contracting models
- Ongoing increasing non elective demand, which is unfunded due to block contract.

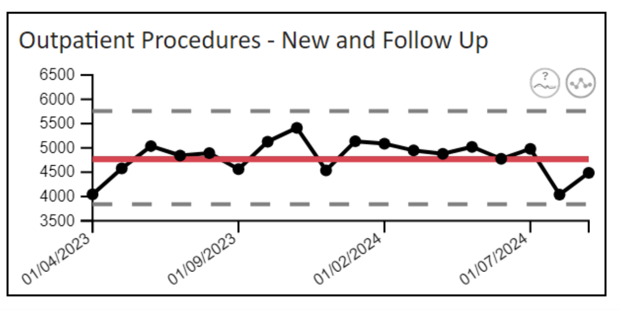
Subtheme: ERF

Data, Context and Explanation









•ERF contracted activity targets are based on 19/20 actuals + 3% (24/25 plans include the 3% increase)

•ERF lines operate on a cost and volume basis as per National Planning Guidance

•In-month Daycase activity is 13 above planned activity levels and casemix is significantly lower than planned levels

•In-month Elective activity is 42 below plan with income deteriorating from the August position

•Outpatient New Attendances are 205 above planned levels. The additional internal and insourced clinics are having a positive impact on the position

•Outpatient Procedures are 282 below plan. Work is continuing to address the Procedure recording/mapping issues.

•September Elective position has been impacted by reduced theatre sessions linked to workforce issues

•ERF Activity plans are aligned to NHSE planning assumptions to ensure consistency of reporting both internally and externally and are based on working days

•September saw a £400k deterioration on ERF and the cumulative year-to-date position continues to underperform

•Early indications show an increase in the number of theatre sessions delivered in October

Metric	Value	Target	Exec Lead	Ops Lead
Daycases	2,012	1,999	Sally Kilgariff	Jodie Roberts
Inpatients - Electives	309	352	Sally Kilgariff	Jodie Roberts
Outpatients New - Attendances	6,254	6,049	Sally Kilgariff	Jodie Roberts
Outpatient Procedures - New and Follow Up	4,486	4,767	Sally Kilgariff	Jodie Roberts

What actions are planned?

•Additional sessions to increase Elective, Day case and Outpatient first activity from September 2024
•Outsourcing of Hand & Wrist activity with further consideration for Hips & Knees
•Activity recording issues continue to be addressed and corrected
•Some issues with an external system data/coding mappings has been identified – this is being urgently addressed and is predominantly linked to Outpatient Procedures
•Analysis of Day Case activity by HRG

What is the expected impact?

- Internal additional sessions and insourcing/outsourcing schemes will support delivery against the 24/25 ERF target and contribute to improving the income position.
- Correction of activity recording issues will ensure activity is correctly aligned and the appropriate income is received.

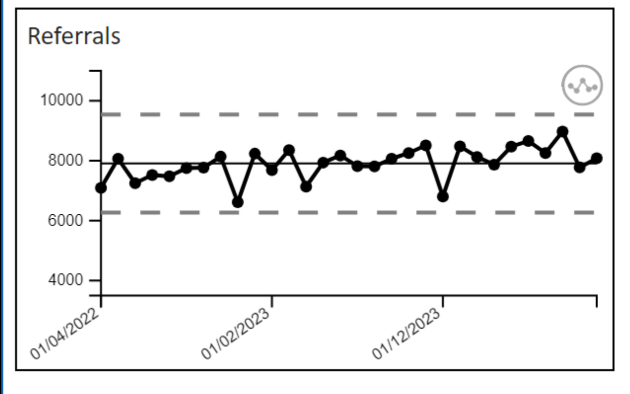
Potential risks to improvement?

- Internal workforce availability (consultant and wider) to support additional sessions
- Efficient utilisation of core capacity (e.g. if core lists are stood-down or consistently underutilised, any additional sessions/insourcing will be replacing that loss of activity as opposed to delivering additional capacity)
- Work to correct the Outpatient procedure recording is much more complex than originally anticipated – however there remains a significant income opportunity

Subtheme: OP Demand

Metric	Value	Target	Exec Lead	Ops Lead
Referrals	8,082	-	Sally Kilgariff	Jodie Roberts
2ww Referrals	1,073	-	Sally Kilgariff	Jodie Roberts

Data



2ww Referrals

1600
1400
1200
1000
800
600
01/04/2022
01/02/2023
01/12/2023

- Changes in referral patterns are key drivers affecting our ability to deliver waiting time and waiting list metrics
- Even small changes in specific specialties can generate significant increases in waits
- Referral patterns and trends are available in the Contract Monitoring Power BI data
- Significant changes generate discussion with Commissioners to identify what is driving the variation

What actions are planned?

- A more detailed review of referrals by specialty will be introduced into monthly Contract Compliance meetings held with Care Groups
- Identify whether duplicate referrals are being made to a range of services (often due to long waits)
- Identify appropriateness of 2WW referrals
- Review of capacity and demand to support 25/26 planning

What is the expected impact?

- Greater understanding of referral patterns internally
- Determine what discussions to have with Commissioners to identify potential solutions and work with Primary Care to ensure clinical referral protocols are being adhered to
- Agree approaches for Demand Management with Commissioners
- Communicate any new systems/processes

Potential risks to improvement?

- Analysis does not identify any inappropriate referrals (i.e. demand has genuinely increased)
- Lack of engagement from Commissioners/Primary Care

Finance

Apr 24 to Aug 24

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)	3,531	2,972	(559)	(369)	(2,573)	(2,204)	(12,616)	(13,198)
I&E Performance (Control Total)	3,592	3,037	(555)	0	(2,180)	(2,180)	(12,591)	(13,176)
Efficiency Programme (CIP)	938	723	(215)	4,822	2,257	(2,565)	(5,657)	(5,895)
Capital Expenditure	912	865	47	4,124	2,996	1,128	0	0
Cash Balance	(2,975)	(3,444)	(469)	7,397	6,383	(1,014)	0	0

Performance Matrix Summary – People and Culture

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**EXCELLENT: LEARN AND CELEBRATE** • Turnover (12 month rolling)	**GOOD: CELEBRATE AND UNDERSTAND**	**CONCERNING: CELEBRATE BUT TAKE ACTION**
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • MAST – Job Specific	**STATIC: INVESTIGATE AND UNDERSTAND** • Vacancy Rate (total)	**CONCERNING: INVESTIGATE & TAKE ACTION** • Sickness Rates (12 month rolling) • Sickness Rates • Appraisal Rates (12 month rolling) Appraisal Rates
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • MAST - Core	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

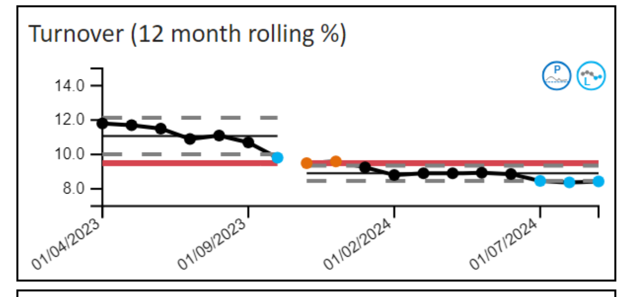
People and Culture

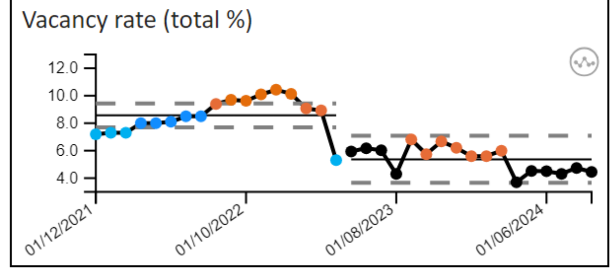
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	8.4	Sep-24					VG
Vacancy Rate (total %)	-	4.5	Sep-24	-	-		-	S
Sickness Rates (12 month rolling %)	4.8	5.9	Sep-24				-	C
Sickness Rates (%)	4.8	5.4	Sep-24					C
Appraisal Rates (12 month rolling %)	90.0	76.9	Sep-24				-	C
Appraisals Season Rates (%)	90.0	73.8	Sep-24				-	C
MAST – Core (%)	85.0	90.8	Sep-24				-	C
MAST – Job Specific (%)	85.0	88.5	Sep-24				-	G

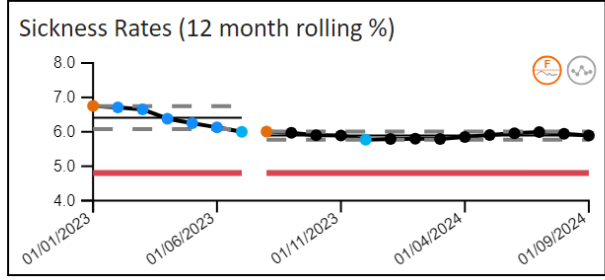
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

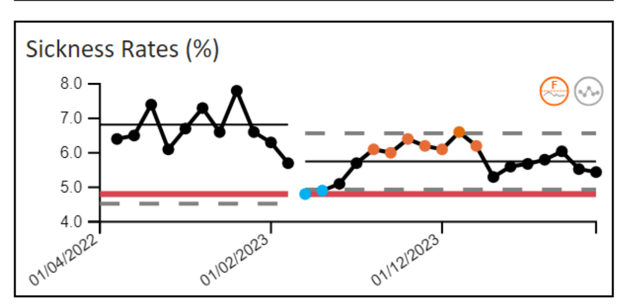
Subtheme: People

Data, Context and Explanation









- Retention performance continues to be strong and in within our target range for 2024/25 of 8-9.5%. Care Groups are all within a healthy range with more detailed breakdowns provided as part of operational management information for action where appropriate.
- Vacancy rate is in a strong position with strong recruitment campaigns for newly qualified nurses and midwives attracting success.
- Sickness absence rate performance, especially the rolling 12 month measure is now static following improvement during 2023/24 and as a result a cause for concern.
- The rate of sickness absence is been driven primarily by long term sickness absence. Links between deprivation, population health and the health and wellbeing of our people are also relevant here.

Metric	Value	Target	Exec Lead	Ops Lead
Turnover (12 month rolling %)	8.4	9.5	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	4.5	-	Daniel Hartley	Paul Ferrie
Sickness Rates (12 month rolling %)	5.9	4.8	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	5.4	4.8	Daniel Hartley	Paul Ferrie

What actions are planned?

- Continued emphasis on delivering our People and Culture strategy – 'We said, we did' action plans to drive engagement and improvement to maintain and strengthen retention and vacancy rate performance
- Comprehensive work on Health Wellbeing and Attendance including a full review of the Trust's approaches to this informed by; evidence based tools; best practice and audit work as per People and Culture Strategy

What is the expected impact?

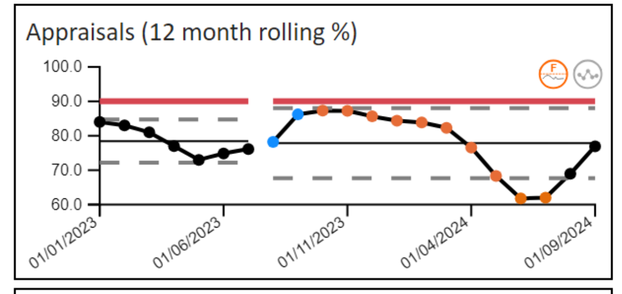
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

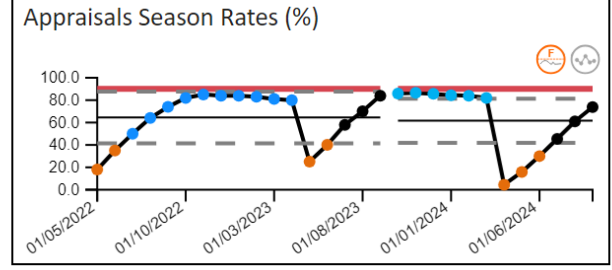
Potential risks to improvement?

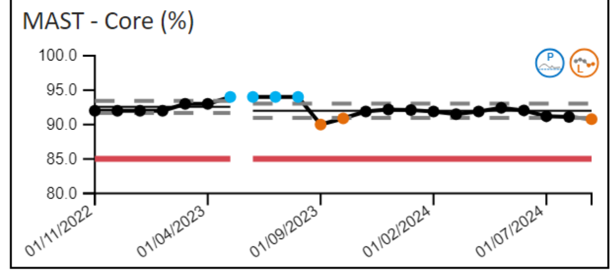
- Continued impact of ill-health of staff on attendance

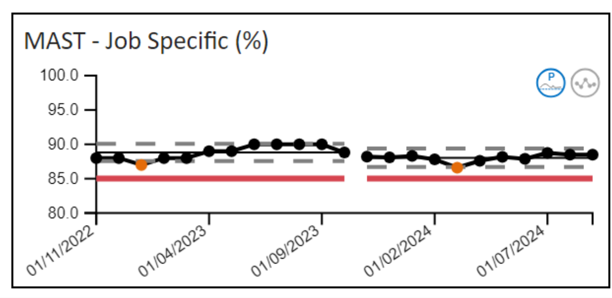
Subtheme: MAST & Appraisals

Data, Context and Explanation









- Rolling 12 month appraisal performance has begun to show an improvement as the appraisal season comes to a conclusion.
- New seasons appraisal completion rate performance is 73.8%, and is expected to improve further over the coming weeks as final appraisals are recorded onto ESR.
- This is a big focus for senior leaders and part of internal performance mechanisms.
- MAST performance is on track with more detailed breakdowns provided as part of operational management information for action where appropriate.

Metric	Value	Target	Exec Lead	Ops Lead
Appraisals (12 month rolling %)	76.9	90.0	Daniel Hartley	Paul Ferrie
Appraisals Season Rates (%)	73.8	90.0	Daniel Hartley	Paul Ferrie
MAST - Core (%)	90.8	85.0	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	88.5	85.0	Daniel Hartley	Paul Ferrie

What actions are planned?

- Focus on continued roll out and cascade of appraisals for this year using new suite of appraisal documentation which was improved based on feedback.
- Emphasis on senior leader accountability for Appraisal and MAST compliance

What is the expected impact?

- Improvement in appraisal completion rates both in month and rolling 12 months
- Improvement in MAST Core and Job Specific completion rates

Potential risks to improvement?

- Operational pressures resulting in reduced time for proactive people management and time for Appraisals and MAST completion

APPENDIX

Assurance

Variation/Performance

	PASS	HIT OR MISS	FAIL
H (improving, high)	**VERY GOOD: CELEBRATE AND LEARN** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**GOOD: CELEBRATE AND UNDERSTAND** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**CONCERNING: CELEBRATE BUT TAKE ACTION** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.
L (improving, low)	This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	• This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	• This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.
(common cause)	**GOOD: CELEBRATE AND UNDERSTAND** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**STATIC: INVESTIGATE AND UNDERSTAND** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.
H (deteriorating, high)	**CONCERNING: INVESTIGATE AND UNDERSTAND** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**VERY CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change
L (deteriorating, low)	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change

APPENDIX: SPC Summary Icons Key

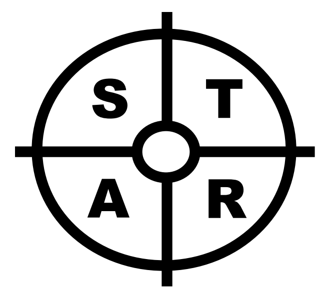
Assurance Icons

Icon	Technical Description	What does this mean?	What should we do?
?	This process will consistently HIT AND MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target will not be consistently achieved.	**Consider** whether this is acceptable and if not, you will need to change something in the system or process.
F	This process is not capable and will consistently FAIL to meet the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process** if you want to meet the target.
P	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can be consistently achieved.	**Celebrate** the achievement. **Understand** whether this is by design and **consider** if the target is still appropriate.

Variation Icons

Icon	Technical Description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable.** If the process limits are far apart you may want to change something to reduce the variation in performance
H	Special cause variation of a **CONCERNING** nature where the measure is significantly HIGHER.	**Something is going on!** Your aim is to have LOW numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is going on. Is it a one-off event that can be explained or do you need to change something?
L	Special cause variation of a **CONCERNING** nature where the measure is significantly LOWER.	**Something is going on!** Your aim is to have HIGH numbers but you have some low numbers – something one-off, or a continued trend or shift of low numbers.	**Investigate** to find out what is going on. Is it a one-off event that can be explained or do you need to change something?
H	Special cause variation of a **IMPROVING** nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is to have HIGH numbers and you have some – either something one-off, or a continued trend or shift of high numbers.	Find out what is going on. **Celebrate** the improvement and **share learning** with other areas.
L	Special cause variation of a **IMPROVING** nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is to have LOW numbers and you have some – either something one-off, or a continued trend or shift of low numbers.	Find out what is going on. **Celebrate** the improvement and **share learning** with other areas.

Data Quality STAR Key



Domain	Definition
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?
Timely and Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data? Are all elements of information need present in the designated data source and no elements of need information are missing?
Audit and Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur?
Robust Systems and 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?

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
SHMI	Ratio between the actual number of patients who die following hospitalisation and the number expected to die based on population average.	Benchmark	As Expected	
Readmissions (%)	Proportion of readmissions within 30 days from the same Treatment Function specialty back to same Treatment Function specialty.	-	-	
VTE Risk Assessments (%)	Proportion of patients eligible for VTE Screening who have had a VTE screen completed electronically as per DH and NICE guidance.	National	95.0	
Care Hours per Patient Day	The Number of Care Hours per patient day.	National	7.3	
Combined Positivity Score (%)	The Positivity Rate of all the Friends and Family tests done combined - includes IP/DC/OP/UECC/Community/Maternity/Paeds/Long Covid	National	95.0	
Complaints	The number of formal complaints received.	Local	-	
Patient Safety Incident Investigations	The number of Patient Safety Incident Investigations that take place.	Local	0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Medication Incidents	The number of recorded medication incidents	Local	-	
Pressure Ulcers (Cat 3/4/STDI and Unstageable) per 1000 bed days	The number of Pressure Ulcers (Cat 3/4/STDI and Unstageable) per 1000 bed days	Local	-	
Patient Falls	The number of Patients Falls (Moderate and Above) per 1000 bed days	Local	0	
C. difficile Infections	The number of recorded C. difficile infections	Local	0	
1:1 Care in Labour (%)	Proportion of women in established labour who receive one-to-one care from an assigned midwife.	Local	75.0	
Breast milk first feed (%)	The percentage of babies born that receive maternal or donor breast milk as their first feed	National	70.0	
Stillbirth rate (per 1000 births)	The number of still births per 1000 live births	Local	4.66	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Waiting List Size	Number of patients waiting to receive a consultative, assessment, diagnosis, care or treatment activity	Local	-	
Number of 52+ Weeks	Number of patients on the incompletes waiting list for more than 65 weeks	Local	200	
Number of 65+ Weeks	Number of patients on the incompletes waiting list for more than 65 weeks	Local	37	
Referral To Treatment (%)	Proportion of patients that receive treatment in less than 18 weeks from referral	National	92.0	
OP Activity moved or Discharged to PIFU (%)	Proportion of patients moved to a Patient Initiated Follow-up Pathway following an outpatient appointment	National	3.0	
Overdue Follow-ups	Number of patients who are overdue their follow-up appointment, based on the requested time-period for the appointment made by the clinician	Local	-	
DM01 (%)	Proportion of diagnostics completed within 6 weeks of referral for 15 Key Tests	National	1.0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Faster Diagnosis Standard (%)	Proportion of patients diagnosed with cancer or informed cancer is excluded within 28 days from receipt of urgent GP referral for suspected cancer, breast symptomatic referral or urgent screening referral	National	75.0	
31 Day Treatment Standard (%)	Proportion of Patients receiving first definitive treatment for cancer within 31 days following an urgent referral for suspected cancer	National	96.0	
62 Day Treatment Standard (%)	Proportion of Patients receiving first definitive treatment for cancer within 62 days following an urgent referral for suspected cancer	National	85.0	
4 Hour Performance (%)	Proportion of Patients that have been seen and treated and left dept within 4hrs (admitted or discharged) based on Dept date.	Local	70.0	
Ambulance Handover Times <15 mins (%)	Proportion of Ambulance Handovers where the time recorded was as waiting less than 15 mins for handover.	-	-	
Ambulance Handover Times >60 mins (%)	Proportion of Ambulance Handovers where the time recorded was as waiting over 60 mins for handover.	National	0.0	
Average time to be seen by a clinician (mins)	The average time a patient waits from Arrival to being seen by a clinician in ED.	Local	60	

NHS
The Rotherham
NHS Foundation Trust

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Patients spending >12 hours in A&E from time of arrival (%)	Proportion of Patients who are in ED for longer than 12hrs from Arrival to Departure/Admission	Local	2.0	
12hr Trolley Waits	Number of patients waiting more than 12 hours after a decision to admit	National	0	
Bed Occupancy (%)	Proportion of Adult G&A beds occupied as at midnight snapshots daily as per KH03 guidance.	Local	91.6	
Criteria to Reside is No (%)	Proportion of inpatients where Criteria to Reside is no	Local	9.9	
Length of Stay over 21 Days	Snapshot of number of Inpatients with a current LOS of 21 days or more as at month end.	Local	70	
Patients where Date of Discharge = Discharge Ready Date (%)	Proportion of patients where date of discharge is same as the recorded Discharge Ready Date	Local	85.0	
A&E Attendances from Care Homes	Number of care home residents attending A&E (based on postcode)	Local	144	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Admissions from Care Homes	Number of care home residents admitted (based on postcode)	Local	74	
Number of Patients on Virtual Ward	Number of patients on a virtual ward in the month	Local	80	
Urgent 2 Hour Community Response (%)	Proportion of standard Urgent 2 Hour Community Response (UCR) referrals seen within 2hrs.	Local	70.0	
Clinic Utilisation (%)	Proportion of Outpatient clinic slots that are utilised	Local	85.0	
Capped Theatres Utilisation (%)	Proportion of time spent operating in theatres, within the planned session time only.	National	85.0	
Model Hospital Daycase Rate (%)	The total number of Day Cases done on patients over 17 where the admission method is elective and the episode is "pre-planned with day surgery intent"	Local	85.0	
Did Not Attend (%)	Proportion of Outpatient clinic slots where the outcome was Did Not Attend	Local	7.0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
First Outpatients (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	103.0	
Inpatients (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	103.0	
Daycases (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	103.0	
Length of Stay over 7 days	Snapshot of number of Inpatients with a current LOS of 7 days or more as at month end.	Local	-	
Mean Length of Stay (Non-elective)	Average LOS for all discharged patients where the admission method is non-elective, 0 LOS are excluded and Observations are excluded.	Local	-	
Mean Length of Stay (Elective excluding Daycases)	Average LOS for all discharged patients where the admission method is elective, 0 LOS are excluded and Daycases are excluded.	Local	-	
Discharged before 5pm (%)	Proportion of patients discharged before 5pm - includes transfers to discharge lounge.	Local	70.0	

Integrated Performance Report Commentary

OVERVIEW

The Integrated Performance Report now includes significant data and trend analysis. Where available, national benchmarking is provided, which in the main illustrates a number of positives that can be taken in relation to delivery and progress and also a number of areas where actions are in progress to improve the position.

This executive summary identifies areas where action is required and is taking place. There are also a number of areas referenced where the Trust is performing well.

QUALITY SUMMARY

• **Care Hours Per Patient Day (CHpPD):** This continues to be in common cause, with an average for the current period of 7.1 against a target of 7.3.

• **Mortality**: The Trust's SHMI has consistently remained in the desired "As Expected" band, out of the three SHMI categories (As Expected, Higher, or Lower), since July 2021.

• **C. difficile infections**: After a period of exceptionally high infections (April-May 2024), these have returned to common cause with the latest value meeting the monthly threshold. These rates are reviewed monthly at Harm Free Care panels, with emerging themes pointing to antimicrobial stewardship and prescribing practices.

• **Friends and Family Test**: The Trust consistently achieves the target of 95% for this measure, with an average score over the past 18 months of 97%.

OPERATIONAL PERFORMANCE

- **Elective waits**: The Trust is in the first quartile for 65 week waits with no patients at the end of September. The national target to clear long waits has been

achieved. 52-week waits are second quartile, although progress in reducing 52-week waits has been limited.

- **Cancer**: all three metrics (Faster Diagnosis, 31- and 62-Day Standard) were once gain achieved in month. FDS showing significant sustained improvement.
- **DM01**: performance against this metric remains very positive and has now been achieving against target since March 2024.
- **4 Hour Performance**: gains have been made against this metric and showing significant sustained improvement, from an average of 58% to 67%
- **2 Hour Urgency Community Response**: this metric continues to achieve target and is expected to continue to do so, additionally the past four points are on an upward trajectory which may indicate the start of a trend demonstrating significant improvement.
- **Did Not Attend (DNA)**: the proportion of appointments where patient DNAs continues to miss target, although a sustained reduction is now being seen.
- **Referrals**: there has been a sustained increase in the number of referrals leading to increased pressure on services.

PEOPLE AND CULTURE SUMMARY

- **Sickness absence rate:** performance is now broadly static following improvement during 2023/24 and as a result is a cause for concern. The rate of sickness absence is been driven primarily by long term sickness absence. Links between deprivation, population health and the health and wellbeing of our people are also relevant here. Other Trusts in SY have seen a deterioration in performance here and actions are being taken through the HWB and attendance programme to tackle this.

- **Appraisal rate completion:** continues to be below the target however signs of improvement noted as appraisal season comes to its conclusion.

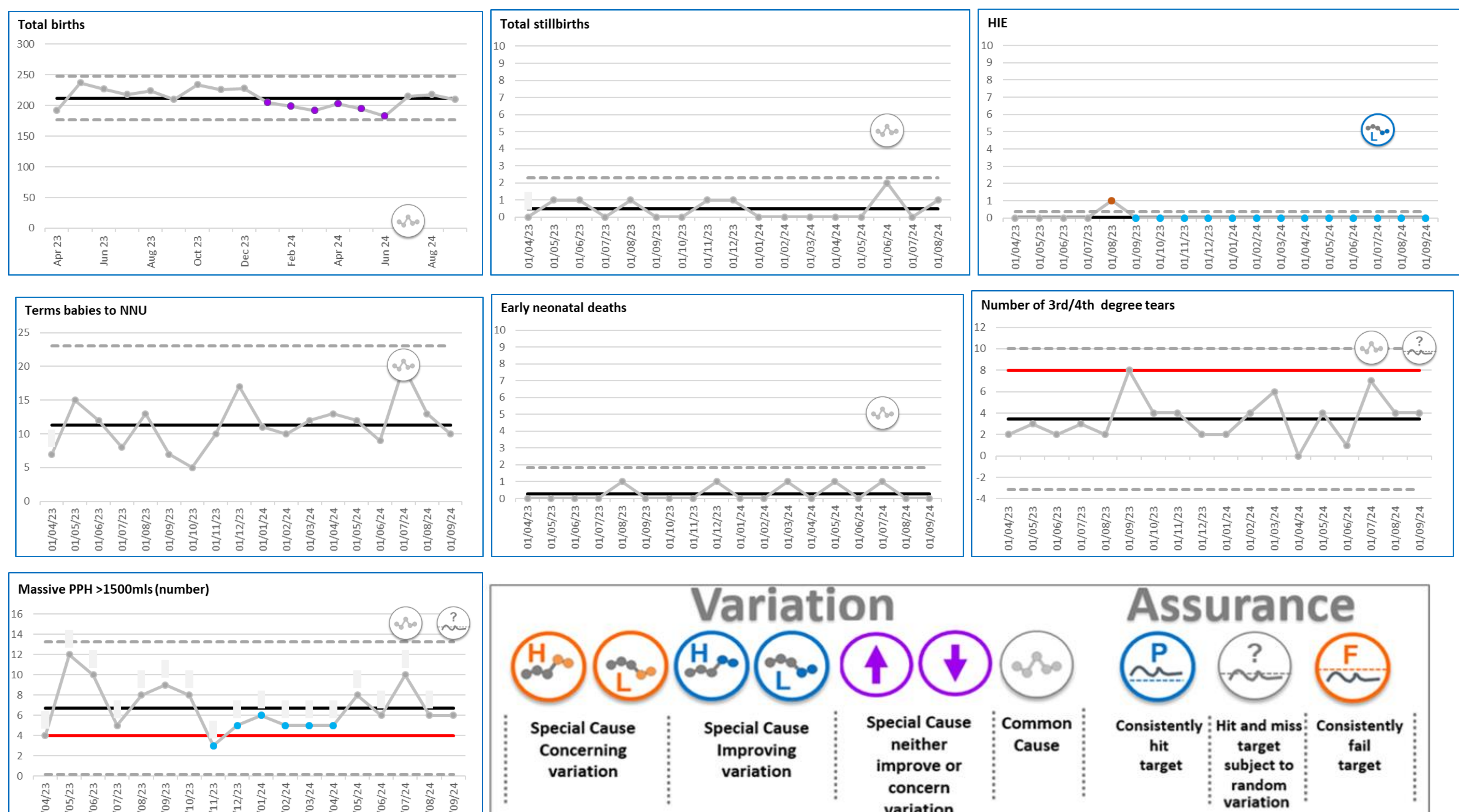
- **Vacancy rate:** performance is a function of the relationship between retention, recruitment and establishment size, and is in a good position.

Board of Directors' Meeting
8 November 2024

Agenda item	P178/24
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. This month's paper is a full maternity and neonatal safety report. • The Perinatal oversight maternity dashboard data is represented below in the Safety Statistical Process Control charts (SPC). There are no escalation as the data represents common cause variations and Low incidence For Hypoxic Ischaemic Encephalopathy (HIE). • The Perinatal Mortality data for September represents an adjusted Perinatal death rate of 3.17 per 1000, for stillbirth 2.39 per 1000. The South Yorkshire perinatal data is provided for 2023/24 reflecting a stillbirth rate of 3.29 per 1000. An update on the Review Tool (PMRT) meeting data and learning is shared • An update on the 3 year delivery plan highlights the progress to date out of the 162 tasks and workstreams. • The Biannual Maternity staffing paper is shared in the paper providing the assurance for Maternity incentive Scheme year 6 Midwifery, Maternity and Neonatal staffing standards. • The Maternity and Neonatal safety Champion's did a walkaround Labour Ward in September and feedback has been shared with teams on the Maternity and Neonatal safety Newsletter. • No PSII relating to maternity were declared in September there were 18 moderate incidents which were reviewed by the MDT. • The NHS Resolution score card has been published, the Trust PSIRP guidance has been updated with the key themes from, incidents, claims and complaints. • Maternity Incentive Scheme (MIS) Year 6 work and progress with the Saving Babies Lives care bundle is on track. • The Avoiding Term Admission to the Neonatal Unit rate (ATAIN) in September has reduced to below 5% with 9 babies admitted to the neonatal unit for further observation.

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 Quality Committee and Trust Board bi-monthly to discuss the Maternity and Neonatal Safety agenda.
Recommendations	It is recommended that Trust Board are assured by Maternity and neonatal outcome data and update provided.
Appendices	The following appendices are available in the 'Review Room': 1. Three Year Delivery plan 2. Maternity and neonatal safe staffing paper 3. Oxytocin safety alert 4. Minutes from Saving Babies Lives deep dive by the South Yorkshire Local Maternity and Neonatal System

Maternity Safety Statistical Process Control charts (SPC)



TRFT Maternity Dashboard: General

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Smoking at booking %	Sep 24	8.8%	6.0%			10.8%	4.4%	17.3%
Smoking at birth %	Sep 24	8.7%	6.0%			10.4%	6.4%	14.4%
Number of bookings	Sep 24	222	-			247	188	307
Booking < 13 weeks	Sep 24	91.0%	90.0%			90.1%	84.3%	95.9%
Booking < 10 weeks	Sep 24	70.3%	90.0%			71.4%	61.1%	81.7%
Personalised Care Plan	Sep 24	96.4%	95.0%			97.7%	94.6%	100.9%
Total Induction rate	Sep 24	38.4%	32.8%			37.9%	29.2%	46.6%
Augmentation IOL	Sep 24	48	-			42	22	62
Augmentation 1st Stage	Sep 24	9	-			13	-1	27
Augmentation 2nd stage	Sep 24	3	-			3	-1	6
Shoulder dystocia	Sep 24	4	2			2	-4	8
Massive PPH >1500mls (number)	Sep 24	6	4			7	0	13
Massive PPH >1500mls (%)	Sep 24	2.8%	2.0%			3.2%	0.1%	6.2%
Number of 3rd/4th degree tears	Sep 24	4	8			3	-3	10
3rd/4th degree tears in spontaneous vaginal birth	Sep 24	2	-			2	-3	7
3rd/4th degree tears in spontaneous vaginal birth (%)	Sep 24	1.8%	2.8%			1.9%	-3.1%	6.9%
3rd/4th degree tears assisted birth	Sep 24	2	-			1	-3	5
3rd/4th degree tears assisted birth (%)	Sep 24	18.1%	6.0%			7.7%	-19.0%	34.4%
Number of eclamptic fits	Sep 24	0	-			0	0	0
Pressure ulcers	Sep 24	0	-			0	-1	1
Optimal Cord Clamping	Sep 24	91.0%	-			90.2%	84.4%	96.1%
APGARS 0-6 @ 1 minute	Sep 24	6	-			11	-3	24
APGARS 7-10 @ 1 minute	Sep 24	203	-			200	168	232
Skin to skin	Sep 24	86.6%	80.0%			82.5%	73.5%	91.4%
Breastfeeding	Sep 24	66.5%	72.7%			60.1%	51.6%	68.6%

DATA MEASURES – REVISED PERINATAL QUALITY SURVEILLANCE TOOL Nic

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.	Questions raised at the review meeting, the cases are to be presented again for further discussion and review.	No perinatal mortality meeting held March 2024	Issues raised with 1 case. Thematic review of processes in triage to be undertaken	No immediate learning identified for cases presented at May perinatal mortality meeting. Some learning to be disseminated to staff via learning points.	June 2024 perinatal mortality meeting (PMRT) cancelled due to Dr's industrial action.	Review of Neonatal death, learning identified and an action plan has been formulated. See Narrative in point 4	Minutes and details pending	No perinatal mortality meeting was held Sept 2024. Cases on the Sept agenda will be reviewed at the meeting to be held 25/10/2024.			
2. Findings of review of all cases eligible for referral to HSIB	1 case in progress. Draft report received with no safety recommendations	1 case completed. Final report shared with staff involved. Tripartite meeting to be held with family in April. No safety recommendations	No cases reported to MNSI in March	1 case referred to MNSI in April. Cat 1 section for pathological CTG. Baby has HIE.	1 case ongoing with MNSI. No new referrals in May.	2 cases referred in June. 1 case referred to MNSI for baby requiring cooling. MRI shows no signs of HIE, therefore case rejected by MNSI. 1 case referred for a maternal death, 1 case remains ongoing.	2 cases ongoing, same as previous months finding, still attempting to gain consent for MNSI to investigate recent maternal death.	1 ongoing case reported in April, report anticipated next month. Unable to gain consent for maternal death. Working with South Yorkshire advocate to continue to gain consent.	1 case ongoing, draft report due October to Trust. 1 case rejected for lack of consent following maternal death. Approaching NoK for consent and will refer again. 1 new case referred for an intrapartum stillbirth at 39+6/40			

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	15 recorded as moderate harm. Following MDT review 0 remained at moderate harm	20 recorded as moderate harm. Following MDT review 0 remained at moderate harm	14 recorded as moderate harm. Following MDT review 1 remained at moderate harm	15 recorded as moderate harm. Following MDT review all were graded as low or no harm.	17 recorded as moderate. Following MDT X1 remained moderate and for further investigation x1 level of harm death for further investigation by MNSI.	In July there were 109 incidents logged of which 25 cases graded as Moderate – following review, only one remained moderate.	In August there was 111 incidents reported of which 15 were graded as moderate. Following MDT review all were graded as low or no harm.	In September there were 100 incidents reported of which 18 incidents were graded as moderate. Following MDT review all but one were graded as low or no harm. One incident remained at moderate, case referred to MNSI			
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.	Training compliance of Obstetric trainees has declined to below 90% due to new rotation of trainees. Training for all other disciplines is >90%	See section 12.2	90% for all disciplines with the exception of junior Doctors.	90% for all disciplines with the exception of junior Doctors. The new programme for obstetric Anaesthetists requires a full day MDT training from April 24	90% of all disciplines with the exception of junior doctors (89%) and anaesthetics. (28%). Plan in place.	90 % for all disciplines with the exception of Anaesthetic colleagues see section 11.1	No training in August 24	See section 11.1			
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.	No issues for escalation	See section 19	No staffing issues for escalation see Appendix 2 for Bi annual staffing report	No staffing issues for escalation see Appendix 2 for Bi annual staffing report	Doctor strike managed well with senior cover. No issues to escalate.	No staffing issues to escalate for the month of July 24.	August report in next month's paper	See section and 9.1 Appendix 2			
3.Service User Voice Feedback	NHS CQC Maternity Survey 2024 Result, see point 5.1 within this report.	MNVP role to change over to the MNVP engagement officer from April	MNVP 15 Steps NNU	Feedback shared from MNVP Facebook page for	Interim MNVP lead supporting TRFT, chairing local	New MNVP substantive role recruited to. To start in	Parents and carer panel focus group feedback	New MNVP lead now in post – to explore	CQC picker survey results received, embargoed			

		2024.		TRFT	MNVP meeting and sharing user feedback.	Aug 24. Work plan reviewed with LMNS.	received from MNVPs. Narrative in report for August.	resources from Sand's and Tommy's to support Equality and Equality plan.	until December 2024			
4. Staff feedback from frontline champion and walk-abouts. Executive / NED meeting with the perinatal leadership team	Walk-about and meeting feedback, see point 13 within this report.	Visit to NNU to support the team. No escalations.	No walk around meeting in March 2024	No walk around meeting in April 2024	Visit to NNU	No walk around in June. Planned for community 2nd July 24.	Community walk around with Board level safety champion – Narrative within Sept report.	Escalations to safety champion around the lack of theatre space for planned LSCS and around the ongoing NND case that will be heard by the Coroner	See Section 10.1			
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil			
6.Coroner Reg 28 made directly to Trust	0	0		0	0	0	0	0	0			
7.Progress in achievement of CNST 10	Achieved	Achieved	Achieved	Achieved New standards began for 24/25	Ongoing	Ongoing	Ongoing	Ongoing				

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 the 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 MBRRACE-UK have published their annual *State of the Nation Report* (2024) in which the UK perinatal deaths of babies born in 2022 are published. Stillbirth rates have decreased across the UK in 2022, but neonatal mortality increased. The Statistical Process Control charts (SPC) (Table 2.2 below) has been updated to demonstrate how Rotherham Foundation Trust is performing against the ambition to half the rates of perinatal mortality from 2010 to 2025. The key national messages from this report are.

- Extended perinatal mortality (all stillbirths and neonatal deaths) rates decreased across the UK in 2022, after a rise in 2021.
- Compared to 2021, stillbirths in all nations of the UK, except Scotland, decreased in 2022.
- There was shown to be an increase in the neonatal mortality rates per 1000 live births in England and Wales compared to the 2021 data.

Table 2.1 show how TRFT compare with Trusts in the region for all extended perinatal deaths. Table 2.2 demonstrates our ongoing figures in comparison to national data.

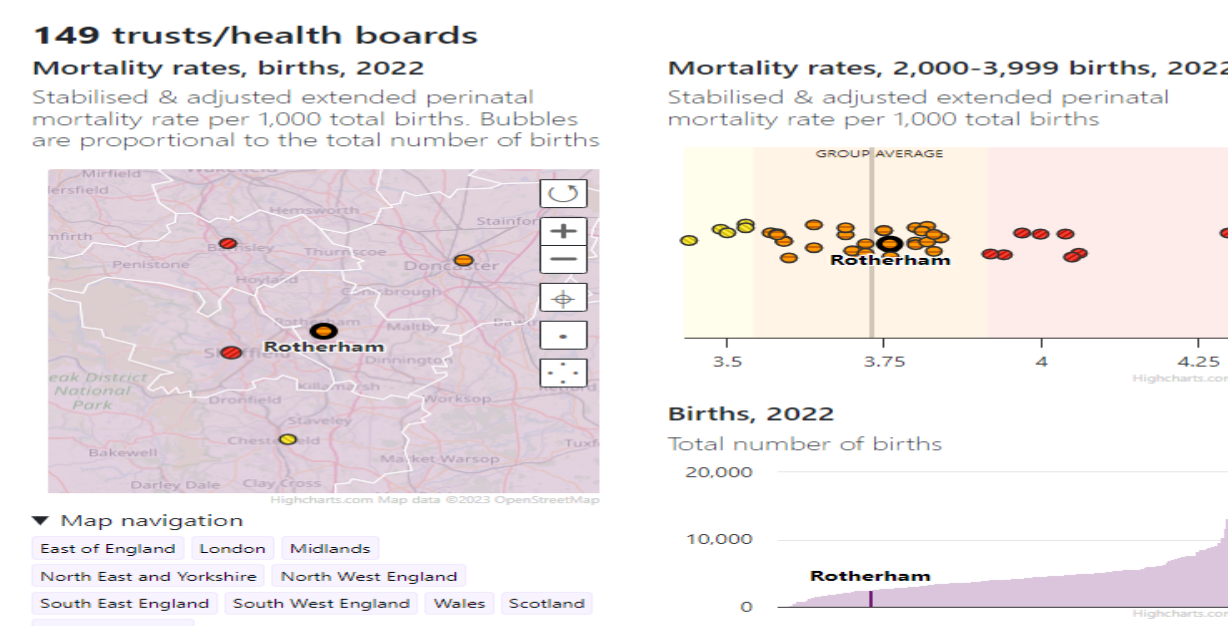
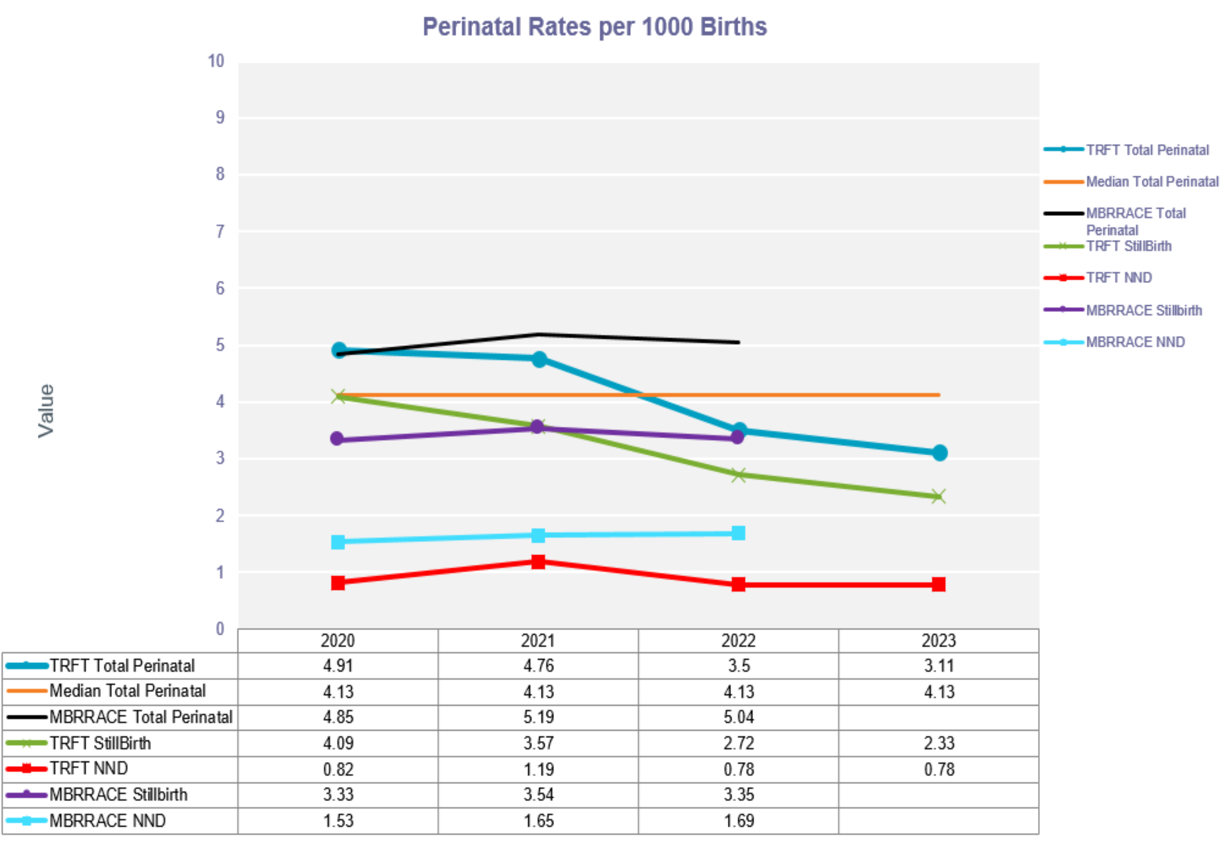


Table 2.1 TRFT in comparison to region

2.2 Within Table 2.2, it can be noted that the UK total perinatal death rate per 1000 births is 5.04 and TRFT data for the same time period of 2022 shows a rate of 3.5 per 1000 births. The national data also indicates that mortality for premature babies improved for all gestations within 2022 apart from babies born between 32- and 36-weeks gestation.



	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
MBRRACE Total Perinatal	4.85	5.19	5.04	
TRFT StillBirth	4.09	3.57	2.72	2.33
TRFT NND	0.82	1.19	0.78	0.78
MBRRACE Stillbirth	3.33	3.54	3.35	
MBRRACE NND	1.53	1.65	1.69	

Table 2.2 Total perinatal deaths

2.3 Table 2.3 shares the most recent South Yorkshire Local Maternity and Neonatal (LMNS) stillbirth data for 2023/24. The current stillbirth rate overall for South Yorkshire is 3.29 per 1000. The rate for TRFT was 1.93 per 1000. The TRFT annual perinatal review meeting is planned for January 2025 to review all 2023 perinatal deaths with support from external partners.

Maternity Equity Metrics		Stillbirths by Trust	2023/24
Trust	Rate	Change	Commentary
Barnsley Hospital NHS FT	2.35	↓	Last 3 quarters were below the mean rate
Doncaster & Bassetlaw Teaching Hospitals NHS FT	2.90	↓	There was a spike in 2022/23 but no common cause found. 2023/24 rate slightly below the 2016-2024 mean (2.95)
The Rotherham Hospital NHS FT	1.93	↓	2023/24 improved relative to 2022/23, which was also improved relative to average rate over the previous 3 years. Suggestive of an improving trend (shown by the dotted red line on the chart below)
Sheffield Teaching Hospitals NHS FT	4.72	↓	2023/24 lower than 2022/23 but still above average rate over the previous 3 years
South Yorkshire	3.29	↓	While 2019 to mid-2021 average rate (3.15) was much improved from 2016-2018 (4.3), the mid-2021 to 2024 average is higher (3.57)

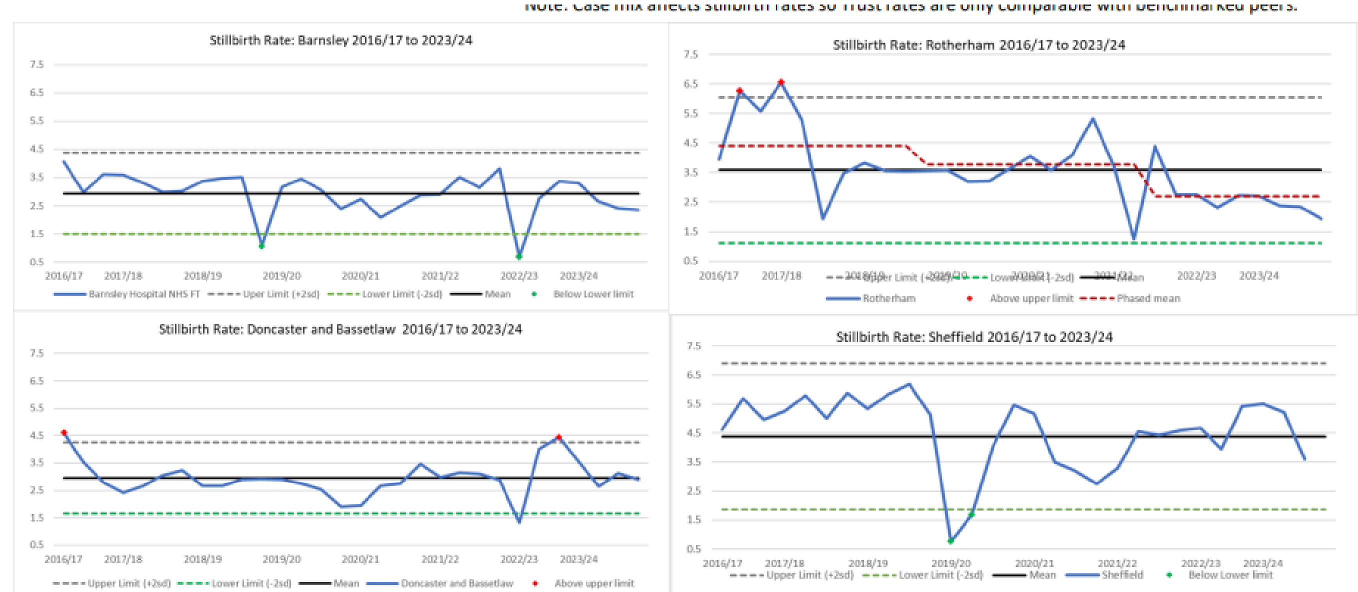


Table 2.3

3. Perinatal Mortality Summary for month of September 2024

3.1 Table 3.1 reports perinatal data from Sept 2024 in comparison to the last two years data as a rolling tracker.

	2022 Total:	2023 Total:	01/01/2024 – 31/08/2024	In Month: Sept 2024
Total Stillbirths (All)	7	6	3	1
Stillbirths >37 weeks	1	1	-	1
Stillbirths 24 - 36+6 weeks	6	5	3	
Intrapartum Stillbirths	1	-	-	-
MTOP Anomaly >24 weeks	0	2	-	-
Adjusted Stillbirths	7	6	3	1
Total Neo-Natal Deaths (NND)	8	4	4	-
ENND >24 weeks up to 7 days of life	7	2	1	-
LNND 7-28 days	1	1	1	-
Adjusted Neonatal Deaths – All gestation (EXCL MTOP)	2	2	1	0
Total Adjusted Perinatal (24 wk – 28 days)	9	8	3	1
MTOP ENND	1	-	-	-
Stillbirth Elsewhere (booked at RFT)	0	-	-	-
Neo-Natal Deaths Elsewhere (outside of TRFT)	2	2	4	-
Maternal Deaths	0	1	1	-
NVF <24 weeks	12	10	10	2
NPMRT entered	12	10	6	1
NPMRT Closed	14	10	5	1

Table 3.1 TRFT perinatal deaths

3.2 The rolling figure of stillbirths and neonatal deaths from Oct 2023 to Sept 2024 are as demonstrated within Table 3.5 below:

Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP) Adjusted Total Perinatal **3.17/1000 births**		
Type of death	Number	Rate per 1000 births
Stillbirth	6	2.39
Neonatal Death	2	0.78

Table 3.5 Adjusted perinatal deaths

4. PMRT real time data monitoring tool

4.1 In July 2024 – September 2024, 1 PMRT case was closed and the report published. Table 4.1 represents the PMRT meeting outcomes from December 2023 - 21st October 2024.

4.2 Following the reviewing of a neonatal death, a new LMNS Standard Operating Procedure (SOP) has been created and is currently going through the Local Maternity and Neonatal System (LMNS) governance to update the process of how cases are managed when parents request for a PMRT to be reopened.

4.3 Whilst there have been no themes or trends identified from this timeframe, learning from the PMRT case following a 28-week neonatal death which occurred on Christmas Day 2023 included, gaining an impact statement from the family to be used within the maternity MAST training to improve bereavement communication with families. A detailed action plan has been created and has been shared via the Maternity and Neonatal Safety Champions meeting.

PMRT Grading of Care Extract for The Rotherham NHS Foundation Trust from reviews of deaths from 8/12/2023 to 21/10/2024

PMRT case ID	Grading of care of the mother and baby up to the point of birth of the baby	Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of her baby	Comments
91027/1	C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	Investigated as a PSII Also referred to coroners Inquest to be held
91842/1	B - The review group identified care issues	A - The review group concluded that there were no	A - The review group concluded that there were no	

	which they considered would have made no difference to the outcome for the baby	issues with care identified from birth up the point that the baby died	issues with care identified for the mother following the death of her baby	
92289/1	B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	Graded as a C due to Issues regarding communication prior to transfer of baby to RFT PSII for another provider.

Table 4.1

5. Maternity and New-born Safety Investigation (MNSI) formally known as Healthcare Safety Investigation Branch (HSIB) and Maternity Patient Safety Investigations (PSII)

5.1 Since the commencement of MNSI (formally HSIB) maternity investigations in 2018, TRFT have reported 24 cases for external review. Of the 24 cases, 10 were rejected, leaving 14 cases progressing to a full external investigation (Table 5.1).

5.2 One case is ongoing for a baby having seizures at 36 hours of age and abnormal head CT which occurred in March 2024. The draft report is expected to be shared with the Trust in October 2024. This will then be shared with staff and the family before being finally published.

5.3 A case that was referred to MNSI in June 2024 was a maternal death 5 weeks postnatally which occurred in the same month. MNSI have stood down the case due to lack of consent from the family. The Next of Kin have been approached for consent and if obtained will be referred to MNSI who will reopen the case.

5.4 A further case was referred to MNSI in September 2024 due to a woman presenting in the latent phase of labour where a intrapartum stillbirth at 39 weeks and 4 days gestation was found on admission. The family have given consent and MNSI are reviewing medical records.

5.5 In Table 5.1 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	20/12/19	2 safety recommendations
1902	430	HIE/Cooling	13/03/20	No safety recommendations
1903	555	Maternal Death	03/02/20	No safety recommendations
1909	1185	HIE/Cooling	30/06/20	2 safety recommendations
1912	1509	HIE/Cooling	18/08/20	4 safety recommendations
2007	2295	HIE/Cooling	18/01/21	No safety recommendations
2009	2470	NND	01/04/21	3 safety recommendations
2101	2893	HIE/Cooling	20/07/21	6 safety recommendations
MI-00	3385	HIE/Cooling	18/10/21	No safety recommendations
MI-00	3662	NND	22/11/21	No safety recommendations
MI-00	5238	Stillbirth	24/05/22	1 safety recommendation
MI-00	28038	HIE/Cooling	22/02/24	No safety recommendations

Table 5.1 MNSI breakdown

5.6 MNSI ongoing cases and progress (Table 5.6)

Ref	Case Ref	Type	Start date	Overview	Progress
167978	MI-037282	MNSI	22/04/2024	Pathological CTG. Seizures at 36 hours old with abnormal head CT and MRI.	Report expected in October 24
170988	N/A	MNSI	Pending	Maternal death following a cardiac arrest. Woman brought to UECC 5 weeks postnatally.	MNSI unable to gain consent from family. MNSI to archive at this time. Case returned to Trust harm free panel, awaiting feedback from Next of Kin(Parents) as the whether this will be MNSI or Trust PSII
175352	MI-038575	MNSI	30/09/2024	Intrapartum stillbirth. Attended in latent phase of labour and sadly no fetal heartbeat on admission.	Family consent gained, record sharing in progress

Table 5.6

5.7 Table 5.8 illustrates the current PSII investigations been undertaken in maternity and neonatal services.

5.8 A review of all cases referred to the MNSI in 2023 to present demonstrated that all families have received full duty of candour along with information of the function and remit of MNSI. There has been one case referred to the NHS Resolution (NHSR) due to a possible HIE injury, however following investigation no HIE was diagnosed, therefore the family did not require information about the NHSR role and purpose as would normally be the case. Offering families involved in maternity incidents Duty of Candour, information of NHSR and MNSI are all a requirement of CNST year 6.

Ref	Type	Overview	Progress
172732	PSII	35/40 vaginal breech birth, traumatic birth with injury to baby.	Draft report in progress
172732	PSII	Bowel and bladder injury following LCSC	Draft in progress
170822	PSII	IUFD: Scan pathway not followed	Draft report going through Q&A

Table 5.8

6. Coroner Regulation 28 made directly to Trust

6.1 TRFT Maternity have no Coroner Regulation 28 orders.

7. Learning from recent closed investigations cases

7.1 Table 7.1 highlights the closed PSII cases, and the learning identified.

Ref	Type	Overview	Learning
168816	PSII	29-day old death of a baby – overlay at home	All processes and guidelines were followed however, learning identified for improvements in documentation and communication between services.
164265	PSII (joint with CYPS)	28/40 preterm birth requiring extensive resuscitation.	Communication, triage calls, equipment. coroners' case.

Table 7.1

7.2 A thematic review has been undertaken for 3 infant overlay cases which occurred between April 2024 and July 2024. The review has prompted an action plan to focus on improving the safe co-sleeping advice shared with families throughout pregnancy and following birth. A text reminder is being created to remind all parents of the safe sleep advice to be sent out at 4 and 7 weeks postnatal. A media campaign has also been funded across South Yorkshire for safe sleep.

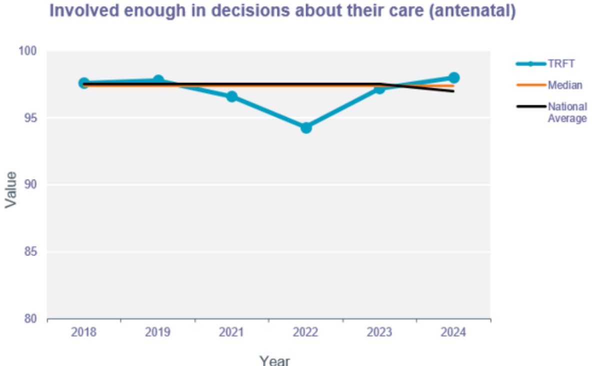
8. Below is an update on the 3 Year Delivery plan for Maternity and Neonatal services for July 2024

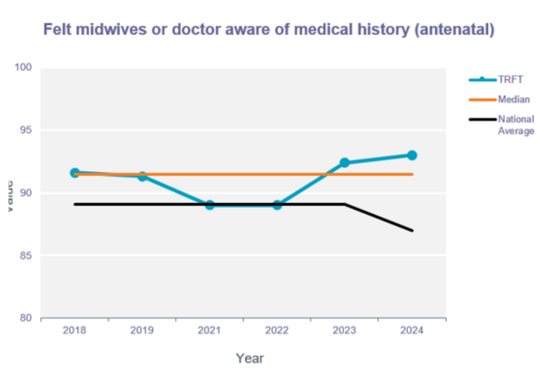
8.1 The 3 year delivery plan tracker Appendix 1 has been updated to demonstrate the progress with all four themes identified in the plan. The tracker demonstrates good progress to date as demonstrated in table 8.1.

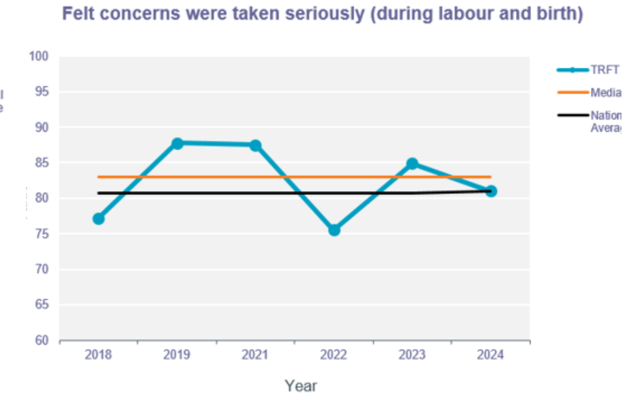
Brag rating Status	Numbers out of the 162 workstream/ tasks
Signed off complete and evidenced	90
Complete	14
In progress	50
Delayed/ not started	8

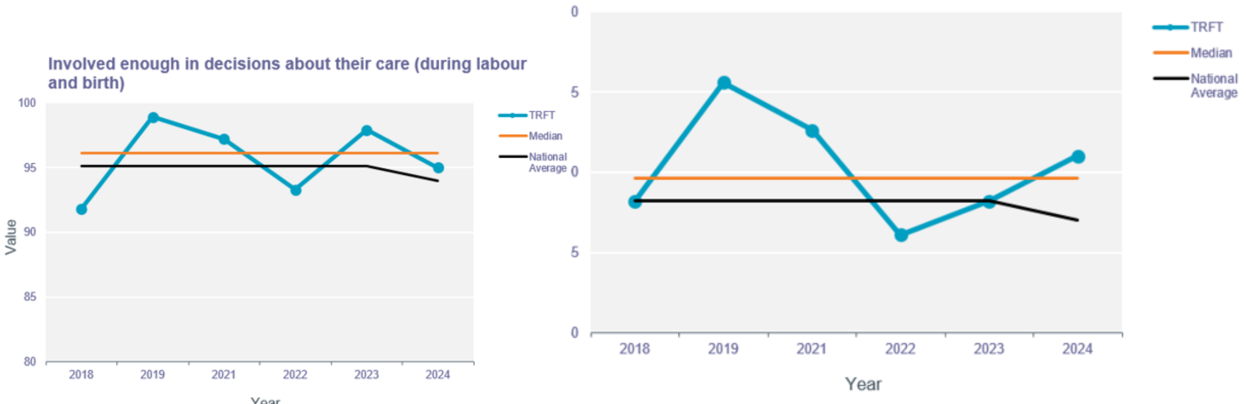
Table 8.1

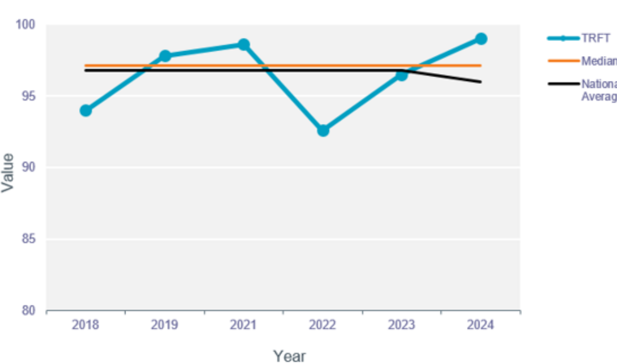
8.2 The Maternity Inpatient survey results remain embargoed until December 2024, the SPC charts below provide the Trust performance for the outcome measures used for Theme 1 of the 3-year delivery plan, listening to women. The results demonstrate some positive improvements in scores. The next steps once the results are published will be to go through the survey with the Maternity and Neonatal voice partnership and create an action plan for sustained and continued improvement of Maternity services at TRFT.











9. Developing our workforce

9.1 The Maternity, neonatal and medical workforce requirements, continues to be monitored closely. Maternity and neonatal services undertake daily staffing huddles to assess acuity, flow and staffing gaps on the day and a weekly forward view. Further analysis is presented in the biannual safer staffing paper Appendix 2. The report is a summary of all measures in place to ensure safe midwifery staffing from the period of April 2024 to September 2024. The paper illustrates; workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours and compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme year 6.

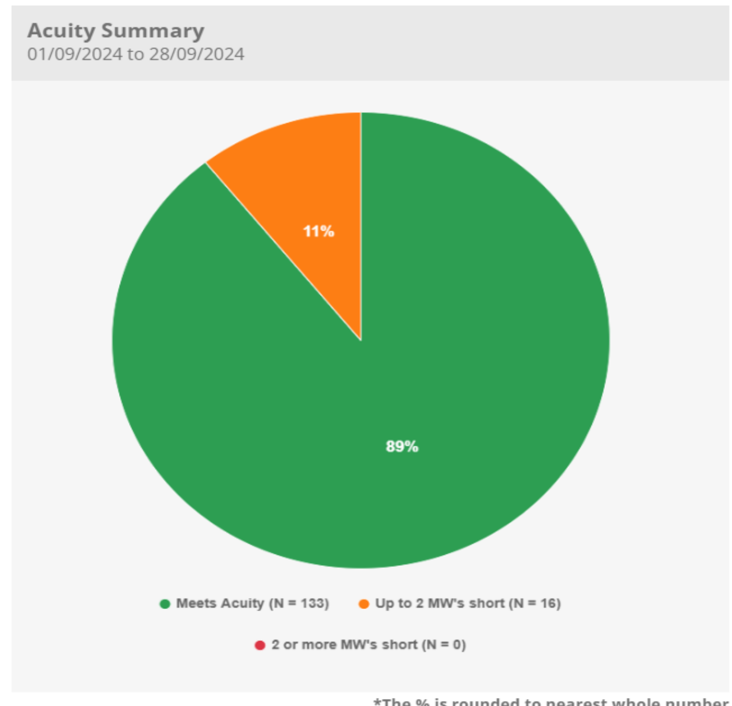
Overall the report provides the assurance that TRFT currently meets Birth rate plus midwifery staffing recommendations, The Royal College of Obstetricians and Gynaecologist (RCOG) Guidance on engagement of long term locums, The Royal College of Anaesthetists (ACSA) standard for the availability of a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. The report also provides evidence for neonatal compliance with the British Association for Perinatal Medicine (BAPM) for neonatal medical and nursing standards.

9.2 Midwifery staffing can be seen in Table 9.2. The maternity leave, long term sickness and planned leavers result in the total gaps of 14.18 WTE for October 2024. The early career midwives will reduce this to 8.73 WTE in November 2024. NHSP is being used only when the gaps equate to above the designated headroom for sickness to maintain grip and control. The current budgeted establishment, which is in line with Birthrate+ shows a deficit of 0.29 with some vacancy and reduction on hours following maternity leave. Maternity leave continues to be the highest contributing reason for workforce gaps.

Maternity Staffing live nominal roll as at : 30/09/2024												
	2024/25											
Trajectory	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Contracted Vacancies	**-3.24**	**-1.64**	**-0.96**	**-0.48**	**0.29**	**0.29**	**0.29**	**0.29**	**0.29**	**0.29**	**0.29**	**0.29**
Maternity leave	7.28	7.28	8.08	6.12	5.76	5.12	7.92	8.12	8.76	8.12	7.48	6.84
Long term sickness	2.64	3.80	4.12	8.88	7.00	2.36	1.56	1.56	0.00	0.00	0.00	0.00
Upcoming Leavers	0.00	0.20	0.00	0.00	0.00	0.00	4.85	5.17	5.65	5.17	5.17	5.17
Other - see detail	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20
Total Gaps	**6.88**	**9.84**	**11.44**	**14.72**	**13.25**	**7.97**	**14.82**	**15.34**	**14.90**	**13.78**	**13.14**	**12.50**
New Starters (reducing gaps)	0.00	-0.09	0.00	0.00	0.00	-0.64	-0.64	-1.44	-1.44	-1.44	-2.44	-2.44
New Starters - students/NQM's	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-5.17	-6.08	-6.08	-6.08	-6.08
Trajectory - for planning	**6.88**	**9.75**	**11.44**	**14.72**	**13.25**	**7.33**	**14.18**	**8.73**	**7.38**	**6.26**	**4.62**	**3.98**
% Workforce Gaps	**7.0%**	**9.9%**	**11.6%**	**14.9%**	**13.4%**	**7.4%**	**14.3%**	**8.8%**	**7.5%**	**6.3%**	**4.7%**	**4.0%**

Table 9.2 Midwifery establishment

9.3 Table 9.3 highlights the acuity data for labour ward for September 2024 and demonstrates that midwifery staffing met acuity 89% of the time, with 11% 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. Compliance in data entry improved in September to >88%.



*The % is rounded to nearest whole number

Table 9.3

9.4 Medical workforce locum covers can be seen in Table 9.4 as of September 2024 including the reasons for the requirement.

Grade	No of Shifts	Reason	Internal / External
ST1/2	16	14 Vacancies 2 x Sickness Absence	1 x External 15 x Internal
ST3/7	10	5 x Vacancy 3 x Additional Theatres 2 x Sickness Absence	9 x Internal 1 x External
CONSULTANT	35	8 x Annual/Study Leave 9 x Additional clinics 7 X Additional Theatres 4 x Vacancies 2 X Sickness Absence (reg) 1 x Entrustability Night 3 x In House Theatre 1 x Additional section	35 x Internal

Table 9.4 Medical vacancies

9.5 Table 9.5 below represents September 2024 workforce data. Sickness rates have reduced slightly, absence is managed in line with the sickness and absence policy. No themes or trends have been identified.

Maternity unit closures	**0**	**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	**1**	**Birth rate plus Acuity (Occasions)**
Redeploy staff from Community	**0**	**Birth rate plus Acuity (Occasions)**
Matron Working Clinically	**0**	**Birth rate plus Acuity**
Delay in Induction of Labour	**13**	**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	**5.44%**	**September 24 data, 1.71% short term 3.73% long term**
Obstetric compliance at mandatory consultant escalation	**100%**	**No Datix incidents reported**
Compliance with twice daily face to face ward round	**100%**	**Datix**

Table 9.5

10. Developing a Safety Culture

Safety Champions meetings:

10.1 The September Safety Champion meeting was a walkaround Labour ward, with Dr Rumit Shah Non-Executive Safety Champion and Helen Dobson Executive Safety Champion. The discussions are highlighted in the table below, as a newsletter which is shared with staff to demonstrate sharing learning around the improvements to support maternity and neonatal safety.

Safety Champions Annual Newsletter
How we have used your feedback to improve safety in 2024

Helen Dobson
Chief Nurse

In 2024 we have met with teams from the Community, Neonatal, Labour Ward, Wharncliffe and Greenoaks.

Rumit Shah
Non-Executive Director

Following your feedback we have;

- Raised the concerns with Board around capacity and demand for elective LSCS.
- Raised concerns from the team around water quality when returning to the refurbished NNU.
- Listened to concerns around our vulnerable families in the community that you are caring for and difficulties with interpretation services – this information will be shared at strategic meetings.
- Raised the concerns of poor estates with the Head of Estate.
- Following a recent PMRT review, learning was shared and we supported your senior leadership team with the recommendations regarding resuscitaires.

Table 10.1

10.2 Concerns Raised by service users:

During September x1 informal complaint was raised and responded to regarding the number of staff in a birthing room at the time of birth. There was x1 formal complaint regarding the care during labour and immediately following a home birth. A local resolution meeting has been held to listen to the woman's concerns and share learning from the feedback.

10.3 Quality Improvement work continues to achieve the Year 6, CNST 10 standards.

Table 10.3 displays the current compliance for TRFT. A confirm and challenge meeting will be held on 22nd October 2024 with the LMNS, and dates have been organised for The Executive Team oversight prior to this been presented at Trust board in January 2025 for Chief Executive sign off to be submitted by 12 noon 3rd March 2025.

No	Safety Action	Compliance	Progress / challenges
1	PMRT		Compliant up to August 2024
2	Digital		Achieved full compliance – all 10 data quality requirements passed.
3	Transitional Care		QI work continues, no challenges anticipated
4	Clinical workforce		Awaiting further Medical workforce audit
5	Midwifery workforce		Complaint , Bi annual midwifery staffing paper October 2024
6	Saving Babies Lives V3		Progress has been demonstrated to the LMNS each quarter. Review September 2024 97% compliance
7	MNVP – working with families		New LMNS chair person in post as of August 2024, no challenges anticipated, Terms of reference currently being updated to strengthen processes
8	Training		Action plan in place to support compliance with medical staff
9	Board assurance		All processes in place
10	HSIB compliance		Compliant up to September

Table 10.3 CNST current compliance

NHS Resolution score card:

10.4 NHS Resolution published the Trust claims score card for 2024

The highlights for the most recent legal score card are reflected in the tables below. Table 10.4 reflects the value of claims for TRFT, sharing the closed and open claims from 2014.

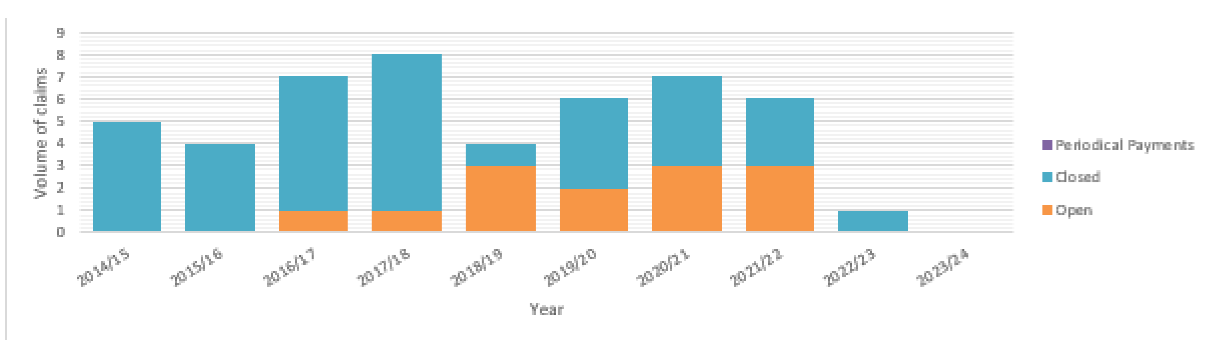


Table 10.4

10.5 Tables 10.5 shares the causes for claims by volume and value. A thematic review of the legal score card incidents and complaints for 2023/24 has informed the Trust PSIRP guidance and the key themes and incident investigations responses for maternity are included in table 10.6. It is anticipated that focusing on these patient safety incidents should reduce harm further improving maternity and neonatal safety.

Top 5 causes by volume for Obstetrics

	Causes	Volume
1	Fail / Delay Treatment	12
2	Failure/Delay Diagnosis	5
3	Fail To Recog. Complication Of	4
4	Perineal Tear-1st,2nd,3rd Deg	3
5	Unexpected Death	3
Total Top 5 causes by Volume for Obstetrics		27

Top 5 causes by value for Obstetrics

	Causes	Volume
1	Fail / Delay Treatment	12
2	Perineal Tear-1st,2nd,3rd Deg	3
3	Delay In Performing Operation	2
4	Fail To Diag Pre-Eclampsia	1
5	Unexpected Death	3
Total Top 5 causes by Volume for Obstetrics		21

Table 10.5 Rotherham Claims Scorecard

10.6 Table 10.6 Planned Patient Safety Incident Investigation responses for top local patient safety risks.

Delays in Care	Delays in diagnosis where a patient came to moderate harm or above and treatment plans had been significantly changed as a consequence	PSII AAR
Significant maternity cases not fitting into any national reporting criteria.	Any case where a baby or mother has suffered serious injury and or damage that does not fit the HSIB/MNSI or PMRT criteria, which has been caused by or suspected to have been caused by substandard care.	PSII / AAR
Maternity specific cases falling into the treatment and procedural criteria.	Post-Partum Haemorrhage Term admissions to the NNU Ruptured ectopic pregnancies Triage issues and complaints Preterm birth	Thematic review plus or minus AAR

Table 10.6

10.7 Table 10.7 highlights the number of women who suffered a moderate harm in the month of September 2024. In September there were 18 incidents reported as a moderate harm. All cases have been examined at the Maternity Weekly Datix meeting by a senior MDT and reduced to low or no harm. Deprivation and ethnicity scores have been collected for this group (Table 10.8 10.9) and highlights that for September, poorer outcomes were sustained by the women who live in the poorest areas of Rotherham. The ethnic demographic is representative of the diversity of women who birth at Rotherham.

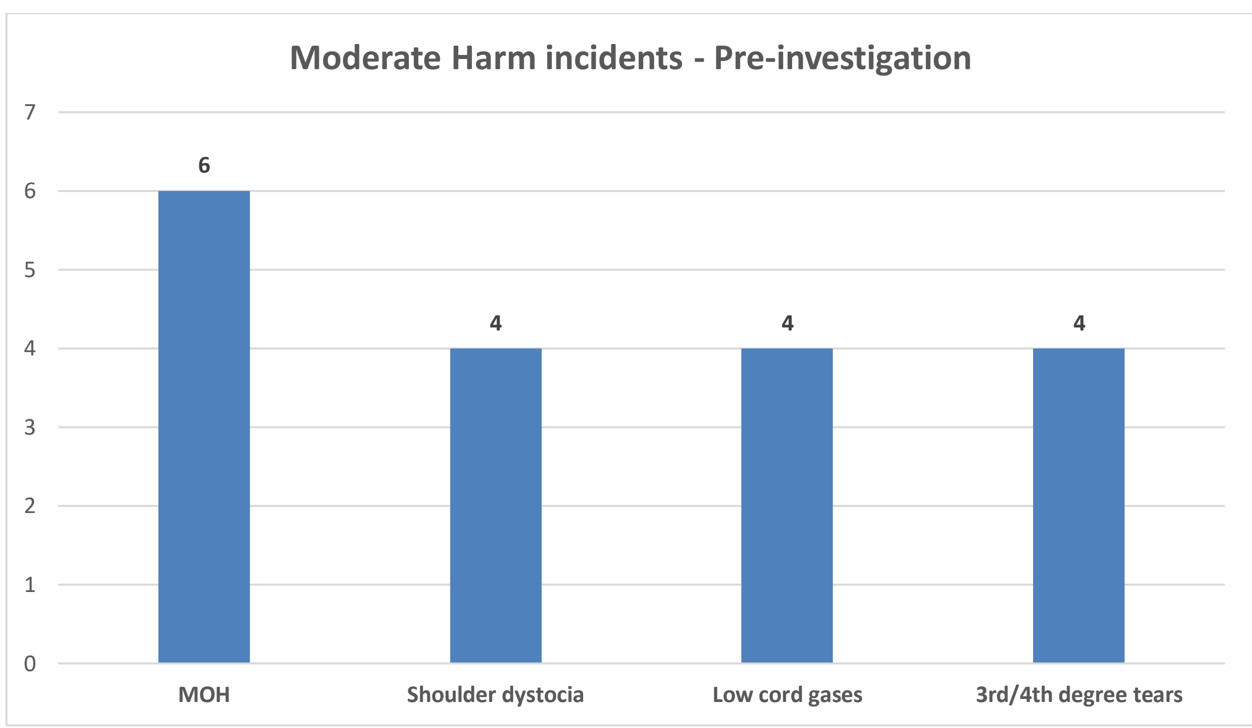


Table 10.7 Moderate harms in maternity

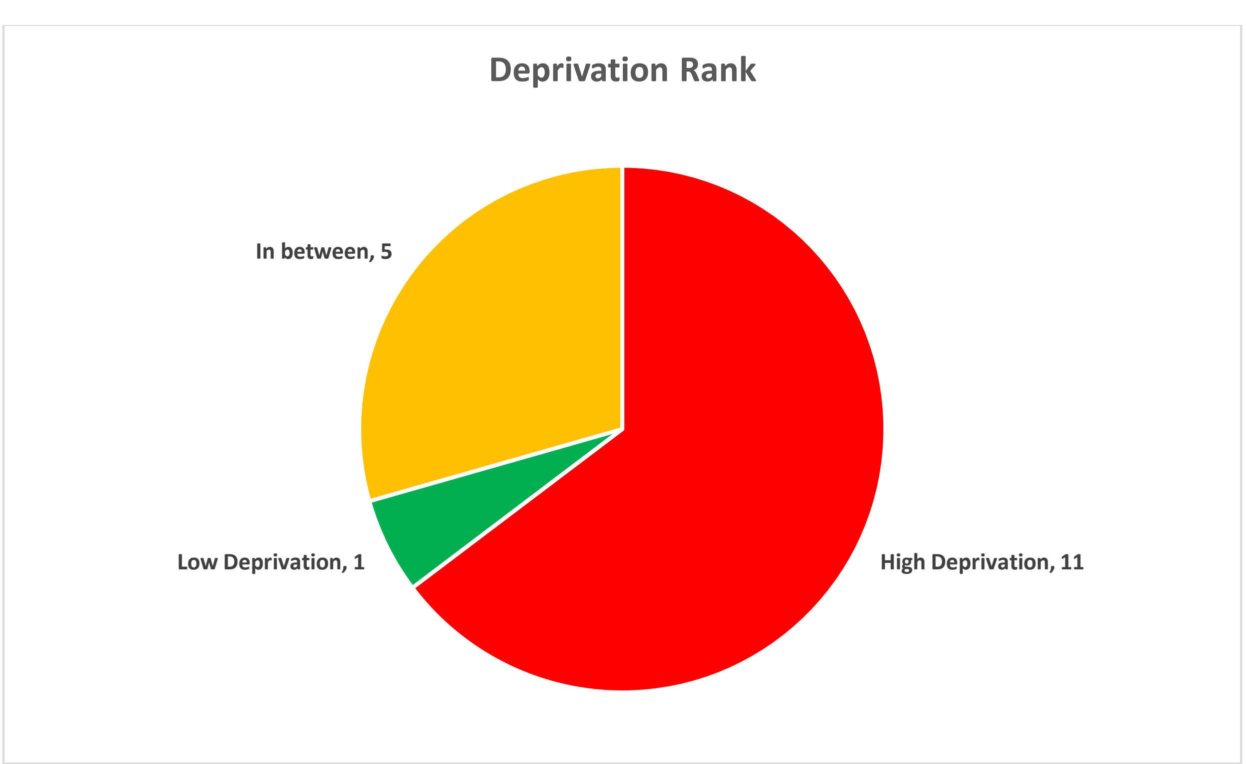


Table 10.8 Women's deprivation of moderate harms suffered

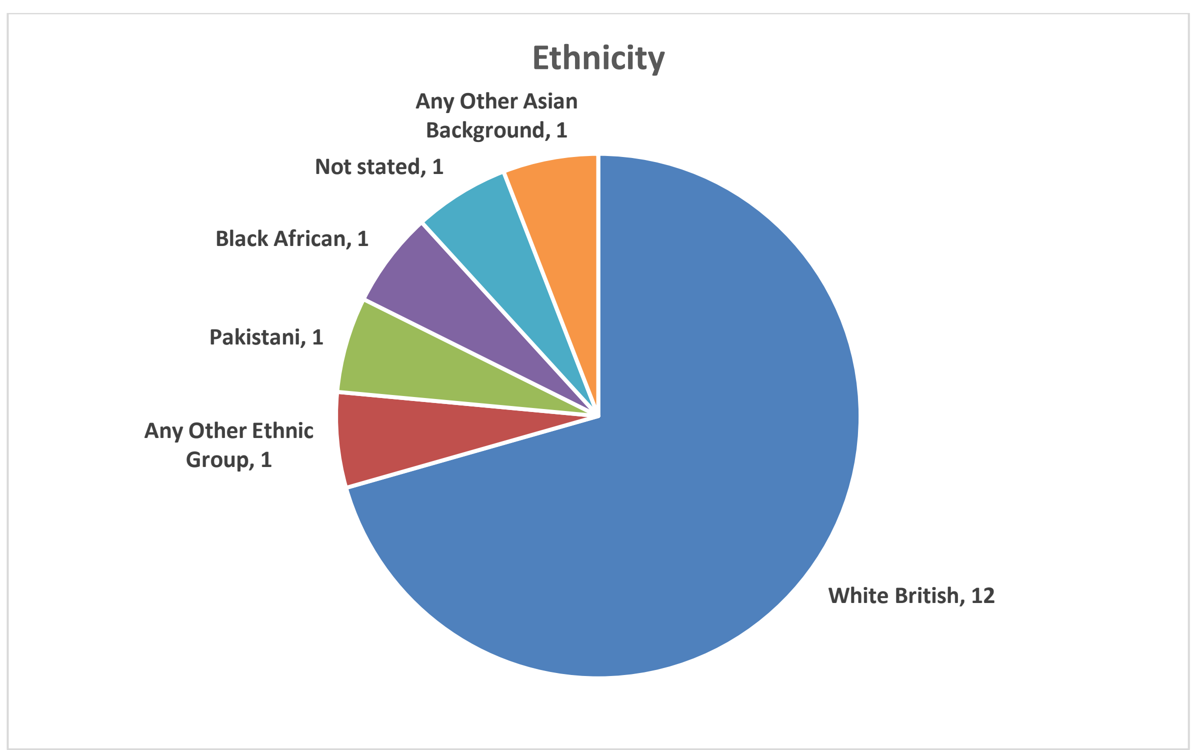


Table 10.9 Ethnicity of women who suffered moderate harms

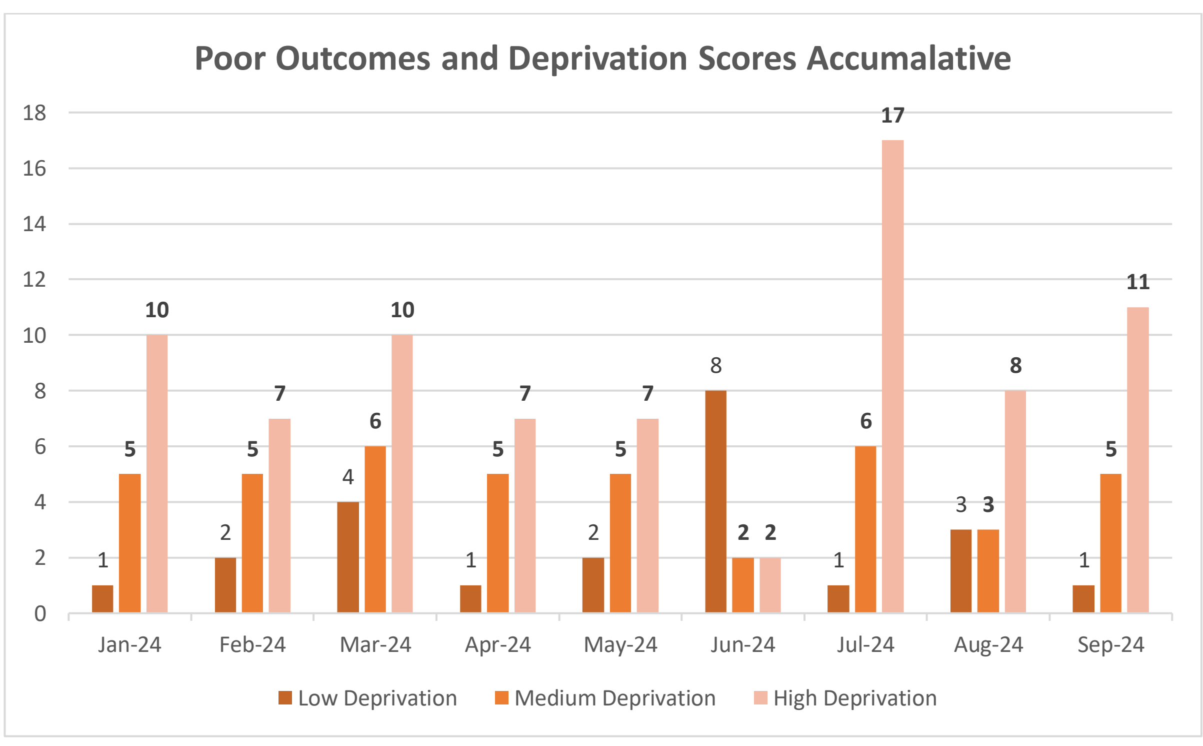


Table 10.10 Ongoing surveillance of deprivation scores and moderate harms

Appendix 3 shares a patient safety alert which was escalated to all Trusts following a review of the National Reporting and Learning Systems over a 5 year period identified 25 incidents including one report of a woman receiving a pre-prepared postpartum oxytocin infusion in place of IV fluids while in labour. The Maternity service has developed an action plan in response to this to demonstrate compliance with the recommendations.

11. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

11.1 The Division continues to work towards the three-year core curriculum local training plan which has had input from service users (MNVP) to create its content and has been informed through learning from themes and trends from incidents and investigations. Table 11.1 demonstrates compliance. Year Six Maternity incentive scheme (MIS 6) guidance published on 2nd April 2024 requires 90% attendance of the relevant staff groups at:

11.1.1 Fetal Monitoring training
11.1.2 Multiprofessional Maternity emergencies
11.1.3 Neonatal life support training

MATERNITY DASHBOARD DATA Post Mast Jan 24 Total Compliance	Obstetric Consultants	Obstetric Registrars (ST3-7)	Obstetric Trainees (ST1-2)	M/W (All bands)	NHSP M/W	MSW	Obs Anaes
Total Attendance PROMPT (Module 3 PROMPT)	100%	64%	17%	96%	100%	91%	95%
Module 6: NLS *SCBU staff and paediatric staff reported on separately	**100%**	**64%**	**17%**	**94%**	**86%**	**85%**	N/A

Fetal Monitoring training for July 24	Midwives (including NHSP)	**97% compliance**
	Obstetric career SHO / Registrars and Ob Cons	**82% compliance**

Table 11.1 PROMPT, NLS Training and Fetal monitoring training**.**

11.2 There is a plan in place to achieve compliance to 90% for all staff groups by 30th November with all outstanding staff being allocated onto training. The challenge with the Obstetric registrars and trainees is the rotation of new doctors in August 2024. The training passport is available, where training is carried over from other Trusts however, this has not been included in the September data.

12. Saving Babies Lives V3 (SBLV3)

12.1 10th September 2024, a fifth deep dive assessment by the LMNS was held as to review the TRFT's evidence of compliance for SBLV3 was undertaken (Appendix 4). The evidence reviewed was for quarter 1 of 2024/25 and each of the 6 elements were presented to the visiting panel as assurance of progress. To achieve Year 6 CNST standard 6, evidence of continual improvement towards meeting the 100% achievement of the whole of the 6 elements must be demonstrated. Table 12.1 demonstrates TRFT's progression since the beginning of the implementation time frame.

Trust: **The Rotherham NHS Foundation Trust**

ICB: **North East and Yorkshire**

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4
Review Quarter	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25
Assurance Review Date	25/09/23	19/12/23	26/03/24	27/06/24	10/09/24
Element 1	20%	90%	90%	90%	90%
Element 2	20%	65%	95%	100%	100%
Element 3	50%	100%	100%	100%	100%
Element 4	40%	80%	100%	100%	100%
Element 5	26%	67%	85%	93%	96%
Element 6	33%	67%	67%	67%	100%
TOTAL	26%	71%	89%	93%	97%

Table 12.1 TRFT progress for SBLV3

12.2 Remaining challenges for the outstanding actions include:

- Element 1 (Reducing smoking) Fully implementing the Very Brief Advice training to all women facing practitioners.
- Element 5 (Pre-term) Medical job plans still required funding and operationalising. Since the review in Q4, the funding has been identified and job plans are being updated.
- Element 5 (pre-term) Preterm birth rates remain above the target of 6%. QI work continues. Regionally this remains a challenge and pre-term interventions whilst showing improvements but need to remain consistent.

13. Avoidable Admission into the Neonatal Unit (ATAIN)

13.1 Following an increase in term admissions into the neonatal unit in Q1 and the beginning of Q2, the end of Q2 showed levels returning to below the national target of 6% in August and below the local target of 5% in September (Table 13.1). A theme of babies requiring increased respiratory support for transient tachypnoea of the newborn (TTN) persists and this has spurred a QI project that is registered on AMAT

as a deep dive into over 50 variables with each admission to explore reasons for this theme, with an aim of identifying change actions to reduce admissions for this reason. This QI project was presented and well received at the LMNS Perinatal Quality & Safety Forum in September and at the Safety Champion meetings locally.

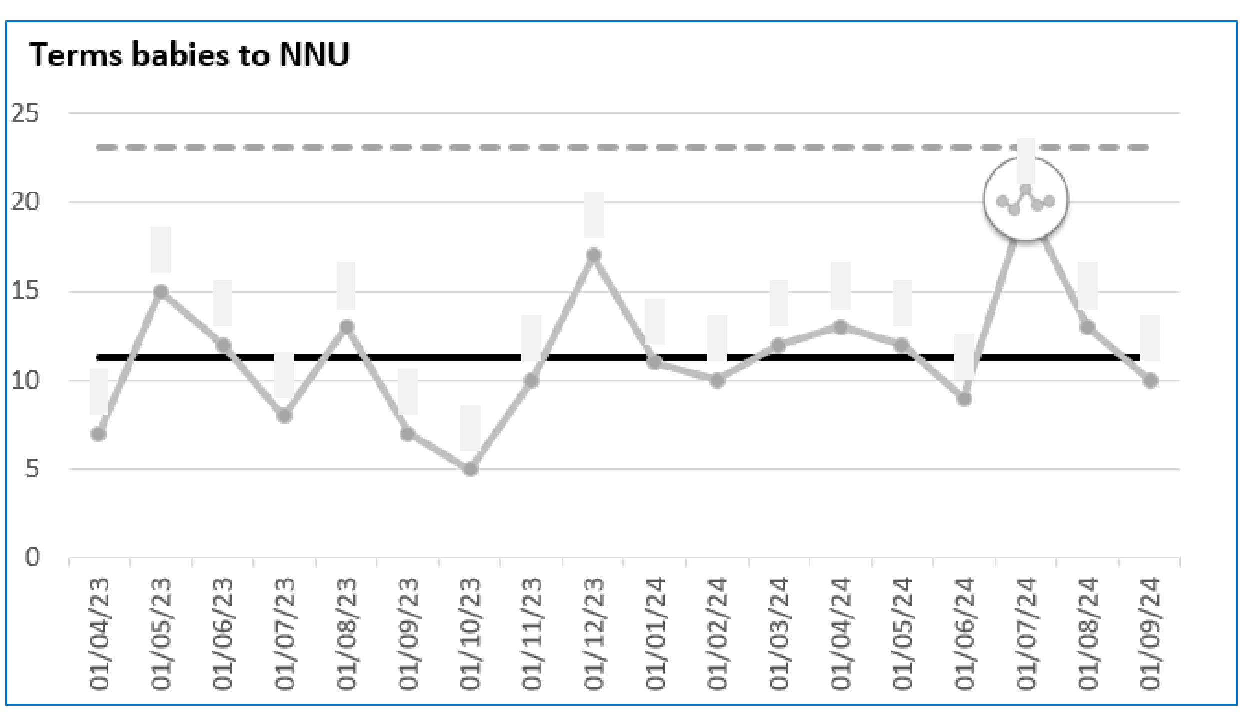


Table 13.1 Term admissions to the NNU

14. 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.	

15. Red Risks/Risk register highlights

There is currently 1 Obstetric risk graded over Moderate 12.

ID	Title	Risk level (current)	Review date	Approval status
7167	Transfer of patients from GreenOak's Outpatients	High 15	03/11/2024	Approved Risk

16. Recommendation

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.

Board of Directors' Meeting
8 November 2024

Agenda item	P179/24
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)	During the last year there have been a number of changes made in the way that we are assured of the quality of care being delivered at TRFT. This paper reports against assurance using the Quality Management System framework. • The Qi strategy has now been approved at Quality Committee and will be published following November Board • Progress has been made against the 3 Trust Quality Priorities • Governance structures continue to support the relevant committees and assurance is gained through the relevant reporting mechanisms • The CQC relationship officer provided good feedback in a recent site visit
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report was presented to Quality Committee on 30 October 2024 prior to being submitted to the Board of Directors.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and	The Board is asked to review the contents of the report.

when should it be completed?)	
Recommendations	It is recommended that the Board of Directors gain assurance of the monitoring systems and processes that are in place and the proposal for quarterly reporting.
Appendices	None

1.0 Introduction

1.1 The purpose of this paper is to provide assurance of clinical quality in TRFT. To achieve this, a Quality Management System (QMS) structure will be used, supported by a Quality Strategy. The QMS aims to enhance patient care, improve operational efficiency, and foster a culture of excellence and continuous improvement.

1.2 A QMS in the NHS refers to the structured system of processes, procedures, and responsibilities for achieving quality policies and objectives. It helps ensure that the NHS delivers high-quality healthcare services that meet patient needs and comply with regulatory requirements.

2.0 Policy and Planning

2.1 A Quality Strategy is in the early stages of development to drive quality governance, assurance and improvement. This will be developed with the Quality Committee over the next few months with a proposal to embed this from the start of 2024/25.

2.2 The Quality Improvement Strategy has now been approved and will available on the Trust website following approval at Board in November. The implementation and progress of this will be monitored through the relevant reporting committees.

2.3 There are two Quality of Care objectives included in the Trust Operational Priorities for 2024/25:

- Deliver care that is consistent with CQC 'Good' by the end of 2024/5
- Ensure improved performance of at least one quartile in the national inpatient and UECC patient experience surveys.

2.4 There are three Quality Priorities for 2024/5:

- Diabetes Management
- Acute Pain Management
- Frailty Assessments

2.5 Progress against the Operational and Quality Priorities is reported to Quality Committee through highlight reports on a quarterly basis. During Quarter 2 the baseline positions have been set, working groups identified, a reporting framework through the PowerBi system completed and key improvements/risks identified through the reporting tool. The required improvement to the national inpatient survey has been achieved and we await publication of the UECC results from CQC in Quarter 3.

2.6 Further work to strengthen the role of the Quality Committee in providing quality assurance to the Board of Directors is planned with a workshop being held in December 2024 to identify where improvements can be made.

3.0 Process Management

3.1 Processes are managed through two distinct but connected pathways – one within Care Groups and a Corporate structure.

3.2 All Committee meetings have taken place as planned with full quoracy.

4.0 Documentation

4.1 The current Trust position for compliance with documents, including policies, guideline and SOPs is 95.1%. There are no overdue documents of high risk.

4.2 There is a programme for assurance and audit of documentation standards which is supported through the Tendable and AMaT systems. There is a new process for Tendable which will see senior nursing colleagues complete peer inspections and specialist teams complete the specialist inspection for great oversight and assurance.

5.0 Training and Competence

5.1 Quarterly reports from all committees into Quality Committee include updated positions against nationally and locally mandated training compliance. Performance against training compliance is also addressed through the monthly performance meetings with executives.

5.2 In Q2, overall training compliance has achieved targets but there are some areas of lower compliance, particularly with medical staff. Resuscitation training however continues to be below the Trust target and unable to improve from 79% compliant. There has been work identified with the learning and development team to ensure that ESR is up to date and ongoing work continues for medical trainees who move across different organisations.

5.3 The need for additional training has to be balanced against responsible use of resources and an Education Governance Framework has been established to support this.

6.0 Monitoring and Measurement

6.1 In Quarters 1 and 2, 13 adult in-patient wards have undertaken accreditation with 5 achieving the bronze award. Work has been completed on developing key performance metrics for maternity and children's areas for accreditation in Q3. UECC will be included in the next phase of planning due to a large number of accessible national and local data/ metrics. Community will be planned to commence in 2026 due to them not currently being fully live on Tendable. During 2025 the Tendable inspections will commence in community providing a level of assurance, whilst allowing time to collect 12 months worth of information prior to accreditation.

7.0 Continuous Improvement

7.1 The Qi team have predominantly been supporting the Exemplar Accreditation programme and Trust quality priorities in Quarter 2.

7.2 The first cohort of ILSEY practitioners has completed training and this has evaluated well.

8.0 Risk Management

8.1 There is a monthly Risk Management Committee with attendance from all Care Groups and Executive Director leadership. As well as considering all risks rated 12 or greater, there is a focus on completion of action plans and regular updates in line with the risk management policy. This has significantly improved over the last year. With the majority of risks now have current SMART action plans.

9.0 Compliance

9.1 As an NHS Trust, we must meet the regulations set out by the Health and Social Care Act 2008 (regulated Activities) Regulations 14. Compliance is monitored by the CQC as part of their regulatory activities, to ensure that basic standards of care, based on the CQC fundamental standards, are met. The Quality Committee agenda is structured to ensure all of these elements are monitored and appropriate assurance is received.

9.2 The Trust currently have an overall ‘Requires Improvement’ rating from the CQC. It is noted that with recent changes to the CQC assessment framework and changes to their internal structure, they have been struggling to achieve their ambitions in terms of completing regular inspections so the organisation are not clear when we can expect to receive a future inspection. We will continue to aim to deliver care equivalent to a CQC rating of ‘Good’ or greater with assurance provided through the newly created self-assessment framework and by undertaking benchmarking activities with local organisations and high performing comparable Trusts.

9.3 Self-assessment work will not be restarted within the financial year. This is due to the fact that CQC have not yet been successful in starting the new assessment framework and this being under review. We will continue with consistent self-assessment and assurance against the CQC domains through the quality dashboards and Exemplar Accreditation programmes.

9.4 There have been no escalations in relation to the CQC through to Patient Safety Committee.

9.5 Compliance is reported externally to the Trust to the ICB and CQC. The ICB receive regular bi-monthly quality assurance updates through the Contract Quality Meeting attended by the Medical Director and Chief Nurse. This in turn is escalated to NHS England if required through the System Quality Group.

9.6 Outside of the inspection programme, CQC receive assurance through quarterly engagement meetings and through ad-hoc queries to which we provide a written response. In Q2 there have been two routine enquiries from CQC. These were closed down following receipt of the response from the Trust. The enquiries, related to a patient within a care facility and a staff member.

9.7 The Trust has now met with the new relationship officer who offered positive feedback on work that was demonstrated to him and the areas visited.

10.0 Conclusion

10.1 There remains good assurance across the QMS reporting framework.

10.2 The reporting committees continue to be quorate, the appropriate information is shared and escalations are then transferred to the Quality Committee.

10.3 The development of a Quality Strategy to underpin this will strengthen the Quality Assurance process.

Board of Directors
8th November 2024

Agenda item	P180/24
Report	**Learning From Deaths & Mortality: Quarterly Report 2024/25 Q1**
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. **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>**Mortality Indicators**</u> The latest **SHMI** Score (latest Month April 2024) is **104.0**. TRFT remain in the 'As Expected' Band. Trusts are placed in the 'As Expected' because any variation from the number of expected deaths is not statistically significant.
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 has established a robust Learning from Deaths process, based on national guidance and best practice. Its aim is to provide intelligence, to be used by the Trust to enhance care for future patients. The major component of the Learning from Deaths process is the case note review of selected deaths, using 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.

	The Trust completes SJRs for around 25% of Trust deaths. The majority are selected after recommendation by a Medical Examiner following a scrutiny, identified from Trust data or recommended by a Trust clinician. The Trust's SJRs are completed by a Team of 7 reviewers who are trained and have protected time to complete. This delivers good quality and timely SJRs. The ultimate objective is for the Trust to use this intelligence to drive improvement. This can be achieved by the sharing of good practice or devising changes to reduce or eliminate the occurrences of poor care. Intelligence from SJRs is disseminated to Trust Groups/Individuals, who have the expertise to devise and implement changes to care processes and procedures. Intelligence from SJRs, either comes from information from an individual review, or more beneficially from the Thematic Analysis of cohorts of SJRs. Thematic Analysis identifies repeated similar occurrences of poor or good care. Learning from Deaths is managed by the Learning from Deaths & Mortality Manager. It is co-ordinated by the Trust Mortality Group, chaired by the Deputy Medical Director. The program has oversight and assurance through the Trust's Patient Safety Committee and the Quality Committee.
Recommendations	It is recommended that the Board notes the progress/updates on the Learning from Deaths program and the latest SHMI values.
Appendices	1. Learning from Deaths, Thematic Analysis Report 2024/25 Q1 2. SHMI Report – Latest Month's Data April 2024 3. Medical Examiner Report 2024/25 Q2 4. Mortality Matters - Issue 23 - Long Waits in UECC and Mortality

John Taylor
Learning from Deaths & Mortality Manager
October 2024

Learning from Deaths Quarterly Report: 2024/25 Q1

	Due Date	SJR Data	SHMI Latest Month
This Report	-	2024/25 Q1	01/03/2024
Next Report	08/11/2024	2024/25 Q2	01/06/2024

*SJR data is grouped & reported by the date of death

SJR Requests

				Source of SJR Request		
Discharge Date	**Adult Inpatient & UECC Deaths**	**SJR Requested**	**SJR Requested %**	**Medical Examiner**	**Trust Data**	**Other**
2024/25 Q1	243	60	25%	34	20	6
2023/24	1070	220	21%	111	95	14

SJR Completion & Timeliness Figures - **% SJR Completed within 60 Days of Death**

Target 75%

Month of Discharge	Completed	Outstanding	% Completed	% Completed < 60 Days	Overall Care Score < 3	Preventability Score < 4
2024/25 Q1	39	21	65%	45%	3	0
2023/24	215	5	98%	57%	39	3

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

Preventability Score
6 - Definitely not preventable
5 - Slight evidence for preventability
4 - Possibly preventable, less than 50-50
3 - Possibly preventable, greater than 50-50
2 - Strong evidence for preventability
1 - Definitely preventable

At Year End	SJRs Completed	< 60 days after death
2022/23	45%	24%
2023/24	90%	57%

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.

This is dependent on timely recommendation by the Medical Examiner Service, timely distribution to the SJR Reviewers and timely completion by the reviewers themselves. Some SJRs such as those requested after a SHMI alert won’t be requested close to the time of death and be able to be completed within target.

Comments from all SJRs are themed and categorised in quarterly Thematic Analysis Reports

Update

Timeliness figures are monitored by the Trust Mortality Group.

For deaths in 2024/25 Q1, to date 63% of SJR have been completed. 45% have been completed within 60 days of death, which is significantly below the 75% target.

There are 33 breaches, which have either been completed >60 days after death, or are yet to be completed. For 20 of these breaches the Reviewers were given at least 28 days to complete.

Measure to improve timelines: SJR Reviewers are sent reminders of incomplete SJRs and the importance of timeliness, which will be achieved if they complete their 3 SJR allocations within the 4 week cycle.

At the time of report writing, the SJR team is reduced from 7 to 4. The vacant roles are being put out to advert in September 2024. To ensure essential SJRs are completed some Reviewers are completing additional SJRs.

Summary & Distribution 2024/25 Q1 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 who receive the report.

Category of Problem
Medication or Treatment
Escalation
Assessment/Opinion/Review
Tests/Results/Monitoring
Location of Care/Bed Availability/Inappr
End of Life/Palliative Care/DNACPR
Communication

Groups Distributed to
Deteriorating Patient Group
Medicine Safety Committee
Patient Safety Committee
Results Flagging & Notification
Safeguarding Operational Group
Clinical Governance - Medicine & its CSUs
Clinical Governance - Surgery & its CSUs
End of Life Group
Sepsis QI Group
Parenteral Nutrition & NG Feed T&F
Quality Governance & Assurance Group
Divisional Mortality Meeting - Medicine
Divisional Mortality Meeting - Surgery
Trust Mortality Group

Update:

The Thematic Analysis report for 2024/25 Q1 has been produced and distributed. The report should be read and themes relating to objectives of Trust meeting be put on the agenda and discussed.

A feedback questionnaire to determine how the intelligence from Thematic Analysis is being used in the Trust was sent out on 04/09/2024. Results will be reviewed and presented in the 2024/25 Q2 Learning from Deaths report.

Next Report:

The next Thematic Analysis Report will be completed in Dec 2024 for 2024/25 Q2 SJRs.

Learning from Deaths – Learning Disabilities, Autism & Serious Mental Illness

As recommended TRFT completes SJRs for Trust deaths for those with a Learning Disability, Autism or a Serious Mental illness.

These deaths are identified by the Medical Examiner during scrutiny, from Trust data or from a request by the Matron for Learning Disabilities and Autism. In addition some SJR requests for patients with a Learning Disability or Autism will come from an ICB LeDer Team.

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. SJRs are requested if the patient died within 14 of a TRFT discharge or longer, if appropriate.

Completed SJRs are distributed to the Matron for Learning Disabilities and Autism, the Head of Safeguarding, the Mental Capacity Act Lead Nurse and to the requesting ICB LeDer Team.

SJR Figures for Adults with a Learning Disability, Autism or Serious Mental Illness

Discharge Month	SJR Requested	SJR Completed	SJR Outstanding	Overall Care Score < 3	Preventability Score < 4
2024/25 Q1	8	7	1	1	0
2023/24	33	32	1	7	0

	Requested SJRs	Learning Disability or Autism	Serious Mental Illness
2023/24 Q1	8	**3**	5

Update

All 2024/25 Q1 deaths for those with an identified Learning Disability, Autism or a Serious Mental illness have has an SJR requested. 1 SJR is outstanding.

All completed SJR have been distributed to the Matron for Learning Disabilities and Autism, the Head of Safeguarding, the Mental Capacity Act Lead Nurse and to the requesting ICB LeDer Team.

Learning from Deaths: Incidents & the Patient Safety Incident Response Framework

All SJRs with an Overall Poor Care Score or judged to be more than likely preventable are entered as Incidents on Datix. As with other logged incidents, these are reviewed/investigated by the appropriate Care Group and clinical team/s.

Although infrequent it is mandated that deaths judged to have been more than likely preventable have a Patient Safety Incident Investigation.

Update

The 3 reportable SJRs for 2024/25 Q1 have been logged as incidents for review and possible investigation on Datix.

All resulting outcomes (Lessons Learnt & Actions) are being reported to the Trust Mortality Group.

Learning from Deaths in the Care Groups & Respective Clinical Support Units

Every four weeks completed SJRs are distributed to the Care Group Mortality leads. Typically 15 to CG1- Medicine, 5 to CG2 – Surgery and 1 to CG1 – UECC.

Each care group is asked to complete a 1-2 minute review of each SJR and determine which ones have learning points, both positive and negative. These SJRs should be disseminated to the relevant CSU for discussion at their Clinical Governance or separate Mortality meeting. All those with an Overall Poor Care Score or judged to be more than likely preventable should be disseminated and discussed.

The suggested format for CSU discussion is a brief presentation of the SJR, followed by a presentation of a local review. This may:

- support findings in the SJR
- refute findings in the SJR
- identify new issues

Each discussion should end in a documented summary with an action plan, if appropriate.

CSUs are invited to present reviews at their respective Care Group Mortality Meeting, held monthly in CG1 – Medicine and bi-monthly in CG2 – Surgery. Where appropriate the CG Mortality leads escalate issues and cases to the Trust Mortality Group, particularly when it has been determined that the problem and solution is system/trustwide.

Due to the small volume, all UECC deaths are discussed at the bi-monthly held CG1-UECC Mortality Meetings.

Update

The Learning from Deaths & Mortality Manager will be working with CG Mortality Leads to complete a review of CSU meeting minutes to determine the level of discussions about SJRs as well as the thematic reviews and whether or not actions are being created.

This is planned for October 2024 and be reported in the 2024/25 Q2 Learning from Deaths Report.

SHMI Alert Investigations

The SHMI has 2 methods which prompt Trusts to investigate potential areas of concerns. Alerts should not be immediately interpreted as indicating good or bad performance and should prompt the Trust to investigate further.

The first method uses upper and lower control limits banding system to indicate that the number of deaths is statistically significantly different from the number of expected deaths. This method is used for the Trust overall mortality numbers and completed for 10 Diagnosis Groups.

The second method is the production of Variable Life Adjusted Display (VLAD) charts for 10 Diagnosis Groups to demonstrate the difference between observed and expected mortality over a period of time in. The VLAD is sometimes called the expected-observed cumulative sum. The VLAD will highlight runs of more deaths than expected over shorter time period than the 1st method.

Last Alerts & Investigations:

SHMI Alerts are presented and discussed at the Trust Mortality Group meeting. Responses are decided and requested at these group meetings.

Fluid & Electrolytes –

The diagnoses in this group are generally signs and symptoms, rather than a specific diagnosis and so the recording of diagnoses is reviewed.

Response

A report was viewed at the July 2024 TMG, including trend data and completed SJRs. At this meeting a coding review was requested. This was presented at the Sept 2024 TMG. The coding report looked at 6 deaths and determined that there were 3 coding errors. The coding manager will work with the team to reduce these errors.

Acute Myocardial Infarction VLAD Alert –

This alert was triggered by a higher than usual amount of deaths in March 2024. There were 7 deaths. The trust usually has between 1 and 4 each month

Response:

A report was viewed at the Sept 2024 TMG. The 7 deaths have been send to the Cardiology CSU for review. In addition 4 of the 7 deaths will have SJRs requested.

Fractured Neck of Femur -

Response:

A report was viewed at the May 2024 TMG, including trend data and completed SJRs. A coding review was also presented. 10 cases were reviewed. There were errors in 2, which have been fed back to the coders. However had these cases been coded correctly they would have still be allocated to the #NOF diagnosis group.

TRFT are no longer alerting for this group.

Coding Changes Affecting the SHMI:

It's now mandatory for Same Day Emergency Care activity to be submitted in the Emergency Care Data Set (ECDS), rather than the Inpatient Commissioning Data set (IPCDS). At TRFT, August 2024 is the first month that will include this change.

The SHMI only uses data from the IPCDS and therefore the SHMI may be effected. The SHMI showed a small increase for early pilot NHS Trusts. However once most Trusts have made the change, the expected values will reflect this, and adjust accordingly.

August 2024, will be included in the January 2025 SHMI release and will be reviewed to determine any effect. Data is isn't being retrospectively changed, therefore the change will be gradual, 1 month at a time.

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30/08/2024

Learning From Deaths
Thematic Analysis SJRs 2024/25 Q1

Content

This report contains the Thematic Analysis of Structured Judgement Reviews (SJRs) completed for deaths in 2024/25 Q1. 38 were completed at the time of this report.

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 2024/25 Q1: Comments Detailing Poor Care

Delay/Omission/Choice - Medication or Treatment Page 3
Delay/Omission - Escalation Page 3
Delay/Omission - Assessment/Opinion/Review Page 4
Delay/Omission/Interpretation - Tests/Results/Monitoring Page 4
End of Life/Palliative Care/DNACPR Page 5
Location of Care/Bed Availability/Inappropriate Moves Page 6
Communication Page 6

Thematic Analysis 2024/25 Q1: Comments Detailing Good Care

Delay/Omission/Choice - Medication or Treatment Page 7
Delay/Omission - Escalation Page 7
Delay/Omission - Assessment/Opinion/Review Page 7
Delay/Omission/Interpretation - Tests/Results/Monitoring -
End of Life/Palliative Care/DNACPR Page 8
Location of Care/Bed Availability/Inappropriate Moves -
Communication Page 8

Data Tables

Overall Care Scores Page 9
Preventability Page 9
Concern Area Page 9
Problems in Care Page 10

Thematic Analysis 2024/25 Q1: Comments Detailing Poor Care

Delay/Omission/Choice - Medication or Treatment

she was discharged without full resolution of the infection and sepsis , which lead to readmission within 24 hours .

long wait in ED for bed over 12 hours with NOF - did get treatment but did not get regular medications for cardiac history as in UECC and needed to be ordered usually this would be from the ward .

Patient also ended up overdosing on opiate which was reversed satisfactorily however could have been avoided.

Delay/Omission - Escalation

Patient waited almost 6 hrs for bed on HDU

Critical care review at the point of worst deterioration was delayed due to activity and delay in transferring possibly due to shortage of CC beds however it is not evident if this was escalated within critical care department.

Delay/Omission - Assessment/Opinion/Review

Critical care review at the point of worst deterioration was delayed due to activity and delay in transferring possibly due to shortage of CC beds however it is not evident if this was escalated within critical care department.

Importance of early dietetic input and consideration of NG tube feeding/supplementation.

It has been documented patient was confused however no formal assessment eg: delirium/dementia screen seen.

lack of regular check of pressure areas and documentation to avoid pressure sore

It was apparent that they would need a community Package of Care from first day but this was not sort until Medically Fit for Discharge Date which caused delay and in this delay developed HAP, this is the current system in place .

Delay/Omission/Interpretation - Tests/Results/Monitoring

There was also a long gap between his last set of obs and his deterioration and no escalation to the medical team as a result when he presumably was deteriorating overnight with a delay in escalation.

Other areas could of been better he had a high pulse rate 122 at 09:35 but no further observations until 15:58

Her poor urine output should have been identified and acted upon sooner as it went unrecognised for 24 hours and in addition she did not have observations during this time. Earlier identification of this deterioration would have enabled earlier commencement of fluids and antibiotics,

Care would have been improved by regular urinary monitoring in the first week post surgery, giving a better fluid balanced when he became over loaded.

End of Life/Palliative Care/DNACPR

however no documented discussion with patient/NOK or ResPECT form in place but this may have been due to not being able to get through to family and non-English speaking patient.

There was some miscommunication within teams (nursing & medical) re: EoL care and commencement of LDL due to documentation not being contemporaneous perhaps.

It is evident that this patient was nearing the end of his life; but there does not seem to have been acknowledgement of this; nor does this seem to be addressed in the community, despite 3 visits from the GP.
His hospital admission/ visit to A&E could have been avoided altogether and he could have been made comfortable in his final days at the care home.

5 hour delay to confirm death

The poor care rating comes directly from the revoking of the End of Life care order that was appropriately placed in the emergency department. This lead to inappropriate investigations and treatment for the patient as well as confusion for the family causing them distress and anxiety.

This elderly frail man had metastatic cancer and likely died from pneumonia and metastatic cancer. I can't help but feel that it would have been more appropriate for him to have been kept at home and received palliative care with family present. He really should have had some advanced care planning in place.

Location of Care/Bed Availability/Inappropriate Moves

It is evident that this patient was nearing the end of his life; but there does not seem to have been acknowledgement of this; nor does this seem to be addressed in the community, despite 3 visits from the GP.
His hospital admission/ visit to A&E could have been avoided altogether and he could have been made comfortable in his final days at the care home.

This elderly frail man had metastatic cancer and likely died from pneumonia and metastatic cancer. I can't help but feel that it would have been more appropriate for him to have been kept at home and received palliative care with family present. He really should have had some advanced care planning in place.

Patient waited almost 6 hrs for bed on HDU

long wait in ED for bed over 12 hours with NOF - did get treatment but did not get regular medications for cardiac history as in UECC and needed to be ordered usually this would be from the ward .

I have some concerns about an acute MI with a significant troponin rise being streamed to AMU and that a CCU bed or telemetry bed was not found as per the senior medical opinion.

Communication

however no documented discussion with patient/NOK or ResPECT form in place but this may have been due to not being able to get through to family and non-English speaking patient.

There was some miscommunication within teams(nursing & medical) re: EoL care and commencement of LDL due to documentation not being contemporaneous perhaps.

Documentation could have been better.

The past medical history appears to have been drip fed to the team and if known at the start may of changed the procedure undertaken

Thematic Analysis 2024/25 Q1: Comments Detailing Good Care

Delay/Omission/Choice - Medication or Treatment

admitted to HDU excellent care

Care overall excellent, as was communication with the family.

there are some excellent examples of quality of care such as the St 6 from palliative care input into this lady and the care received by ward staff on A3

Excellent documentation and decision making for interventions: ascitic and pleural taps, including consideration to patient's wishes.

Delay/Omission - Escalation

Timely action for Sepsis 6

Delay/Omission - Assessment/Opinion/Review

Involvement from LD team was good.

Respiratory doctor offering support to critical care for chest drain insertion and specialist opinion at a weekend when covering general medical admissions. Excellent team work.

End of Life/Palliative Care/DNACPR

Excellent communication, involvement from palliative care team and well managed end of life care.

Excellent acknowledgement and documentation from A&E doctors about the fact that this gentleman is approaching his end of life and exploring his wishes by communicating with family and acting in his best interests.

Excellent with daily reviews from palliative care team

Excellent consideration given to patient's best interest and the social circumstances to decide on treatment measures. Excellent effort at trying to facilitate EOL care at

Communication

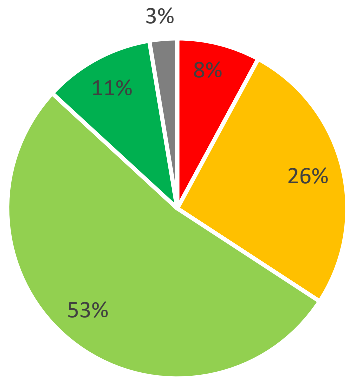
Care overall excellent, as was communication with the family.

Some aspects excellent such as documentation of communication with him

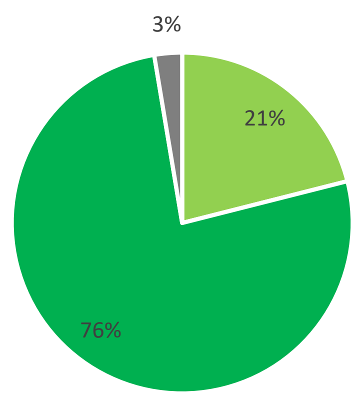
He had good involvement of the therapy teams and excellent communication between the consultant in charge of his care the patient and the family regarding deteriorations and changes in his condition.

Data Tables

Overall Care Score	SJRs
1 - Very Poor	0
2 - Poor	3
3 - Adequate	10
4 - Good	20
5 - Excellent	4
Not Recorded	1
Total	38



Preventability	SJRs
1 - Definitely preventable	0
2 - Strong evidence	0
3 - Possibly (more than 50:50)	0
4 - Possibly (less than 50:50)	0
5 - Slight evidence	8
6 - Definitely not preventable	29
Not Recorded	1
Total	38



Comment Relates to	Negative Comments	Positive Comments
Delay/Omission/Choice - Medication or Treatment	3	4
Delay/Omission - Escalation	2	1
Delay/Omission - Assessment/Opinion/Review	5	2
Delay/Omission/Interpretation - Tests/Results/Monitoring	4	0
End of Life/Palliative Care/DNACPR	6	4
Location of Care/Bed Availability/Inappropriate Moves	5	0
Communication	4	3
Total	29	14

Type	Problems
Problems leading to readmission	4
Problems in assessment	2
Problem with medication	3
Problem with nutrition	2
Problem with infection control	1
Problem related to operation	0
Problem in clinical monitoring	4
Problem in treatment plan	3
Problem in resuscitation	1
Problem in IV fluids	2
Problems in communication	5
Problems in relatives communication	5
Problems in team communication	3
Problem of any other type	3
Total	38

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Latest Publication Date: 12/09/2024
Latest Data Month: Apr-24

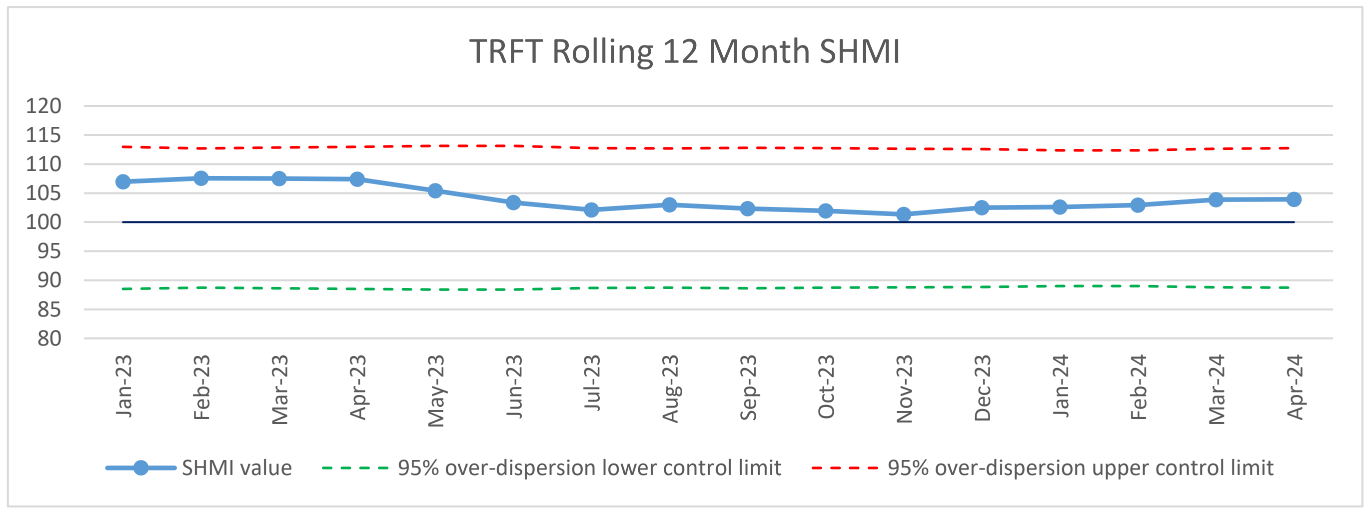
TRFT SHMI Report

Summary

TRFTs latest Rolling 12 Month SHMI Value is 104.0. TRFT remain in the Band 2 'As Expected' band. The previous value was 103.9.

TRFT has 1 Diagnosis Group in the Higher than Expected Band.

- Fluid & Electrolytes

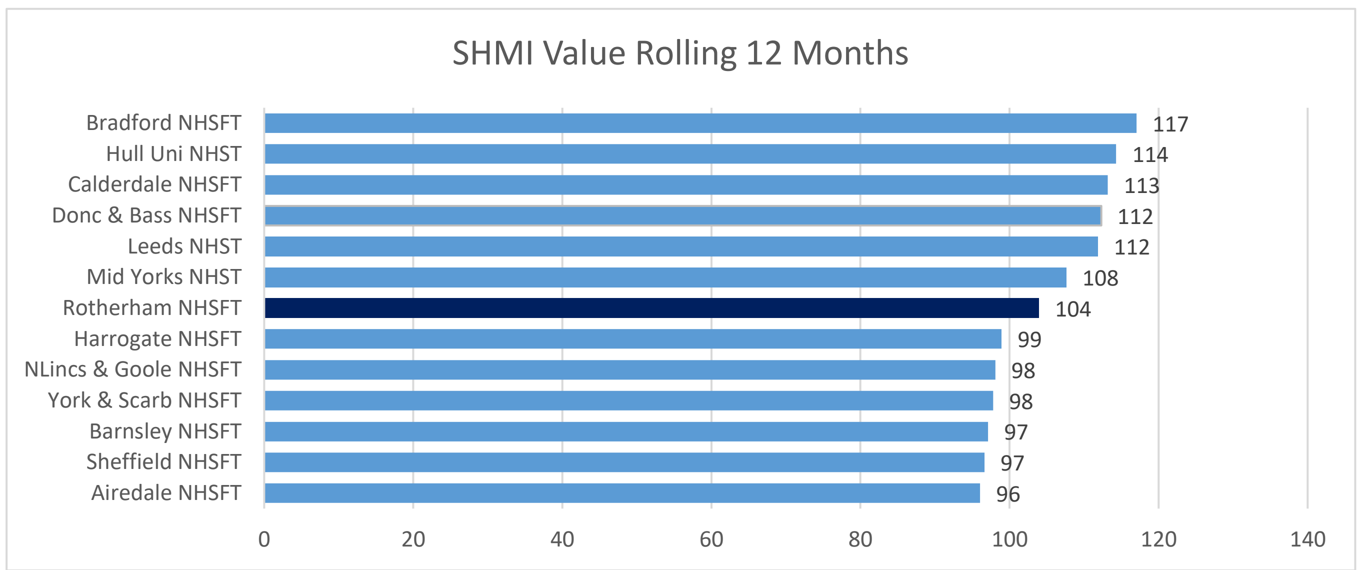


TRFT Latest SHMI Value

End Month	SHMI value	SHMI banding	Number of spells*	Observed deaths	Expected deaths
Apr-24	104.0	2	51250	1510	1455

* Excluded Day Cases and Regular Attendances

Region Comparator - Yorkshire & Humber Non Specialist Trusts



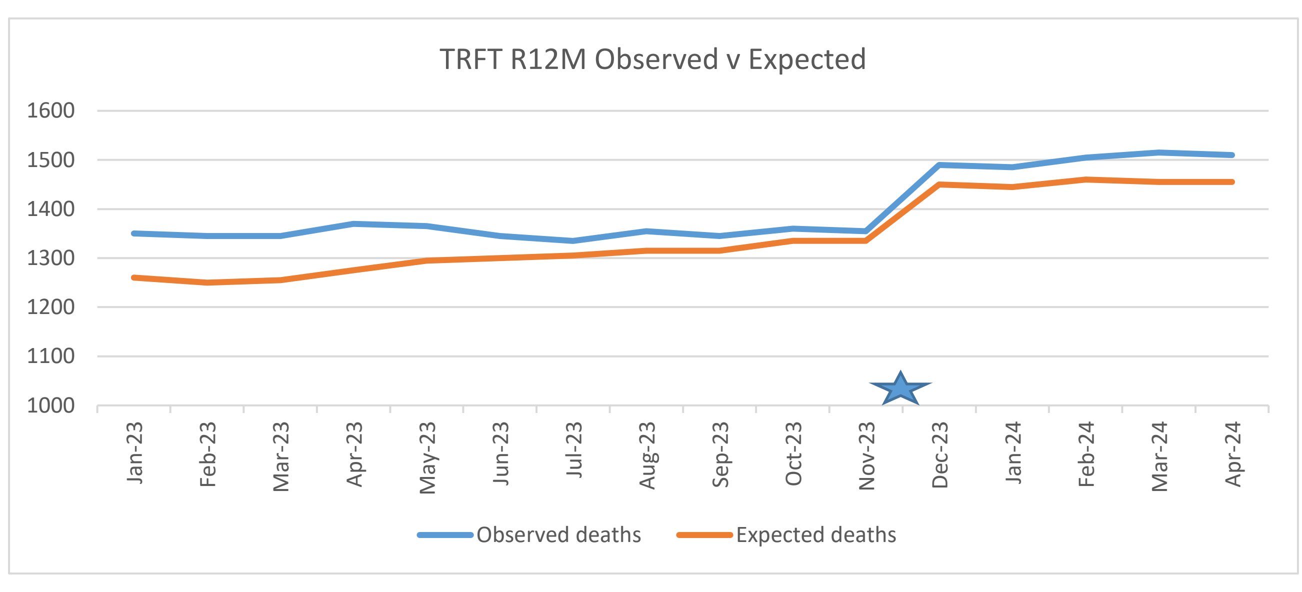
SHMI Diagnostic Group Breakdown

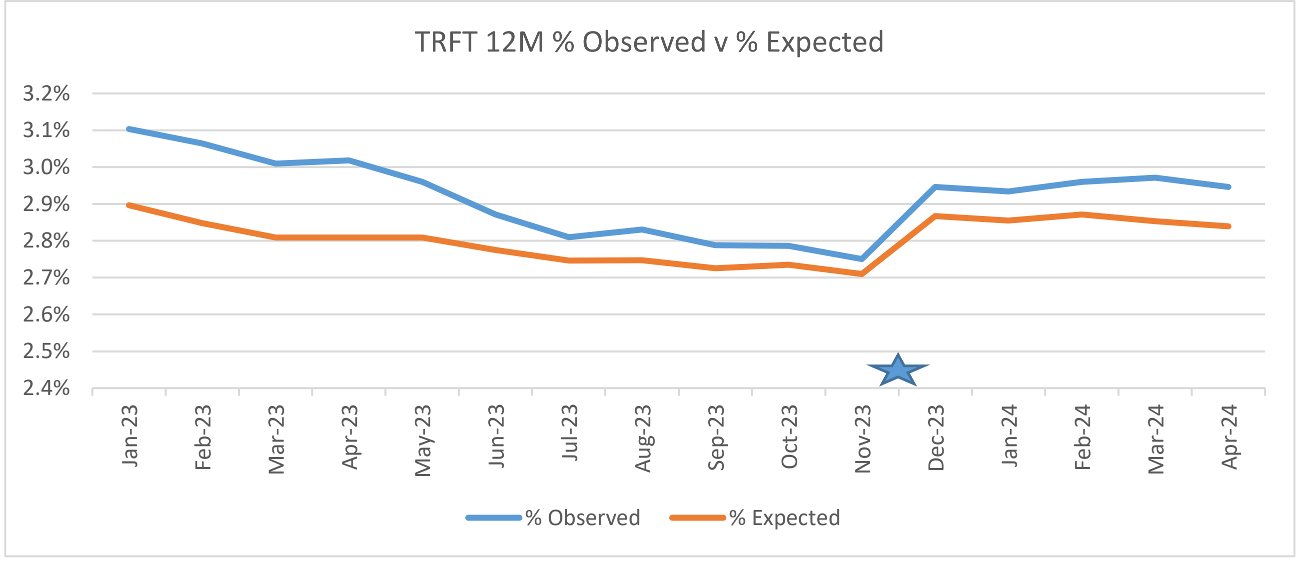
Diagnosis Group	Number of spells	Observed deaths	Expected deaths	SHMI Value	SHMI banding
Fluid and electrolyte disorders	385	35	25	160.02	1
Acute myocardial infarction	410	35	30	122.87	2
Acute bronchitis	1285	30	25	119.92	2
Fracture of neck of femur (hip)	340	30	25	117.2	2
Septicaemia (except in labour), Shock	585	145	125	116.49	2
Pneumonia (excluding TB/STD)	1695	235	225	104.61	2
Secondary malignancies	125	25	25	99.68	2
Cancer of bronchus; lung	55	20	20	96.97	2
Gastrointestinal hemorrhage	415	15	20	88.86	2
Urinary tract infections	970	30	35	86.06	2

Coding Data

TRFT Rank of 13	3rd Highest	4th Highest	2nd Highest	7th 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**
Harrogate NHSFT	27.4	13.5	4.2	1.4	30
NLincs & Goole NHSFT	20.4	3.6	4.7	1.2	25
Rotherham NHSFT	16.8	2.8	6.8	1.9	48
Barnsley NHSFT	14.2	0.0	7.6	2.5	42
Airedale NHSFT	14.0	0.0	4.7	1.2	26
York & Scarb NHSFT	13.4	0.0	6.0	1.2	27
Bradford NHSFT	12.5	3.3	3.7	1.1	35
Donc & Bass NHSFT	11.7	0.1	4.8	2.2	51
Sheffield NHSFT	9.6	0.0	5.0	1.8	37
Mid Yorks NHST	9.0	0.5	6.8	2.0	38
Hull Uni NHST	7.8	*	6.0	2.1	35
Calderdale NHSFT	7.7	0.0	6.6	2.6	44
Leeds NHST	5.7	0.0	6.3	2.1	34
England	13.6	1.5	5.9	2.1	43

Comparison of the SHMI Observed and Expected Deaths





SHMI Methodology Change Dec 2023
(May 2024 release):

Covid Activity was included in the SHMI after being excluded. This increased spell, expected and observed death numbers.

Medical Examiner Service (MES) – Q2 (2014-5)

The new legislation began on 9th September and the MES is now scrutinsing all Acute & Community non coronial deaths

- This quarter the MES has commenced the full statutory system with the full community rollout of the ME system. This has been challenging for a few reasons:
- Not fully established staffing- from the ME and MEO aspect
- GP practices who did not engage with the trial have struggled with the process but after 3 weeks this seems to be settling
- There seems to be minimal delay in registering deaths with the new process
- Families are appreciative of the additional step of being contacted by The ME office
- We have now had all the new ME's start-which will help the new process
- New MEOs recruitment should be finalised by the end of October.

Feedback from families has been positive and in view of lack of communication from the wards the families they have been extremely grateful that the ME and the MEO have been available to discuss their cases. Many complaints have been avoided by the ME answering medical queries in a timely manner so that the anxiety does not escalate and cause hospital complaints.

The service has a dedicated mobile phone number available through switchboard for any urgent out of hours questions by the medical teams. This has avoided many unnecessary coronial referrals due to discussing the most appropriate cause of death.

The coroner and her team have been complimentary about the appropriateness of the referral and the number of unnecessary referrals has been reduced. Also, the medical advice given to the coroner's officers, in some cases avoiding inquest, the ME has been sighted as being very welcome.

We have not noticed any significant issues currently - the only issue we have identified is that there has been a couple of incidents with delay in reporting of radiology

Acute deaths

During Q2 there were 212 deaths.

96% of the deaths were scruntised within 5 days or less

29% of deaths were referred to Coroner

95% of MCCDs were completed within 5 days and sent the Register office on the same day received

Community Deaths

During Q2 there were 196 deaths.

95% MCCDs were completed within 5 days or less and 100% of the deaths were scrutinised and sent the Register office the same day received.

SABAR, Jessie (THE ROTHERHAM NHS FOUNDATION TRUST)

From: COMMUNICATIONS (THE ROTHERHAM NHS FOUNDATION TRUST)
Sent: 18 October 2024 13:07
Subject: Mortality Matters - Issue 23 - Long Waits in the UECC and Mortality

Issue 23 – Long Waits in the UECC and Mortality

October 2024

Lord Darzi was asked to undertake a rapid investigation of the state of the NHS, assessing patient access, quality of care and the overall performance of the health system. He published his report in September 2024.

His report informed that in 2010, 94% of people attending an A&E department were seen within 4 hours; by May 2024 this figure had dropped to 60%, with 10% waiting more than 12 hours.

It is well established that long waits in A&E are associated with patient harm and excess deaths.

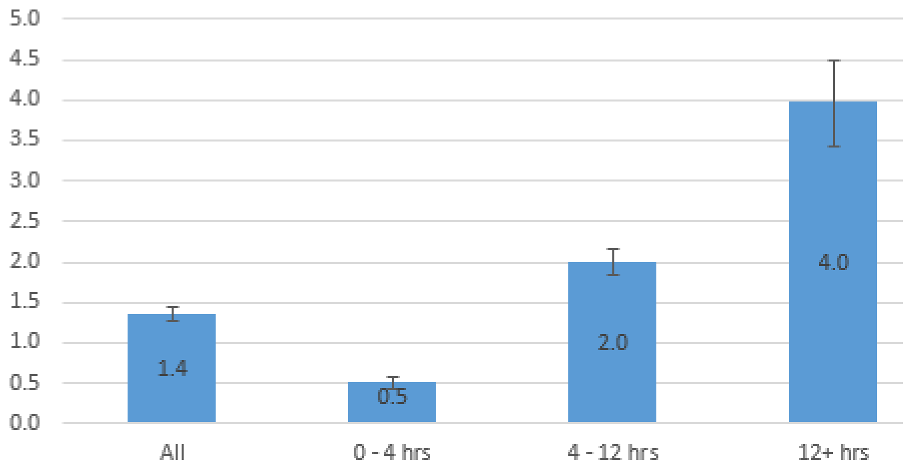
In his report Lord Darzi refers to the Royal College of Medicine study, which estimated that long waits caused an additional 14,000 more deaths in the NHS during 2023. It was estimated there was one additional (excess) death for every 72 patients that spend 8-12 hours in A&E.

Although the RCEM study doesn't identify individual deaths, as will all studies based on national NHS Data, TRFT data represents a small proportion of this.

Does TRFT Data Support a link between Long Waits and Excess Deaths?

As expected from the RCEM study, analysis of TRFT's data for adult UECC attendances for 2023/24 suggested a link between longer UECC waits at TRFT and mortality.

This chart shows that that people who waited longer in UECC had a higher likelihood of death during their UECC stay or subsequent inpatient admission. The percentage increases for each wait category. The differences are statistically significant (95% Confidence Intervals).



This chart only considers people who were admitted after a UECC attendance and therefore reduces the effect of those with minor injuries. The percentage risk of death increases for each wait category. The differences are statistically significant for waits above 4 hours (95% Confidence Intervals).

% of Admitted Patients who Died during the Inpatient Admission
Grouped by the UECC Length of Stay

Summary

As was expected from the national data, analysis of TRFT's UECC attendance data indicates a link between increased UECC waits and mortality. The data doesn't suggest which deaths may have been avoidable or identify deaths where the wait in UECC was a contributing factor.

In addition to UECC patients waiting for inpatient beds, there are many other influencing factors such as the co-morbidities of the patient and the complexity of treatment. For some deaths where it has been recognised that the patient is in the last hours of life, it may be preferable for the patient and family to be continued to be cared for in UECC rather than have an additional move.

This data does highlight the importance of work going on at TRFT and throughout the NHS to reduce long waits in A&E Departments.

The Trust is working towards achieving the objective of 78% for the 4 hour wait target, set in the 2024/45 Priorities & Operational Planning Guidance. There is also ongoing work to improvement patient flow, both from UECC to inpatient wards and discharging patients back into the community either directly from UECC or from the wards.

The 4 hour target of 78% represents a challenge. Recent measures to help reach this include:

- 8 new clinical fellows and a new medical rota since August 2024 increasing doctor capacity in UECC at peak times.
- Work continues to develop SDEC –3 Quality Improvement events taking place early September to improve pathways and to support productivity through the area
- Digital dashboards in place to have increased visibility of patients in the department and to ensure patients identified early into the department
- CHAT (community hospital admission avoidance team) to move to B6 which aims to reduce patient waiting times from 1st Oct
- Focus sessions on Radiology through the month of September improve patient flow

All issues of Mortality Matters are available on the Hub

Board of Directors
8th November 2024

Agenda item	P181/24
Report	NHSE 2024 Trust Provider Self-Assessment
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	
Purpose	Decision ☐ To note ☐ Approval ☒ For information ☐
Executive Summary (including reason for the report, background, key issues and risks)	The annual NHSE 2024 Trust Provider Self-Assessment was due for submission at the start of October, however we were granted an extension due to dates of our Board. The final submission is via an online portal however a PDF version has been provided to allow for Board sign off. The attached NHSE 2024 Trust Provider Self-Assessment has been collated by Medical Education with support from other areas. However, we did not receive information for all learner groups within the timeframe. The Trust have regular Monitoring the Learning Environment meetings with HEE, so there no unexpected answers within the report. The report was presented to ETM on the 24th October 2024. A few changes were requested which have been made.
Recommendations	It is recommended that Board approve the completed self assessment for before it is submitted to NHSE via the online portal.
Appendices	NHSE 2024 Trust Provider Self-Assessment (PDF version)

Debbie Harrison
Medical Education Manager
October 2024

NHS England Self-Assessment for Placement Providers 2024

1. Introduction

The NHS England Self-Assessment (SA) for Placement Providers is a process by which providers carry out their own quality evaluation against a set of standards. Providers are asked to complete this online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most questions to provide comments to support your answer.

Completing the Self-Assessment

- **Your region and trust name has been pre-populated - do not amend this**.
- The SA saves your progress at the end of each page - **click save** and next page button.
- **You can amend/change your responses any time prior to completing the final submission** box in section 12 (click save after any changes).
- Anyone completing any part of the SA can do so using the same link supplied by your regional NHS England WT&E quality team. **Only one person should use the link at any one time**. You must close the weblink for someone else to access the survey to avoid overwriting previous entries.
- **To print the SA**, prior to/after submission, skip through to the last page and use the print button. Only questions with responses will print.
- You can move around the SA without being forced to complete questions/sections before moving to another section. **Save each update even if only partially completed**.
- **All sections are mandatory**, please undertake a final check that every question has been completed prior to submission. If a question/section has not been answered after submission, the SA will be returned to you for completion.
- Where free text comments are available the word or character limits are shown within each question.
- The SA does not support the upload of attachments. If we require any evidence as part of your submission, we will contact you separately after submission.

****This submission should be completed for the whole organisation. It's important that those responsible for each section feed into and contribute to the response.****

Sections of the Self-Assessment

Section 1: Provide details of (up to) 3 challenges within education and training that you would like to share with us.

Section 2: Provide details of (up to) 3 achievements or good practice within education and training that you would like to share with us.

Section 3: Confirm your compliance with the obligations and key performance indicators of the NHS Education Funding Agreement (EFA). This should be completed once on behalf of the whole organisation.

Section 4: Confirm your compliance with the Quality, Library, Reporting Concerns, and Patient Safety training obligations and key performance indicators of the NHS Education Funding Agreement (EFA). This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas feed into this section.

Section 5: Confirm your policies and processes in relation to Equality, Diversity and Inclusion. Should normally be completed by your placement provider EDI Lead.

Section 6 - 11: Self-assess your compliance against the Education Quality Framework and Standards. Each section must be completed once on behalf of the whole organisation. There are opportunities to share good practice examples. You are asked to confirm whether you meet the standard for all professions / learner groups or provide further details where you do not meet or partially meet the standard(s). Where you are reporting exceptions, you are asked to provide the professions impacted and a summary of the challenges you face in meeting the standard.

Section 12: Final sign-off.

Further Questions

If you have any queries regarding the completion of the SA, please review the FAQ document. If you still require further information, you can contact your regional NHS England WT&E quality team.

2 – 9 Region and Provider Selection – Do Not Amend

Please do not amend the region you have been allocated to. If you feel this is incorrect please continue to complete the SA and email your regional NHS England WT&E quality team.

- [ ] East of England
- [ ] London
- [ ] Midlands
- [ ] North East and Yorkshire
- [ ] North West
- [ ] South East
- [ ] South West

10. Training profession selection

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

2. Please select from the list below those professional groups your organisation currently train, please select all those which apply. Please select only one option for each row.

	Yes we train in this professional group	N/A we do NOT train in this professional group
Advanced Practice	x	
Allied Health Professionals	x	
Dental	x	
Dental Undergraduate		x
Healthcare Science		x
Medical Associate Professions	x	

	Yes we train in this professional group	N/A we do NOT train in this professional group
Medicine Postgraduate	x	
Medicine Undergraduate	x	
Midwifery	x	
Nursing	x	
Paramedicine		x
Pharmacy	x	
Psychological Professions		x
Social Workers		x

11. Section 1 - Provider challenges

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to provide details of (up to) 3 challenges within education and training that you would like to share with us. Please consider whether there are any challenges which impact your ability to meet the education quality framework standards. Please select the category which best describes the challenge you are facing, along with a brief description/narrative of the challenge (*the character limit is set at 1000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

3. Example 1: Please choose the most appropriate category for your challenge.

- [ ] Apprenticeships
- [ ] Burnout / Wellbeing
- [ ] COVID / Post COVID return to norms
- [ ] Culture
- [ ] Curricula / Training Standards
- [ ] Educational Governance & Strategy
- [ ] Funding - Requirements / Unpredictability / Timeliness
- [ ] HEI Issues/ Processes
- [ ] Increase in LTFT / Reasonable Adjustment Requests
- [ ] IT Systems
- [ ] NHS England Issues/ Processes
- [ ] Other
- [ ] Placement Management / Capacity
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (recruitment / retention)
- [ ] Supervisors / Educators (training)
- [ ] Training affected by service pressures (cannot release staff)
- [ ] Training Equipment / Systems
- [x] Training Space / Facilities
- [ ] Trust Merger or Reconfiguration
- [ ] Workforce Challenges (recruitment / retention)

Please provide your narrative in the comments box

The Trust faces ongoing demand for education spaces, particularly as learner groups grow, leading to competition for larger rooms. For example, there is only one training room available that can accommodate all the current medical students, necessitating multiple sessions to accommodate everyone.

Additionally, staff areas supporting these students have become overcrowded, limiting access to quiet spaces for breaks and confidential discussions.

The facilities also lack dedicated resource areas within departments, hindering their overall learning experience. Creative solutions are needed to address these challenges.

4. Example 2: Please choose the most appropriate category for your challenge.

- [ ] Apprenticeships
- [ ] Burnout / Wellbeing
- [ ] COVID / Post COVID return to norms
- [ ] Culture
- [ ] Curricula / Training Standards
- [ ] Educational Governance & Strategy
- [ ] Funding - Requirements / Unpredictability / Timeliness
- [ ] HEI Issues/ Processes
- [ ] Increase in LTFT / Reasonable Adjustment Requests
- [ ] IT Systems
- [ ] NHS England Issues/ Processes
- [ ] Other
- [x] Placement Management / Capacity
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (recruitment / retention)
- [ ] Supervisors / Educators (training)
- [ ] Training affected by service pressures (cannot release staff)
- [ ] Training Equipment / Systems
- [ ] Training Space / Facilities

- [ ] Trust Merger or Reconfiguration
- [ ] Workforce Challenges (recruitment / retention)

Please provide your narrative in the comments box

The number of learners has increased across the professional groups. This places pressure on facilities, departments and supervisors.

The Physiotherapy and Occupational Therapy teams are facing significant challenges due to an increased demand for student placements without a corresponding rise in staff numbers. The influx of undergraduate and degree apprentice students has led to back-to-back placements with overlapping schedules, leaving little time for respite. Compounding this issue, the requirement for the Speech and Language Therapy (SLT) degree apprentices to be arranged by service leads places additional pressure on an already strained staff base, particularly as many staff are part-time. The turnover of experienced staff post-COVID has resulted in a reliance on more junior personnel, further limiting placement capacity.

While the increase in student numbers is intended to support future workforce expansion, it creates bottlenecks in community placements, strains staffing ratios, and hampers the ability to provide quality feedback on students' proficiencies. A more structured placement capacity throughout the year could help alleviate these pressures.

5. Example 3: Please choose the most appropriate category for your challenge.

- [ ] Apprenticeships
- [x] Burnout / Wellbeing
- [ ] COVID / Post COVID return to norms
- [ ] Culture
- [ ] Curricula / Training Standards
- [ ] Educational Governance & Strategy
- [ ] Funding - Requirements / Unpredictability / Timeliness
- [ ] HEI Issues/ Processes
- [ ] Increase in LTFT / Reasonable Adjustment Requests
- [ ] IT Systems
- [ ] NHS England Issues/ Processes

- [ ] Other
- [ ] Placement Management / Capacity
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (recruitment / retention)
- [ ] Supervisors / Educators (training)
- [ ] Training affected by service pressures (cannot release staff)
- [ ] Training Equipment / Systems
- [ ] Training Space / Facilities
- [ ] Trust Merger or Reconfiguration
- [ ] Workforce Challenges (recruitment / retention)

Please provide your narrative in the comments box

There has been a significant increase in the number of learners (students and trainees) that require learning support plans, working/studying less than full time or requiring adjustments to their rotas.

Staff are often extremely busy, providing learning can often be an additional pressure of their busy role.

12. Section 2 - Provider achievements and good practice

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to provide details of (up to) 3 achievements within education and training that you would like to share with us. Please select the category which best describes the achievement you wish to share, along with a brief description/narrative (*the word limit is set at 1000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

6. Example 1: Please choose the most appropriate category for your achievement.

- [ ] Collaboration / Partnerships
- [ ] Covid - Response / Catch up
- [ ] CPD
- [ ] Culture
- [ ] Development of TEL Provision
- [ ] Improved Facilities
- [ ] Increased SIM for Training
- [x] Innovative Training / Course Development
- [ ] Learner / Trainee Support or Wellbeing
- [ ] Multi-professional Initiatives
- [ ] New/Improved Strategy or Governance
- [ ] Other
- [ ] Placement Capacity / Expansion
- [ ] Quality - Improvement Initiatives, response to data, positive feedback
- [ ] Recruitment / Retention Initiatives
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (training)

Please provide your narrative in the comments box

All Junior and Senior Clinical Fellows as well as trainee ACPs and trained ACPs are provided with a PeP (Practitioner's ePortfolio) account when they join the Trust.

This is particularly supportive for the trainee ACPs as a number of national curriculums are on the system to help provide a framework for evidence collection.

We now have x2 Degree Operating Department Practitioner Apprenticeships in Theatres. This has been great for morale in our department as it is career progression for our HCSW's and is a course we had never done before up until the last 18 months or so.

7. Example 2: Please choose the most appropriate category for your achievement.

- [ ] Collaboration / Partnerships
- [ ] Covid - Response / Catch up
- [ ] CPD
- [ ] Culture
- [ ] Development of TEL Provision
- [ ] Improved Facilities
- [ ] Increased SIM for Training
- [ ] Innovative Training / Course Development
- [x] Learner / Trainee Support or Wellbeing
- [ ] Multi-professional Initiatives
- [ ] New/Improved Strategy or Governance
- [ ] Other
- [ ] Placement Capacity / Expansion
- [ ] Quality - Improvement Initiatives, response to data, positive feedback
- [ ] Recruitment / Retention Initiatives
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (training)

Please provide your narrative in the comments box

At TRFT, we consistently receive positive student feedback through the PARE review. There is a responsive approach to the feedback which we use to enhance the student experience. We work collaboratively with the universities and we have an open door approach to any supportive adjustments to support student on placement.

We have recently implemented health and wellbeing champions in our area of Theatres. Leaners therefore are better supported and can be signposted to further support should they need it. We understand that the challenges of Learning and challenges of home life can often be overwhelming.

There has been investment in several leadership development programmes for Registered Nurses to further help strengthen the learner's experience. We have

also expanded Team Rostering across 10 inpatient wards and the UECC department to help give our staff a voice.

Also, support given to learners in the form of drop-in sessions, placement area visits and WhatsApp groups, enables our learners to share feedback, worries, concerns and positive comments quickly and easily. The “Golden Hours” initiative offered by the majority of clinical areas also enables our students time to reflect on the shift and share learning.

We are on the second year of a cultural celebration event for our diverse workforce, have achieved the pastoral care quality award for our internationally educated nurses and are currently supporting the
Refugee Support, Training, Orientation, Recruitment and Education for refugee nurses living in South Yorkshire.

8. Example 3: Please choose the most appropriate category for your achievement.

- [ ] Collaboration / Partnerships
- [ ] Covid - Response / Catch up
- [ ] CPD
- [ ] Culture
- [ ] Development of TEL Provision
- [ ] Improved Facilities
- [ ] Increased SIM for Training
- [ ] Innovative Training / Course Development
- [ ] Learner / Trainee Support or Wellbeing
- [ ] Multi-professional Initiatives
- [ ] New/Improved Strategy or Governance
- [ ] Other
- [ ] Placement Capacity / Expansion
- [ ] Quality - Improvement Initiatives, response to data, positive feedback
- [x] Recruitment / Retention Initiatives
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (training)

Please provide your narrative in the comments box

We have had an increase in training post for doctors as well as an increase in recruitment to Junior Clinical Fellows.

Two initiates for attracting JCF are:

1. In medicine there are recruited to a rotational programme

2. In Emergency Medicine they have 25% non clinical time in their job plan

Although we have mentioned above that capacity is a challenge we have expanded placements to support workforce development and we successfully recruited x16 ECM in 2023.

We are very proud of the additional placement we have provided for a number of years in collaboration with our HEI the University of Sheffield. This additional placement, Conversation Partners, has been in operation for around 12 years which provides additional skills and experience for SLT students. We have also offered another additional placement, Life Stories, too. These placements enhance the pathway we offer for patients with communication difficulties once individual therapy is completed. We are very pleased to be able to offer a place on the SLT Degree Apprenticeship to one of the longstanding Assistant Practitioners in our service. The SLT Degree Apprenticeship course is only in its second year so it is excellent that TRFT has supported our service and the staff member to develop her career in this way. We are proud of this development which broadens access to the SLT profession resulting in a more diverse workforce in the longer term.

Our Nursing Qi on retention has seen great results with reduced attrition due the holistic approach undertaken. This has included expanded numbers of Professional Nurse Advocate (PNA), new staff changing rooms and locker facilities for learners. New education framework, careers pathways and Joy-In Work approach to work.

13. Section 3 - Contracting and the NHS Education Funding Agreement

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the obligations and key performance indicators set out in Schedule 3 of the **NHS Education Funding Agreement (2024-27)**. This should be completed once on behalf of the whole organisation. Please select only one option for each row. There is an option to provide additional comments to support your answer, this is restricted to 2000 characters.

9. Please confirm your compliance with the obligations and key performance indicators set out in Schedule 3 of the NHS Education Funding Agreement (EFA).

This should be completed once on behalf of the whole organisation. Please select only one option for each row.

	Yes	No
There is board level engagement for education and training at this organisation.	x	
The funding provided via the NHS Education Funding Agreement (EFA) to support and deliver education and training is used explicitly for this purpose.	x	
We undertake activity in the NHS Education Funding Agreement which is being delivered through a third party provider.	x	
The Provider or its sub-contractor did not have any breaches to report in relation to the requirement of the NHS Education Finding Agreement (EFA)	x	
We are compliant with all applicable requirements of the Data Protection Legislation and with the requirements of Schedule 5 of the NHE Education Funding Agreement.	x	

	Yes	No
The Provider did not have any health and safety breaches that involve a learner to report in the last 12 months.	x	
The organisation facilitates a cross-system and collaborative approach, engaging the ICS for system learning.	x	
We have collaborative relationships with our stakeholders (e.g. education providers) which provide robust mechanisms to deliver agreed services.	x	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The Trust promotes learning and education for its staff. Such educational activities are made available to allow who qualify and the opportunity is there to apply or to ask to attend.

Funds received via the LDA are disseminated to support learners across professions.

A number of in house teaching sessions are provided both for staff and learner which provides platforms for updating on areas, networking and promoting multi professional learning.

We are support at a Board level by Dr Joanne Beahan - Medical Director and Helen Dobson - Chief Nurse.

10. Please provide the name and email address of the board named individual responsible for education and training.

Name: Joanne Beahan

Email Address: jbeahan@nhs.net

11. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

14. Section 4 - Education Quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training obligations and key performance indicators of the **NHS Education Funding Agreement (EFA)**. This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas are able to feed into this section. There is an option to provide additional comments to support your answer, this is restricted to 1000 characters.

12. Can you confirm as a provider that you...
Please select only one option for each row.

	Yes	No	N/A
We are aware of the requirements and process for an education quality intervention, including who is required to attend.	x		
We are reporting and engaging with the requirements and process to	x		

	Yes	No	N/A
escalate issues, in line with NHS England's education concerns process.			
Have developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services.	x		
Has the provider been actively promoting, to all learners, use of the national clinical decision support tool funded by NHS England?		x	
Have a Freedom to Speak Up Guardian and they actively promote the process for raising concerns through them to their learners.	x		
Have a Guardian of Safe Working (if	x		

	Yes	No	N/A
postgraduate doctors in training are being trained), and they actively promote the process for raising concerns through them to their learners.			
Are aware of the Safe Learning Environment Charter (SLEC)	x		
Are actively implementing and embedding the SLEC multi-professionally.	x		

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Within each learner structure, there is regularly communication with teams in the Trust and external stakeholders.

Issues can be escalated accordingly.

The Trust is proud of its Library & Knowledge Service who received a positive outcome from the LQAF.

We have a Freedom to Speak up team within the Trust. Their details are available on the intranet, screensavers and posters.

The Guardian of Safe Working hours attends the monthly Junior Doctor Forum.

SLEC is an area that the Trust is working on across a multi professional platform. We are working on SLEC by using the maturity matrix to self-assess our own fields of registration, then coming together to develop an action plan to ensure the trust is using SLEC to support our learners in practice.

Learner feedback has been collected to support this, directly from learners, and from PARE evaluations.

13. <u>As an organisation, have you been referred to a regulator for education and training concerns in the last 12 months (with or without conditions)</u> (e.g., GMC, GDC, HCPC, NMC, etc)
Note: we are not seeking information about the referral of an individual learner.

[x] **We have not** been referred to a regulator

[ ] **We have** been referred to a regulator and the details are shared below.

If you have received conditions from a regulator please provide more details including the regulator, the profession involved and a brief description

14. Did you actively promote the National Education and Training Survey (NETS) to all healthcare learners?

[x] Yes

[ ] No

Please briefly describe your process for encouraging responses including your organisations response rate for the 2023 NETS.

Information is emailed to all learners and supervisors as appropriate.

However the response rate can always be improved for further communications will be sent

15. Have you reviewed, at Board Level, and where appropriate, taken action on the outcome of the results of the National Education and Training Survey (NETS).

[ ] Yes

[x] No

Please provide a brief description of the action you have taken as a result; if 'no' please provide further details including your plans to use the NETS data for quality improvement activity in the future:

Where necessary, areas for improvement have been highlighted and discussed with the relevant lead and departments.

Results are discussed at the Medical Education Committee as well as other relevant meetings.

Going forward NETS and GMC data will be presented to the People Committee and Executive Team Meeting.

16. 2024's NETS will be open from 1 October 2024 until 26 November 2024. How will your organisation increase their NETS response rate for 2024?

Increase visibility with posters and email signatures.

17. Patient Safety and the promotion of a Patient Safety culture is integral to the Education Quality Framework. Please provide the following information:

Name and email address of your Board representative for Patient Safety	Helen Dobson helen.dobson11@nhs.net
Name and email address of your non executive director representative for Patient Safety	Following 2021 guidance, this now falls under the remit of the Quality Committee.
Name and email address of your Patient Safety Specialist/s	Alison Walker - alison.walker32@nhs.net Victoria Hazeldine - victoria.hazeldine@nhs.net
What percentage of your staff have completed the patient safety training for level 1 within the organisation (%)	95%

18. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

15. Section 5 - Equality, Diversity and Inclusion

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks about your policies and processes in relation to equality, diversity and inclusion and should normally be completed by your nominated EDI lead. There is an option to provide additional comments to support your answer, this is restricted to 1000 characters.

19. Please confirm whether your organisation has an Equality, Diversity and Inclusion Lead (or equivalent):

[x] Yes

☐ No

If 'yes' please add comments to support your answer sharing details of governance and links with education and training alonside the nominated name of your EDI lead for education and training; if 'no' please provide further detail

Hashim Din is the Head of OD, Wellbeing and Inclusion. His role is duel remit, also functioning as the HR Head of L&D (corporate mandatory training and alignment to the Core Skills Training Framework). Hashim chairs the Operational Education Group which is the Trust's governance forum for learning and development. He works closely with colleagues in Post Graduate Medical Education as well as the Education matrons, providing advice, guidance and support when required.

20. Please confirm that you liaise with your Equality, Diversity and Inclusion Lead (or equivalent) to...
Please select only one option for each row.

	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	x	
Implement reasonable adjustments for learners with a disability?	x	
Ensure policies and procedures do not negatively impact learners who may have a protected characteristic(s)?	x	
Ensure International Graduates (including International Medical Graduates) receive a specific induction into your organisation?	x	
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	x	
Ensure a policy is in place to manage Sexual Harassment in the Workplace?	x	

	Yes	No
Do you have initiatives to support reporting of sexual harassment?	x	
Has your organisation signed up to the NHS England Sexual Safety in Healthcare - Organisational Charter?	x	
Does your organisation have a designated sexual safety lead, such as a Domestic Abuse and Sexual Violence (DASV) lead?	x	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Helen Dobson the Chief Nurse is our named executive lead for Sexual Safety and Harassment, in reality this role is shared with our People Director, Daniel Hartley.

We wanted to recognise that men too are victims and more often than not, men are the perpetrators. An action plan to implement recommendations from the charter is being worked on alongside the Safeguarding team.

21. How does your organisation manage sexual harassment reports?

Presently, reports can be made to HR Business Partners, Line Managers, Placement or other Supervisors, Wellbeing Team, Wellbeing champions or via our Freedom to Speak Up ambassadors. Before the end of the year, we will also be advertising the Safeguarding team as another mechanism for reporting. All of this will be supported with a new Allegations policy.

The safeguarding team work closely with the HR Business Partners to ensure that intel is shared and concerns are adequately reported and responded to, consistently across the organisation. If required, we will also liaise with external partners like the police or universities if appropriate/necessary.

22. Postgraduate Deans and their teams are keen to consider responses and initiatives and share good practice. Please share details on EDI initiatives that are specific to or have an impact on education and training in your organisation and the email address for someone we can contact to discuss this further.

We have an “All About Me” passport, similar to reasonable adjustments or disability passports. The take up from learners isn’t high but some staff groups have found it useful for having conversations with their manager. Everyone is encouraged to complete one when they are recruited to the organisation.

23. For education and training, what are the main successes for EDI in your organisation?

We have a workforce disability advisor who has both professional and lived experience of disabilities, long term health conditions and neurodiversity. Staff, managers and educators can contact them for advice and support.

24. For education and training, what are the main challenges for EDI in your organisation?

Unclear processes in the past – this has developed significantly in 2024 including new sign off processes for personal development including a Study Leave policy. Closer working between colleagues in PGME and L&D has helped to reduce duplication and work together to overcome issues.

Oversight and overview of the protected characteristics of learners requires more work and to improve our statistics and be able to report on this.

25. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

16. Section 6 - Assurance Reporting: learning environment and culture

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 2000 characters per text box. **This section should be completed once on behalf of the whole organisation,** however it is important that those responsible for these areas are able to feed into this section.

26. Thinking about the learning environment and culture of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Please ask Debbie Harrison debbie.harrison10@nhs.net for further contact details as they may vary.

- We have 3 SAS Leads in the Trust: SAS Tutor, SAS Advocate and CESR Lead. They support all the SAS doctors as well as the LEDs within the Trust. We host a SAS Forum and monthly SAS/LED study days.
- In Medical Undergraduate, we are currently on our 2nd Clinical Teaching Fellow. We received positive feedback about the support and extra teaching session they provide to the medical students.
- The ODP students and ODP apprenticeships have regular meetings with the Clinical Educator to check on progress and to see if there is any further support they need.
- Implementation of Health and Wellbeing champions to support staff and students.
- Providing online mentorship updates post-covid to maximise accessibility for mentors to update on educational topics and ensure they are a current Practice Supervisor instead of trying to do face-to-face.
- New Student and Mentor board in Theatres to communicate updates and information easily.

- Over the last year we have recruited a large number of our own ODP students into newly qualified posts.

- Our nursing learners are encouraged to attend our informal sessions where they are given the opportunity to meet with Head of Nursing and Matrons, in a safe and supportive environment. This gives our learners the opportunity to give direct feedback regarding all aspects of their placement experiences. They are invited for a "cup of tea" and a chat in a relaxed environment, and this feedback has directly led to placement changes and improvements. By senior leaders listening directly to our learners, addressing their needs and concerns, and sharing the positive experiences as well, learning can be shared quickly and actions and support expedited where needed.

- We have identified the need to increase our educator numbers and have included Practice Assessor and Supervisor training on our Preceptorship Programme, which has increased our number of educators out in practice to support our learners.

27. Quality Framework Domain 1 - Learning environment and culture Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
The learning environment is one in which education and training is valued and championed.	x	
The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.	x	
The organisational culture is one in which all staff, including learners, are treated fairly,	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
with equity, consistency, dignity and respect.		
There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.	x	
Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.	x	
The environment is one that ensures the safety of all staff, including learners on placement.	x	
All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
The environment is sensitive to both the diversity of learners and the population the organisation serves.	x	
There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.	x	
There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.	x	
The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities,	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
and access to knowledge and library specialists.		
The learning environment promotes multi-professional learning opportunities.	x	
The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	x	

28. Areas of exception
<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

☐ **All professions**	☐ **Site specific**	☐ Dental Postgraduate
☐ Dental Undergraduate	☐ Medicine Postgraduate	☐ Nursing
☐ Midwifery	☐ Allied Health Professionals	☐ Pharmacy
☐ Paramedicine	☐ Medical Associate Professions	☐ Advanced Practice
☐ Psychological Professions	☐ Healthcare Science	☐ Medicine Undergraduate

☐ Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

29. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

30. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

17. Section 7 - Assurance Reporting: educational governance and commitment to quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether the you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. **This section should be completed once on behalf of the whole organisation,** however it is important that those responsible for these areas are able to feed into this section.

31. Thinking about the educational governance and commitment to quality of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you to would like share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Please ask Debbie Harrison debbie.harrison10@nhs.net for further contact details as they may vary.

- The Trust holds monthly Junior Doctor Forums as well as regular SAS Forums.
- Bi Monthly Medical Education Committee meetings. Chaired by the Associate Medical Director – Medical Education. All TPDs based at TRFT and the Rotherham GP scheme are invited along with Royal College Tutors, Medical Undergraduate, SAS Tutor, Future Leader, Library & Knowledge Service, Educational Pharmacist, Medical Workforce.
- Monthly Learning Environment Manager meetings held by the Education and Development Team.
- We have a student of the month board where ODP students who are recognised as going above and beyond are recognised with a short description of why.
- We do training out of the clinical placement area around twice a year where a group of ODP students do sims and/or focus on areas that they feel they need more experience on like certain instrument trays.
- The Trust has developed a SOP that sets out the support our learners receive when on placement with us, this is for all educators and students to refer to and lays the foundations for student support and development whilst with us.

32. Quality Framework Domain 2 - Educational governance and commitment to quality
Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
appropriate, inter-professional approach to education and training.		
There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.	x	
The governance arrangements promote fairness in education and training and challenge discrimination.	x	
Education and training issues are fed into, considered and represented at the most senior level of decision making.	x	
The provider can demonstrate how educational resources (including financial) are allocated and used.	x	
Educational governance arrangements	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.		
There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.	x	
Consideration is given to the potential impact on education and training of service changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
key stakeholders (including WT&E and Education Providers).		

33. Areas of exception
<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- ☐ **All professions**
- ☐ **Site specific**
- ☐ Dental Postgraduate
- ☐ Dental Undergraduate
- ☐ Medicine Postgraduate
- ☐ Nursing
- ☐ Midwifery
- ☐ Allied Health Professionals
- ☐ Pharmacy
- ☐ Paramedicine
- ☐ Medical Associate Professions
- ☐ Advanced Practice
- ☐ Psychological Professions
- ☐ Healthcare Science
- ☐ Medicine Undergraduate
- ☐ Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

34. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

35. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

18. Section 8 - Assurance Reporting: developing and supporting learners

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

36. Thinking about how you develop and support learners within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Please ask Debbie Harrison debbie.harrison10@nhs.net for further contact details as they may vary.

- Additional learning outside of Theatres such as simulations
- Extra learning opportunities in other areas such as ODP students going to other departments, Labour Ward, ITU, Endoscopy etc
- Extensive Induction orientation and student package
- Shift Timetabling to help with previous feedback that the students didn't know who they were working with from one day to another and that their mentors were not expecting them
- Regular 1-1 meetings with Clinical Educator
- Health and Wellbeing Champions specifically in departments
- Student of the month
- Student and Mentor Board in Theatres
- Access to the University of Sheffield Gateway Course.
- Access to Practitioner's ePortfolio.
- Clinical staff supporting learners with additional roles:
  - PATs Tutors
  - Placement Support Officers.
  - Learning Support Officers
  - Undergraduate Leads & LICP Supervisors
  - SAS Tutor
  - SAS Advocate
  - CESR Lead
- Learners are invited to all appropriate teaching events and training sessions provided by in the Trust either with internal or external providers. They are also invited to attend Health and Wellbeing indicatives run by the wellbeing team.
- Students in difficulty are supported by the PLF and placement area, University lecturers are contacted to offer advice and support where needed.
- Student Induction is delivered including a session from our Freedom to Speak Up Lead, ensuring they have the details for support should it be needed.
- Students are supported to work with other learners and junior staff in order to develop their delegation, team working and leadership skills.

37. Quality Framework Domain 3 - Developing and supporting learners
Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	x	
The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.	x	
Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.	x	
Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
to their scope of practice.		
Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	x	
Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.	x	
Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
work of those teams.		
Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.	x	
Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.	x	
Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	x	
Learners are encouraged to access resources to support their physical and mental health and wellbeing as a critical foundation for effective learning.	x	

38. Areas of exception
<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- [ ] **All professions**
- [ ] **Site specific**
- [ ] Dental Undergraduate
- [ ] Dental Postgraduate
- [ ] Medicine Postgraduate
- [ ] Nursing
- [ ] Midwifery
- [ ] Allied Health Professionals
- [ ] Pharmacy
- [ ] Paramedicine
- [ ] Medical Associate Professions
- [ ] Advanced Practice
- [ ] Psychological Professions
- [ ] Healthcare Science
- [ ] Medicine Undergraduate
- [ ] Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

39. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

40. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

19. Section 9 - Assurance reporting: developing and supporting supervisors

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

41. Thinking about how you develop and support supervisors within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Please ask Debbie Harrison debbie.harrison10@nhs.net for further contact details as they may vary.

- The Associate Medical Director - Medical Education aims to run two Educational Supervisor Course a year within the Trust. This allows for new supervisors to attend and current supervisors to refresh.

- All named clinical and educational supervisors within the Trust must have completed this course. If they have completed the online modules and are awaiting a face to face course. They can start supervising with a mentor.

- We actively encourage our SAS doctors to attend the course and become supervisors if appropriate.

- Support Horary Senior Clinical Teacher Applications.

- Support both the Future Leader and Clinical Teaching Fellow to complete a PGCert.

- Dedicated Clinical Educator to escalate any student concerns and to support staff and students. Mentor Update is shared via email that we get from SHU yearly. Dedicated staff and mentor board in Theatre which includes information such as student rotas, pictures of new students, any mentor updates or changes. A link lecturer from the SHU ODP team comes in yearly to chat to staff and support them.

- Use the Practice Educator and Assessor preparation course on E Learning for health, to ensure PA and PS are fully supported we then offer a one day course to help with action planning and support, going through good and poor examples of feedback to help educators see the impact feedback makes.

- PLF and Link lecturers visit areas weekly to support both learners and educators, and offer support with pebblepad

42. Quality Framework Domain 4 - Developing and supporting supervisors

Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.	x	
Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, WT&E).	x	
Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.		x

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of learners' programmes and career pathways, enhancing their ability to support learners' progression.		x
Clinical supervisors are supported to understand the education, training and any other support needs of their learners.	x	
Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional	x	

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
development and role progression and/or when they may be experiencing difficulties and challenges.		
Supervisors can easily access resources to support their physical and mental health and wellbeing.	x	

43. Areas of exception
<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

[ ] **All professions**	[ ] **Site specific**	[ ] Dental Undergraduate
[ ] Dental Postgraduate	[ ] Medicine Postgraduate	[ ] Nursing
[ ] Midwifery	[ ] Allied Health Professionals	[ ] Pharmacy
[ ] Paramedicine	[ ] Medical Associate Professions	[x] Advanced Practice
[ ] Psychological Professions	[ ] Healthcare Science	[ ] Medicine Undergraduate
[ ] Social Workers		

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

TACPs/ACPs

44. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

Some lack of knowledge within the advanced practice supervisor community on the apprentice pathways and also a lack of supervisors given a rising number of TACPs/ACPs. The more advanced AP workforce are developing and taking on the role of educational supervisor with support from Lead ACP and education & training provided by regional/local faculties

Challenges: lack of supervisors for number of ACPs

Robust training on educational supervision from NHSEWT&E at a national level rather than in pockets within regions- this training should look the same across the country

45. Thinking about the Educator Workforce Strategy, please confirm that your organisation

	Yes	No
Is aware of the Educator Workforce Strategy.	x	
Ensures educators/supervisors undertake a skills gap / learning development needs analysis for this role.	x	
Ensures educators/supervisors have formal development to undertake this role.	x	
Considers the educator workforce in		x

	Yes	No
wider clinical workforce planning.		

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

46. Implementation of the Educator Workforce Strategy

- [ ] We have **fully implemented** the recommendations of the Educator Workforce Strategy.
- [x] We have **partially implemented** the recommendations of the Educator Workforce Strategy.
- [ ] We have **not yet started** implementation of the recommendations of the Educator Workforce Strategy.

47. Signature

- [ ] I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

20. Section 10 - Assurance reporting: delivering programmes and curricula

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

48. Thinking about how you deliver programmes and curricula to support training within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Please ask Debbie Harrison debbie.harrison10@nhs.net for further contact details as they may vary.

- Regular Practice Partner meetings with the Universities.
- Training updates required every two years.
- Our PLF attends monthly meetings with local HEI's, other Trust and patient advocates to share ideas and support and discuss options for improvement.
- Review feedback both informal and formal from meetings and surveys.
- Piloting a half day communication course for the Foundation Doctors using senior trainees as faculty.
- Clinical Teaching Fellow has developed a Bed Side Teaching initiative to encourage the junior trainees to get involved in teaching medical students.
- A number of national curriculums are available on PeP for the trainee ACPs.
- Regular check ins with Sheffield Hallam University in order to ensure we are up to date with any changes in their curriculum and a Practice Supervisor from Theatres always attends the CPC Update Day at SHU to again update ourselves on any changes.
- The collaborative learning in practice model is in use in the Trust on 3 areas, this has increased capacity and changed how we supervise and support our learners, enabling them to work as a team of learners and support each other, whilst being overseen by a PA or PS.

49. Quality Framework Domain 5 - Delivering programmes and curricula

Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.	x	
Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.	x	
Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
delivery models, as well as a focus on health promotion and disease prevention.		
Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.	x	
The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.		x
Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.	x	

50. Areas of exception
From the professional groups you train, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- [ ] **All professions**
- [ ] **Site specific**
- [ ] Dental Postgraduate
- [ ] Dental Undergraduate
- [ ] Medicine Postgraduate
- [ ] Nursing
- [ ] Midwifery
- [x] Allied Health Professionals
- [ ] Pharmacy
- [ ] Paramedicine
- [ ] Medical Associate Professions
- [ ] Advanced Practice
- [ ] Psychological Professions
- [ ] Healthcare Science
- [ ] Medicine Undergraduate
- [ ] Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Physio and Occupational Therapy

51. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

Not aware of any active involvement of patients or service users in the development of education delivery.

52. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

21. Section 11 - Assurance reporting: developing a sustainable workforce

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

53. Thinking about developing a sustainable workforce within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like yo share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Please ask Debbie Harrison debbie.harrison10@nhs.net for further contact details as they may vary.

- The Trust includes a career conversation for all staff in its non-medical appraisals, as a way of identifying for individual staff how they and their managers work together to increase job satisfaction and encourage them to stay at the Trust.

- Retained 15 University of Sheffield medical students for the 24/25 F1 cohort.

- Education and Development Team attend recruitment events at Sheffield Hallam University. As well as holding Open Days at the Trust.

- Having engaged SAS Leads to support new SAS/LEDs.

- A working group has been created to look at support for IMG.

- We have an employee of the month board where someone nominates a staff member/mentor for going above and beyond. We also have a staff shout out board where any feedback given to staff or teams..

- Two initiates for attracting JCF are:
  1. In medicine there are recruited to a rotational programme
  2. In Emergency Medicine they have 25% non clinical time in their job plan

- Nursing students stay at one Trust for the full programme, this enables us to build good relationships and support our students to move into areas of their choice upon qualifying. To aid this we offer student drop-in sessions for a “cupper and a chat” with our senior leadership team members and heads of department.

- Towards the end of the course and pre-registration, we offer employment preference events, where our potential newly registered colleagues can come in and meet with Matrons, Heads of Nursing and Ward managers to discuss and support their future employment choices. We offer advice to help them choose the path for them considering their interests and future aspirations

54. Quality Framework Domain 6 - Developing a sustainable workforce Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	x	
Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues	x	
The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	x	
Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
underpinned by a clear process of support developed and delivered in partnership with the learner.		

55. Areas of exception
From the professional groups you train, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- ☐ **All professions**
- ☐ **Site specific**
- ☐ Dental
- ☐ Dental Undergraduate
- ☐ Medicine Postgraduate
- ☐ Nursing
- ☐ Midwifery
- ☐ Allied Health Professionals
- ☐ Pharmacy
- ☐ Paramedicine
- ☐ Medical Associate Professions
- ☐ Advanced Practice
- ☐ Psychological Professions
- ☐ Healthcare Science
- ☐ Medicine Undergraduate
- ☐ Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

56. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

57. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

22. Section 12 - Final Submission

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

Before completing your final submission please ensure you have:
1. Completed all questions within the Self-Assessment (including the free text sections)
2. Received Board level sign off for your submission

58. Board level sign-off (Premises, Learning Environment, Facilities, and Equipment)

☐ I confirm that our premises, learning environments, facilities and equipment are: suitable for the performance of the Services; accessible, safe and secure; comply with any applicable Health and Safety Legislation, any other Applicable Law, Guidance, appropriate risk management clinical guidance, good healthcare practice and the requirements of any relevant Regulator; and are sufficient to enable the Services to be provided at all times and, in all respects, in accordance with the NHS Education Funding Agreement.

59. Board level sign-off

☐ I confirm that the responses in this SA have been signed off at board level

Name, email address and role of Board representative for education and training

60. Please confirm the date that board level sign off was received:

*

61. Final Submission (please only tick this box when you ready to submit your self-assessment)

☐ I confirm that all sections of this self-assessment have been completed and that this is the final version for submission

23. Thank you for your time

Thank you for your time on the NHS England Self-Assessment for Placement Providers

You can continue to update this self-assessment using the link supplied to your by your regional NHS England WT&E education quality team.

If you would like to print a version of your draft submission at any time, please use the print button on the next page (note that you will only print those sections currently completed)

Once you have completed all sections in full of this self-assessment please ensure that you complete section 12 final submission and tick the box Complete Submission. At which point your final response will be sent to your regional NHS England WT&E education quality team.

Board of Directors' Meeting
8 November 2024

Agenda item	P182/24
Report	**Standing Financial Instructions & Scheme of Delegation – Annual Review**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D8: We will not be able to sustain services in line with national and system requirements because of a potential deficit in 2024/25 leading to further financial instability.
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	The Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) are reviewed annually, to update for changes in guidance, legislation, and for matters of accuracy. In addition to the annual review, updates to SFIs and SoD are recommended to Audit & Risk Committee, as and when required, for the Trust to remain compliant with financial governance requirements. Following the annual review of the SFIs and SoD, there have only been minor changes to update the change in title from Deputy Chief Executive to Managing Director, and changes applicable to the current Care Group structure.

	The updated SFIs and SoD are included in Appendix 1. These were reviewed by the Audit & Risk Committee on 25th October 2024 and were recommended for approval by the Board.
Due Diligence	The existing SFIs and SoD are reviewed annually.
Board powers to make this decision	SFIs and SoD form part of the statutory regulatory framework for the business conduct of the Trust.
Who, what and when	The SFIs and SoD have been reviewed by: - the Finance Director and Deputy Director of Finance. Clarification has been sought from colleagues on matters specific to their area of work and responsibilities. - the Audit & Risk Committee on 25th October 2024
Recommendations	It is recommended, by Audit & Risk Committee, for the Board to approve the updates to the SFIs and SoD.
Appendices	Standing Financial Instructions – updated October 2024

STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION

Version:	Version 5g
Approved by	Board of Directors
Date Approved	To be confirmed
Title of Author:	Deputy Director of Finance
Title of Responsible Committee/Individual:	Audit Committee
Date Issued:	To be confirmed
Review Date:	18th October 2024
Target Audience:	All Colleagues, Contractors, Volunteers

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DOCUMENT HISTORY SUMMARY

Version	Date	Author	Status	Comment
1	April 2007	Deputy Director of Finance	New policy	New document to comply with gaining foundation trust status.
1a	April 2010	Deputy Director of Finance		Minor amendments following a planned periodic review.
2	October 2012	Deputy Director of Finance		Major review following serious incident (STEIS 2011/968)
3	September 2014	Interim Director of Finance		Major review following an external financial review of the trust after the departure of the turnaround team.
4	October 2015	Deputy Director of Finance		Significant changes following a planned periodic review.
4a	May 2017	Deputy Director of Finance		Minor amendments following a planned periodic review.
4b	October 2017	Director of Finance & Chief Executive		Minor amendments following discussions at Trust Management Committee.
4c	November 2018	Deputy Director of Finance		Amendments to approval limits and process for business case approval and increasing the quotation threshold for procurement. Other minor changes also incorporated.
4d	December 2018	Director of Finance		Minor amendments following the December Board of Directors.
5	June 2021	Deputy Director of Finance		Amendments to approval limits and process for business case approval. Further review of all sections with the Interim Director of Finance and Chair of Finance & Performance Committee.
5a	July 2021	Deputy Director of Finance		Further amendments to approval limits from the newly appointed substantive Director of Finance.
5b	August 2021	Deputy Director of Finance		Further amendments following discussions at Executive Team and with Divisional Finance Managers.
5c	September 2021	Deputy Director of Finance		Insertion of diagrammatical presentation in Appendices 2, 5 and 6.

5d	July 2022	Deputy Director of Finance		Realignment of procurement thresholds consistent across the Integrated Care System.
5e	January 2023	Deputy Director of Finance		Increase in procurement thresholds consistent across the Integrated Care System; changes to SFI waiver requirements and an increased delegated limit for provider capital investment from £15m to £25m.
5f	October 2023	Deputy Director of Finance		Minor amendments following a planned periodic review. Amendments to Appendix 8 to add clarity to limits for the procurement of Works. Amendments to Appendix 10 authorisation of expenditure from Charitable Funds (funds held on trust).
5g	October 2024	Deputy Director of Finance		Minor amendments following the annual review to update references applicable to Care Groups and the change in title from Deputy Chief Executive to Managing Director.

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1. FOREWORD

1.1 The Board operates within a statutory framework in which it is required to adopt standing orders. The Code of Conduct and Code of Accountability in the NHS requires boards to draw up standing orders, a schedule of decisions reserved to the board and standing financial instructions. The Code also requires boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to senior executives.

1.2 Additionally, boards will need locally generated rules and instructions, including financial procedural notes, for use within their organisation. Collectively these must comprehensively cover all aspects of (financial) management and control. In effect, they set the business rules, which all employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

1.3 The purpose of this document is to provide clarity about the financial framework in which the Trust provides patient services. Once these Standing Financial Instructions have been adopted by the Board, they are mandatory for all employees of the Trust and any contractors, consultants or volunteers engaged by the Trust.

2. INTRODUCTION

2.1 General

2.1.1 These Standing Financial Instructions are issued in accordance with financial provisions of The National Health Service Act 2006, and The Health and Social Care Act 2012, as amended by The Health and Care Act 2022 for the regulation of the conduct of foundation trusts in relation to all financial matters. They shall have effect as if incorporated in the Trust's Standing Orders.

2.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Matters Reserved to the Board adopted by the Trust.

2.1.3 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust, including trading units. They do not provide detailed procedural advice. These statements should therefore, be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

2.1.4 Should any difficulties arise regarding the interpretation or application of any of these Standing Financial Instructions, then the advice of the Director of Finance MUST BE SOUGHT BEFORE ACTING. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders and Matters Reserved to the Board.

2.1.5 **FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.**

2.2 Terminology

2.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

(a) "Authorised Signatory" means an employee with delegated authority to commit expenditure on behalf of the Trust/Charity from within approved budgets.

(b) "Board" means the Board of Directors.

(c) "Budget" means a resource, expressed in financial terms, sanctioned by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

(d) "Budget Holder" means an employee with delegated authority to

manage finances (income and expenditure) for a specific area of the Trust with a delegated transactional financial limit of £5,000. Authorised signatories may commit expenditure on behalf of the budget holder for transactions above £5,000.

(e) “Chief Executive” means the chief officer of the Trust who is designated as the Accounting Officer under The NHS Act 2006, as amended.

(f) “Corporate Trustee” means a corporation that has been appointed to act as trustee of a charity. A corporation is a collection of persons, which, in the eyes of the law, has its own legal existence (and rights and duties) separate from those of the persons who form it from time to time. The Board is the corporate trustee for the Rotherham Hospital and Community Charity.

(g) “Delegated Transactional Financial Limit” is the maximum amount of expenditure that any authorised signatory can commit in one transaction. A delegated transactional limit also applies to the Executive Team, Finance & Performance Committee and the Board for approving procurement contracts that can then be ordered against by an authorised signatory (see Appendices 3 and 4).

(h) “Division” refers to a number of service units that are managed and controlled collectively and reported upon as a single entity to the Board. For clarity, the portfolio of each executive director and the Company Secretary is regarded as a separate division. A list of all divisions is included within Appendix 1.

(i) “Funds Held on Trust” refers to those funds that the Trust held as at 1st April 1996 or date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Section 90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

(j) “Legal Adviser” means the properly qualified person appointed by the Trust to provide legal advice.

(k) “Management Team” refers to a number of budgets that are managed and controlled collectively and reported upon as a single entity (See Appendix 1).

(l) “NHS England” means the body responsible for overseeing foundation trusts, NHS trusts, independent providers and commissioning organisations.

(m) “Service Unit” refers to a number of budgets that are managed and controlled collectively and reported upon as a single entity (See Appendix 1).

(n) “Trust” means The Rotherham NHS Foundation Trust.

2.2.1 Wherever the title Chief Executive, Director of Finance or other nominated officer is used in these instructions, it shall be deemed to include such other employee who has been duly authorised to represent them.

2.2.2 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2.2.3 All financial values quoted in these Standing Financial Instructions are exclusive of VAT where and when it is applicable.

2.3 Responsibilities and Delegation

2.3.1 The Board exercises financial supervision and control by:

(a) Formulating the financial strategy.

(b) Requiring the submission and approval of budgets.

(c) Defining and approving essential features in respect of procedures and financial systems, including the need to obtain value for money.

(d) Defining specific responsibilities placed on employees as indicated in the Scheme of Delegation (see Appendices 1 to 10).

2.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the “Matters Reserved to the Board” document.

2.3.3 Within these Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as accountable officer to NHS England, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust’s system of internal control.

2.3.4 The general and specific responsibilities of the Chief Executive as the Accounting Officer for the Trust are outlined in more detail in the NHS Foundation Trust Accounting Officer Memorandum published by NHS England.

2.3.5 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

2.3.6 It is a duty of the Chief Executive to ensure that existing employees and all new appointees are notified of and understand their responsibilities within these Standing Financial Instructions.

2.3.7 The **Director of Finance** is responsible for:

(a) Implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies.

(b) Maintaining an effective system of internal financial control including financial procedures, and systems incorporating the principles of separation of duties and internal checks, documenting, maintaining and disseminating procedures to supplement these Standing Financial Instructions. Appropriate registers of these procedures will be maintained.

(c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

And, without prejudice to any other functions of employees of the Trust, the duties of the Director of Finance include:

(d) The provision of financial advice to the Trust and its employees.

(e) The design, implementation and supervision of systems of internal financial control.

(f) The preparation and maintenance of financial accounts, certificates, estimates, records and reports as the Trust may require for the purposes of carrying out its work, including its statutory duties.

Additionally, the Director of Finance should ensure that all necessary requirements are fulfilled to enable the Trust's external auditors to be able to comply with the Code of Audit Practice published by the National Audit Office, which prescribes the way in which auditors are to carry out their functions as set out in the National Health Service Act 2006, as updated.

2.3.8 **All employees**, severally and collectively, are responsible for:

(a) Security of the property of the Trust in accordance with NHS guidelines.

(b) Avoiding loss.

(c) Exercising economy and efficiency in the use of resources.

(d) Conforming with the requirements of Standing Orders, Standing Financial Instructions, financial procedures, Scheme of Delegation and Matters Reserved to the Board.

(e) Notifying the Director of Finance of any known instances of non-compliance with Standing Financial Instructions.

2.3.9 Under no circumstances should any **contractor or employee of a contractor** be empowered by the Trust to commit it to expenditure or authorised to obtain income on its behalf. This will help ensure compliance with the requirements of Intermediaries Legislation (IR35): Countering Avoidance in the Provision of Personal Services.

2.3.10 For any and all employees who carry out a financial function, the form in which financial records are kept and the manner in which employees discharge their duties must be to the satisfaction of the Director of Finance.

2.4 Escalation Procedures for Non-Compliance

2.4.1 Any instance of non-compliance with Standing Financial Instructions must be notified to the Director of Finance as soon as it has been identified.

2.4.2 The Director of Finance will investigate all significant instances and report the detailed circumstances of each to Audit Committee at its next meeting.

2.4.3 The Director of Finance will determine what disciplinary or other action, if any, is necessary, having sought appropriate advice from the Director of People.

2.4.4 If the Director of Finance is suspected of breaching Standing Financial Instructions, then this should be notified to the Chief Executive who will similarly take action identified above.

2.4.5 Any potential breaches of Standing Financial Instructions by executive directors will be escalated to the Chair of the Audit Committee, who will advise on further actions to be instigated in accordance with the approved Governance and Compliance Framework. Any such breaches not involving the Director of Finance will also be reported to the Director of Finance.

3. AUDIT AND ASSURANCE

3.1 Audit Committee

3.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference, consistent with 'Code of governance for NHS provider Trusts'. Specifically this will include:

(a) Monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained therein.

(b) Ensuring that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

(c) Reviewing the internal financial controls.

(d) Reviewing the internal control and risk management systems.

(e) Monitoring and reviewing the effectiveness of the internal audit and counter fraud functions.

(f) Reviewing and monitoring the external auditors' independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

Additionally, the Audit Committee will be responsible for:

(g) Monitoring compliance with Standing Orders and Standing Financial Instructions.

(h) Reviewing the appropriateness of waiving quotation and tender requirements in accordance with Section 11.5 and Appendix 8.

(i) Reviewing schedules of losses and compensations and making recommendations to the Board.

3.1.2 The Audit Committee shall meet at least quarterly and in accordance with its terms of reference.

3.1.3 Where the Audit Committee considers that there is evidence of ultra vires transactions, evidence of improper acts, or other matters to raise, the chairperson of Audit Committee should report them to a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS England (to the Director of Finance in the first instance or the Chief Executive, if the matter involves the Director of Finance).

3.1.4 Similarly, the Audit Committee shall report to the Council of Governors, identifying any matters in respect of which it considers that action or

improvement is needed and making recommendations as to the steps to be taken in accordance with 'Code of governance for NHS provider Trusts'.

3.1.5 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when the internal audit service provider is changed.

3.2 Fraud and Corruption

3.2.1 The Chief Executive and Director of Finance shall monitor and ensure compliance with the Government Functional Standard (GovS 013: Counter Fraud) Management of Counter Fraud, Bribery and Corruption Activity issued by the Counter Fraud Centre of Expertise, part of the Cabinet Office) as well as any other best practice and guidance.

3.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as required by Government Functional Standard (GovS 013: Counter Fraud).

3.2.3 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with NHS Counter Fraud Authority staff in accordance with the NHS Counter Fraud Manual and in compliance with the Government Functional Standard (GovS 013: Counter Fraud).

3.2.4 The Local Counter Fraud Specialist shall develop a work plan following a comprehensive fraud risk assessment. This work plan shall be agreed with the Audit Committee at the beginning of each financial year, with progress against the plan being reported quarterly.

3.2.5 The Trust must maintain a Counter Fraud, Bribery and Corruption Policy and Response Plan.

3.3 Security Management

3.3.1 The Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State and NHS England on NHS security management.

3.3.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist as specified by the Secretary of State and NHS England in guidance on NHS security management.

3.3.3 The Trust shall nominate a non-executive director to be responsible to the Board for NHS security management.

3.3.4 The Chief Executive has overall responsibility for controlling and co-ordinating security. However, key tasks are delegated to the Security Management Director and the appointed Local Security Management Specialist.

3.4 Director of Finance

3.4.1 The Director of Finance is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function and will normally attend Audit Committee meetings.

(b) Ensuring that the internal audit is adequate and meets the Internal Audit standards.

(c) Deciding at what stage to involve the police in cases of misappropriation, and other irregularities, in conjunction with the Local Counter Fraud Specialist.

(d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee, as a minimum covering:

(i) A clear statement on the effectiveness of internal control.

(ii) Major internal financial control weaknesses discovered.

(iii) Progress on the implementation of internal audit recommendations.

(iv) Details of actual performance against plan.

(e) Ensuring that regular and timely reports are prepared for the consideration of the Audit Committee, covering:

(i) Progress against plan over the previous year.

(ii) A detailed plan for the coming year.

3.4.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice (although this will usually be given unless circumstances warrant otherwise) to require and receive:

(a) Access to all records (for patient records this will require approval by the Caldicott Guardian), documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature.

(b) Access at all reasonable times to any land, premises or employee of the Trust.

(c) The production of any cash, stores or other property of the Trust under an employee's control.

(d) Explanations concerning any matter under investigation.

3.5 Role of Internal Audit

3.5.1 Internal audit will review, appraise and report upon:

(a) The extent of compliance with and the financial effect of, relevant established policies, plans and procedures.

(b) The adequacy and application of financial and other related management controls.

(c) The suitability of financial and other related management data.

(d) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) Fraud and other offences.

(ii) Waste, extravagance and inefficient administration.

(iii) Poor value for money or other causes.

3.5.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature (of or pertaining to money), the Director of Finance must be notified immediately.

3.5.3 The Head of Internal Audit shall be accountable to the Director of Finance, where internal audit services are provided internally. Where internal audit services are provided by a third party organisation it will be the responsibility of the Director of Finance to manage the contract between the two organisations and agree a nominated individual to fulfil the role of Head of Internal Audit. At all times the Head of Internal Audit and internal audit services must remain independent and objective and must not be compromised by the role of the Director of Finance.

3.5.4 The Head of Internal Audit will normally attend the Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

3.5.5 The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. This agreement shall be in writing and shall comply with the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every 3 years or whenever a new internal audit provider is appointed.

3.6 External Audit

3.6.1 The external auditor is appointed by the Council of Governors and paid for by the Trust.

3.6.2 In accordance with NHS England's 'Code of governance for NHS provider Trusts':-

(a) The Council of Governors should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.

(b) Audit Committee shall:

(i) Make a report to the Council of Governors in relation to the performance of the external auditor, including detail such as the quality and value of the work, and the timeliness of reporting and fees, to enable the Council of Governors to consider whether to re-appoint them.

(ii) Make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.

(c) If the Council of Governors does not accept the recommendations from Audit Committee, the Board should include in the annual report a statement from the latter explaining the recommendation and should set out the reasons why the Council of Governors has taken a different position.

3.6.3 The Audit Committee must ensure a cost-efficient service by periodically seeking competitive tenders for the Trust's external audit service. Cost efficiency must not be used as a reason to compromise the quality of the external audit service and compliance with Code of Audit Practice issued by the National Audit Office.

3.6.4 Competitive tenders should be sought at least every 3 years, with an option to extend this to 5 years at the discretion of the Audit Committee. The reasons for agreeing to any extension must be clearly documented in the minutes of the meeting when it was discussed and agreed. The results of the tendering exercise should be reported to the Board.

3.6.5 Should there appear to be a problem with the external audit service being provided, then this should be raised with the external auditor and escalated appropriately within the external audit firm to ensure that the issue is resolved promptly and to the satisfaction of the Audit Committee.

3.6.6 If requested by the external auditor, during part of one Audit Committee meeting each financial year, executive directors and others normally in

attendance will be excluded from the meeting in order to allow private discussions between Audit Committee non-executive members and the external auditor.

3.6.7 The External Audit Engagement Lead and/or the Audit Manager will normally attend Audit Committee meetings.

4. FINANCIAL PLANNING, BUDGETS AND BUDGETARY CONTROL AND MONITORING

4.1 Preparation and Approval of Financial Plan and Budgets

4.1.1 The Chief Executive will compile and submit to the Board an annual financial plan that takes into account financial targets and forecast limits of available resources. The annual financial plan will contain:

(a) A statement of the significant assumptions on which the plan is based.

(b) Details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.2 The plan must take into account the views of the Council of Governors in accordance with the Constitution of The Rotherham NHS Foundation Trust and be submitted to NHS England in line with required deadlines.

4.1.3 The local Integrated Care System will be responsible for reviewing the Trust's financial plan as part of its co-ordinating role in compiling a system wide plan for submission to NHS England.

4.1.4 The Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. This will normally happen prior to the start of the financial year or in exceptional circumstances as soon as possible after the start of the financial year, but only in agreement with the Board. Such budgets will:

(a) Be in accordance with the aims and objectives set out in the annual business plan and also meet the necessary requirements within the Trust's terms of authorisation granted by NHS Improvement.

(b) Be consistent, wherever practical and possible, with national guidance and/or instructions.

(c) Accord with workload and workforce plans.

(d) Be produced following discussion with appropriate budget holders.

(e) Be prepared within the limits of available income, unless agreed otherwise by the Board.

(f) Identify potential risks and opportunities.

4.1.5 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board on a monthly basis.

4.1.6 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

4.1.7 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

4.2 In Year Changes to Budgets

4.2.1 With the exception of budget transfers and virements (see Appendix 6) there will be no changes to budgets in year unless duly authorised via the approval of a business case. Only expenditure that has already been budgeted for can be committed by budget holders and in accordance with their delegated spending limits.

4.2.2 The only corporate bodies with the authority to commit additional (net) expenditure on behalf of the Trust are:

(a) The Executive Team;

(b) Finance & Performance Committee;

and

(c) The Board;

in accordance with limits detailed in Appendix 6.

4.2.3 Where a workforce re-structure is proposed this must follow the establishment change process and only where additional costs are incurred would the above process need to be followed.

4.2.4 Where additional expenditure has already been approved in accordance with either Paragraphs 4.2.2 or 4.2.3 above and there is a likelihood that this resource will be insufficient to fulfil the objectives of the original business case then the budget holder must ensure that:

(a) This is brought to the attention of the Director of Finance as soon as is practicably possible;

(b) No additional expenditure is incurred beyond that already approved in the first instance;

(c) A revised business case is submitted in accordance with limits detailed in Appendix 6 for the additional expenditure to be incurred.

4.2.5 These requirements apply equally to both income and expenditure (see also Paragraph 7.2.4 below) and capital budgets.

4.3 Retrospective Approval for In Year Changes to Budgets

4.3.1 Under normal circumstances, all in year changes to budgets need to be

approved prospectively in accordance with Section 4.2 above before any additional expenditure is committed or incurred.

4.3.2 In exceptional circumstances, approval can be sought and granted retrospectively, but only with the approval of the Director of Finance who will be responsible for ensuring that the necessary governance arrangements are then followed in accordance with the limits detailed in Appendix 6.

4.3.3 Should the Trust come to a view that the expenditure thus committed and or incurred, prior to retrospective approval being granted, cannot be legitimately justified and supported via arrangements contained in Section 4.2 above, then the Director of Finance must:

(a) Consider the necessary actions required to expedite the cancellation of any existing and/or contractual commitments with a view to limiting the amount of any further unapproved expenditure to be incurred in the future;

(b) Escalate the matter in accordance with Section 2.4 above, for non-compliance.

4.3.4 Legitimate justification and support referred to in Paragraph 4.3.3 above, is a matter of subjectivity, but is intended to prevent any authorised signatories making decisions that cannot be substantiated appropriately via consideration of a proper business case.

4.4 Budgetary Delegation

4.4.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation will be in accordance with the financial plan and the Scheme of Delegation (See appendices 1 to 10), both approved by the Board.

4.4.2 The Director of Finance is responsible for maintaining the lists of authorised signatories and their delegated transactional financial limits. Managers are responsible for advising the Director of Finance of all changes in accordance with agreed procedures. An overview of budget delegation within the budgetary control process is diagrammatically presented in Appendix 2.

4.4.3 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.4.4 The Board, as advised by Finance & Performance Committee, will determine what action is necessary where budgetary totals are being exceeded, if appropriate action has not already been instigated by the Executive Team.

4.4.5 Any budgeted funds not required for their designated purpose(s) must be declared to the Director of Finance who will determine what action, if any is to be taken.

4.4.6 Non-recurring budgets must not be used to finance recurring expenditure.

4.5 Budgetary Control, Forecasting and Reporting

4.5.1 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, containing:

(i) Monthly income and expenditure to date showing trends and, as advised by the Director of Finance and/or requested by Finance & Performance Committee, forecast year-end position.

(ii) Monthly movements in working capital, including cash, where significant.

(iii) Capital scheme spend, commitments and forecast year-end position.

(iv) Explanations of any material variances from plan.

(v) Details of any corrective action where necessary and the Director of Finance's view of whether such actions are sufficient to correct the situation.

(vi) Details of the financial risk ratings and indicators of forward financial risk as set out in NHS England's Risk Assessment Framework.

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible. These will be produced monthly and will be made available to budget holders and authorised signatories in a format agreed by the Director of Finance.

(c) Investigation and reporting of variances from financial, activity and workforce budgets.

(d) Monitoring of management action to correct variances.

(e) Arrangements for the authorisation of budget transfers and virement.

4.5.2 Each budget holder is responsible for ensuring that:

(a) Any likely overspend or reduction of income, which cannot be met by virement, is not incurred without the formal approval of the Board. This will be achieved via the Board's acceptance of the monthly finance report produced by the Director of Finance.

(b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement.

(c) Permanent employees are appointed in accordance with agreed procedures and numbers provided for in the budgeted establishment as approved by the Board. Establishment will be reviewed annually as a minimum.

(d) Their use of temporary staff complies with Trust policies.

4.5.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual financial plan.

4.6 Capital Expenditure

4.6.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are contained in Chapter 13.

4.7 Monitoring Returns

4.7.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHS England and any other requisite monitoring organisations. These returns must be accurate and timely and key financial returns will be subject to review by the Director of Finance prior to submission.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance, on behalf of the Trust, will:

(a) Prepare annual accounts in accordance with International Financial Reporting Standards, as adjusted from time to time with accounting policies and guidance issued by the Department of Health & Social Care in its annually updated Group Accounting Manual, together with the Trust's own accounting policies and generally accepted accounting practice, as appropriate.

(b) Prepare and submit annual financial reports to NHS England certified in accordance with current guidelines.

(c) Submit financial returns to NHS England for each financial year in accordance with the prescribed timetable.

5.2 The annual accounts must be approved by the Board, although this may be delegated to the Audit Committee, which will then make recommendations to the Board, as appropriate.

5.3 The Trust's audited annual accounts must be presented to a public meeting within six months of the end of the financial year to which they relate.

5.4 The Trust will publish an annual report in accordance with its Constitution and in compliance with the NHS England's NHS foundation trust annual reporting manual 2022/23.

5.5 The annual report will be presented to the Council of Governors at a general meeting and similarly presented to the same public meeting as the annual accounts.

6. BANKING AND GOVERNMENT BANKING SERVICES

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by NHS England, which will be consolidated in a Treasury Management Policy.

6.1.2 The Board, via Audit Committee, shall approve the banking arrangements.

6.2 Bank and Government Banking Services Accounts

6.2.1 The Director of Finance is responsible for:

(a) Bank accounts and Government Banking Services accounts.

(b) Establishing separate bank accounts for funds held on trust on behalf of the Corporate Trustee.

(c) Ensuring payments made from bank or Government Banking Services accounts do not exceed the amount credited to the account except where arrangements have been made i.e. accounts should not become overdrawn without explicit prior approval.

(d) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 Banking Procedures

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and Government Banking Services accounts, which must include:

(a) The conditions under which each account is to be operated.

(b) The limit to be applied to any overdraft.

(c) Details of those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated. This will normally be achieved through the list of authorised signatories supplied to the bank.

6.3.3 All funds shall be held in the name of the Trust.

6.3.4 No employee other than the Director of Finance shall open any bank account in the Trust's name. For the Trust's main commercial bank and Government Banking Services, the Director of Finance has discretion to open the number

and type of accounts as necessary to expedite normal day-to-day business activities. For accounts to be used for investment of surplus cash these must be in accordance with the requirements of the Treasury Management Policy.

6.4 Tendering and Review

6.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

6.4.2 Competitive tenders should be sought at least every 3 years, with an option to extend this to 5 years at the discretion of the Audit Committee. The reasons for agreeing to any extension must be clearly documented in the minutes of the meeting when it was discussed and agreed. The results of the tendering exercise should be reported to the Board.

6.5 Electronic Transfer of Funds

6.5.1 All electronic transfers of funds must only be made under secure arrangements approved by the Director of Finance.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

7.2 Fees and Charges

7.2.1 The Trust shall follow guidance issued by the Department of Health and Social Care for the pricing of its patient related services with commissioners, supplemented by any additional guidance provided by NHS England.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health & Social Care or by statute. This should be incorporated into and documented in the financial planning process to ensure that this happens annually as a minimum.

7.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. This must be via prompt and regular presentation of cash transactions for banking or through the formal debt recovery process for credit income.

7.2.4 The Director of Finance, shall approve business cases for schemes where potential gross income generation exceeds £20,000 per annum (excluding VAT), in order to ensure profitability of such schemes to the Trust overall. Schemes with gross income above £20,000 will need to be approved, similar to business cases, in accordance with the limits referred to in Appendix 6.

7.2.5 The requirements outlined in paragraph 7.2.4 above equally apply to a discontinuation of, or disinvestment in a service or operation.

7.2.6 All contracts and/or service level agreements must be agreed by the Head of Contracts & Business Development who will then sign contracts under £100,000 and pass contracts over £100,000 for signing by the Director of Finance. All such contracts must be retained and stored securely by the Head of Contracts & Business Development.

7.3 Tendering for Services

7.3.1 A decision to submit a bid for services tendered by another organisation must be approved by the Chief Executive in accordance with the formal Business Case Process and Guidance document.

7.3.2 Once a decision has been made to submit a bid for services so tendered, the bid will be co-ordinated, prepared and presented in a form determined by the tender specification and process.

7.3.3 The financial elements of the tender bid must have been agreed by the Director of Finance.

7.3.4 The final tender bid must be approved prospectively in accordance with the financial limits contained in Appendix 6. A register of all submitted tenders will be maintained.

7.4 Debt Recovery

7.4.1 The Director of Finance is responsible for the appropriate recovery action for all outstanding debts. This will include the use of external debt recovery services, where appropriate.

7.4.2 Income not received should be dealt with in accordance with losses procedures described in Section 15.2 and delegated financial limits detailed in Appendix 9.

7.4.3 Overpayments should be detected (or preferably prevented) wherever is reasonably possible and recovery initiated.

7.5 Security of Cash, Cheques and Other Negotiable Instruments

7.5.1 The Director of Finance is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

(b) Ordering and securely controlling any such stationery.

(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines.

(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.5.2 Official Trust monies shall not under any circumstances be used for the encashment of private cheques.

7.5.3 All cheques, postal orders, and cash, shall be banked intact. Disbursements shall not be made from cash received under any circumstances.

7.5.4 The holders of safe keys shall not accept unofficial funds for depositing in their

safes under any circumstances.

7.5.5 The opening of post shall be undertaken by two employees together and all cash, cheques and other forms of payment shall be entered in an approved register before handing to the Director of Finance.

7.5.6 The opening of cash tills, telephones and other coin operated machines and the counting and recording of takings shall be recorded by two officers together. Both shall sign the records and the keys shall be held by a separate nominated officer.

8. CONTRACTING FOR PROVISION OF HEALTHCARE SERVICES

8.1 The Chief Executive is responsible for:

(a) Negotiating legal contracts with commissioners for the provision of services to patients in accordance with the financial plan; and for

(b) Establishing the arrangements for providing non-contract activity treatment services in accordance with the guidance contained in 'Who Pays? - Determining which NHS commissioner is responsible for making payment to a provider' published by NHS England and any other best practice guidance.

8.2 In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

(a) Costing and pricing of services.

(b) Payment terms and conditions.

(c) Amendments to contracts.

(d) Non-contract activity arrangements.

(e) Provision of contract data.

(f) Any other financial matters.

8.3 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.

8.4 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices shall comply with guidance issued by the Department of Health & Social Care and NHS England.

8.5 The Director of Finance shall produce regular reports detailing actual and forecast contract income linked to patient activity with a detailed assessment of the impact of the variable elements of income. These will be presented monthly for review to Finance & Performance Committee and the Board.

8.6 Any pricing of contracts at marginal cost must be approved by the Director of Finance and reported to the Board if material. Materiality is deemed to be when such contracts have a financial impact in excess of £100,000 (excluding VAT) in this instance.

8.7 The Chief Executive is responsible for ensuring procedures are in place to ensure all patient related activity is recorded appropriately and that flex and freeze dates for agreeing actual levels of activity against contracts are strictly adhered to in order to maximise the level of income received by the Trust.

8.8 Where the Trust wants to procure healthcare services from a third party organisation in order to deliver its contractual obligations with one or more of its commissioners, then this will:

(a) Require a business case to be approved in accordance with Section 4.2 above and financial limits contained in Appendix 6; and

(b) Be undertaken by the Procurement Department, consistent with the requirements contained in Chapter 11.

8.9 Submission of bids for services tendered by another organisation must be undertaken in accordance with the requirements of Section 7.3.

9. TERMS OF SERVICE AND PAYMENT OF ALL STAFF

9.1 Remuneration and Terms of Service

9.1.1 In accordance with Standing Orders, the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Trust's Remuneration Committee will:

(a) Review the ongoing appropriateness and relevance of the Trust's remuneration policy.

(b) Agree the appropriate remuneration and terms of service for the Chief Executive and other executive directors, including:

(i) All aspects of salary (including any performance-related elements/bonuses).

(ii) Provisions for other benefits, including pensions and cars.

(iii) Arrangements for termination of employment and other contractual terms.

(c) Monitor the evaluation of the performance of individual executive directors.

(d) Advise on and oversee appropriate contractual arrangements for executive directors including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

(e) Approve remuneration or other awards made to executive directors outside of contractual obligations only with the approval of HM Treasury, where applicable.

(f) Monitor compliance with Off Payroll Working (IR35): Deemed employer responsibilities under off-payroll working rules.

(g) Monitor redundancy and capitalised pension costs for all staff groups and to approve any such individual arrangements in excess of £100,000.

The Remuneration Committee will take into account the principles contained in NHS England's 'Code of governance for NHS provider Trusts' when exercising its responsibilities.

9.1.3 There shall be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration of individual executive directors. No executive director should be involved in deciding their own remuneration.

9.1.4 Whilst the Board may delegate decision-making about remuneration to the Remuneration Committee, it remains accountable for taking decisions on the remuneration and terms of service of executive directors.

9.1.5 The Trust will remunerate the Chairman and non-executive directors in accordance with instructions issued by the Council of Governors.

9.2 Funded Establishment

9.2.1 The people plans incorporated within the annual business plan and budgets will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive, in accordance with the requirements of establishment control procedures agreed by the Director of People.

9.2.3 Increases to funded establishments can only be approved in accordance with Section 4.2 and financial limits contained in Appendix 6.

9.2.4 The funded establishment of any department may not be exceeded without the prior approval of the Director of Finance and subject to authorised powers of virement contained in Appendix 5.

9.3 Staff Appointments

9.3.1 No employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) Unless authorised to do so by the Chief Executive and in accordance with the requirements of establishment control procedures agreed by the Director of People; and

(b) Within the limit of their approved budget and funded establishment.

9.3.2 The arrangements for securing the services of temporary (agency) staffing must follow establishment control procedures agreed by the Director of People in accordance with :

(a) Master vendor arrangements for all medical staff; and

(b) NHS Professionals for all other staff.

The only exception to this is Board level posts, which will be dealt with as and when required by the Nominations Committee.

9.3.3 The Board will approve procedures presented by the Director of People and Director of Finance for the determination of pay rates and conditions of service, for groups of staff not linked to national terms and conditions whose period of employment has not yet commenced. This relates to the initial establishment of local terms and conditions, which can then be supplemented by the requirements contained in Section 9.4 below.

9.3.4 When appointing staff, authorised signatories must ensure that:

(a) The recruitment, selection and contracting processes are consistent with Trust policies.

(b) Any offer of employment complies with the appropriate terms and conditions of employment for that category of staff.

(c) Appropriate documentation is completed prior to the offer of employment being made and immediately on commencement of duty with the Trust or to a new post within the Trust.

9.3.5 Where a budget holder requires to deviate from national terms and conditions, or locally agreed terms and conditions where these exist, for an individual member of staff, this will need to be prospectively approved jointly by the Director of Finance and the Director of People prior to an offer of employment being made.

9.4 Changes to Rates of Pay

9.4.1 Proposals to pay individual members of existing staff other than in accordance with national terms and conditions, or locally agreed terms and conditions where these exist, will need to be prospectively approved jointly by the Director of Finance and the Director of People.

9.4.2 Proposals to pay groups of existing staff other than in accordance with national terms and conditions, or locally agreed terms and conditions where these exist (for example, changes in rates of pay for bank staff or local on call arrangements) should be approved in the form of a business case and in accordance with the financial limits contained in Appendix 6. There is provision for retrospective approval to support operational and clinical decision making in exceptional circumstances (See Section 4.3 above).

9.4.3 Where proposals outlined in Paragraph 9.4.2 are approved, a post implementation review should be carried out and reported to the Director of Finance and Director of People, with the outcome presented to the Finance & Performance Committee.

9.5 E-Rostering

9.5.1 Staff rosters will be maintained electronically in the E-Allocate system and will be managed and controlled in accordance with procedures agreed by the Director of People.

9.5.2 A separate list of authorised signatories will be maintained by the Director of People in order to ensure compliance with the aforementioned procedures.

9.5.3 An interface will be managed and controlled by the Director of People to ensure appropriate access to e-rosters by NHS professionals in accordance with the aforementioned procedures.

9.6 Processing of Payroll

9.6.1 The Director of People is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other notifications.

(b) The final determination of pay, jointly with the Director of Finance.

(c) Making payment on agreed dates.

(d) Agreeing the method(s) of payment.

9.6.2 The Director of People will issue instructions, having taken appropriate advice from the Director of Finance, regarding:

(a) Verification and documentation of data.

(b) The timetable for receipt and preparation of payroll data and the payment of employees.

(c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay.

(d) Security and confidentiality of payroll information.

(e) Checks to be applied to the completed payroll before and after payment.

(f) Authority to release payroll data under the provisions of the Data Protection Act 2018.

(g) The payment of pay awards and arrears.

(h) Procedures for the change of bank account details by staff.

9.6.3 The Director of Finance will issue instructions regarding:

(a) Methods of payment available to various categories of employee.

(b) Procedures for payment by cheque or bank credits to employees.

(c) Procedures for the recall of cheques and bank credits.

(d) Pay advances and their recovery.

(e) Maintenance of regular and independent reconciliation of pay control accounts.

(f) Separation of duties between the preparation of records and the handling of cash and other types of payment.

(g) A system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

(h) The secure operation of the system for payments by BACS.

9.5.4 Budget holders have delegated responsibility for:

(a) Submitting time records, and other notifications in accordance with agreed timetables.

(b) Completing time records and other notifications in accordance with instructions and in the form prescribed by the Director of People.

(c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of People must be informed immediately and prompt action taken as necessary to prevent any over-payments arising.

This must be consistent with the requirements of establishment control procedures agreed by the Director of People and transactional financial limits detailed in Appendices 3 and 4, as appropriate.

9.5.5 Regardless of the arrangements for providing the payroll service, the Director of People, having taken appropriate advice from the Director of Finance, shall ensure that payments made by the payroll function are supported by appropriate contracted terms and conditions, adequate internal controls and audit review procedures where appropriate.

9.5.6 The Director of Finance will ensure that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.7 <u>Contracts of Employment</u>

9.6.1 All contracts of employment shall be in a format agreed by the Director of People, in conjunction with the Remuneration Committee, as appropriate.

9.6.2 The Board shall delegate responsibility to a budget holder for:

(a) Ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation (see also Paragraphs 9.3.3 and 9.3.4);

and

(b) Dealing with variations to, or termination of, contracts of employment (save for instances arising from clause 9.4); in accordance with the requirements of establishment control procedures agreed by the Director of People.

9.6.3 Where termination of employment involves redundancy (voluntary or compulsory) agreements or any other form of contractual payments, this shall require formal and prospective approval from the Director of Finance or the Remuneration Committee if individually in excess of £100,000 as per Paragraph 9.1.2 (g) above. He or she will seek appropriate advice, as necessary, from the Director of People before making any such decision.

9.6.4 All payments outside contractual obligations (for example, compromise agreements) require formal and prospective approval from the Remuneration Committee to approve a submission to HM Treasury. All payments outside contractual obligations require prospective HM Treasury approval, irrespective of value.

10. NON-PAYROLL EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

10.1.2 No employee shall commit or authorise expenditure unless they have delegated authority to do so.

10.1.3 As part of the approval of annual budgets, as set out in section 4.1, the Board will approve non-pay budgets.

10.1.4 Authorised signatories have delegated authority to commit or authorise non-pay expenditure up to the budget, for the purpose of the budget, subject to the transactional financial limits set out in Appendices 3 and 4.

10.1.5 Virement of budget is permissible within the Trust's approved rules and limits (See Appendix 5).

10.1.6 **Requisitions and Orders:** In line with best practice, most goods or services will be ordered through the Procurement Department (via web-based requisitioning) following a requisition raised by an authorised signatory. A list of goods and services where an official purchase order may not be required will be agreed, maintained and held by the Director of Finance and made available via the intranet.

A single requisition may involve, for example, the requisition of a contract involving a number of annual payments; these payments are added together to determine the transactional financial limit.

Requisitions may not be split or otherwise placed in a manner devised so as to avoid the transactional financial limits.

Requisitions should be placed prior to any goods or services being received and must not be used as a means to retrospectively comply with these instructions.

10.1.7 **Signing of Contracts or Licences:** An order for goods or service may result in a contract or license to be signed by both the Trust and the supplier. All contracts must be agreed by the Head of Procurement who will then sign contracts under £100,000 (excluding VAT) and pass contracts over £100,000 (excluding VAT) for signing by the Director of Finance. All such contracts must be retained and stored securely by the Head of Procurement.

10.1.8 **Authorisation of Invoices:** Most invoices relating to goods requisitioned and purchased via an order issued by the Trust do not require authorisation. The Finance Department will match the Goods Received Note to the invoice and invoice value, and resolve any differences, seeking assistance from

authorised signatories where this is necessary.

Invoices not matched in the way described above, will require authorisation before payment in accordance with delegated transactional financial limits.

10.2 Procedures for Obtaining Goods and Services

10.2.1 In choosing the item to be supplied (or the service to be performed), the advice of the Procurement Department shall be sought in order to obtain value for money and, as far as possible, meet the sustainability obligations of the Trust.

10.2.2 The only exceptions to the above are the Pharmacy Department, which is permitted to procure drugs without seeking the advice of Procurement and patient bespoke Orthotics procurement.

10.2.3 Where the advice of Procurement is not accepted by an authorised signatory, the Director of Finance (and/or the Chief Executive) shall be consulted and may approve procurement contrary to the advice received, as long as the Trust complies with statutory requirements.

10.2.4 Goods may not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

10.2.5 The procedure that the Trust shall follow to raise official orders and the authorised signatory's role in this is set out in Chapter 11. All orders must:

(a) Be consecutively numbered in batches, as controlled by the Head of Procurement, unless automatically system generated.

(b) Be in a form approved by the Director of Finance.

(c) State the Trust's terms and conditions of trade.

(d) Only be generated based on the delegated authority of the appropriate signatory as detailed in Appendices 3 and 4.

(e) Be authorised in accordance with procedures determined by the Director of Finance. All orders in excess of £1,000,000 (excluding VAT) must have already been approved in accordance with limits referred to in Appendices 3 and 4.

10.2.6 No order shall be issued for any item or items to any firm that has made an offer of gifts, rewards or benefit to directors or employees, other than isolated gifts of a trivial character or inexpensive seasonal gifts.

10.2.7 All contracts for example; leases, tenancy agreements and other commitments that may result in a liability shall be notified to the Director of Finance.

10.2.8 These Standing Financial Instructions apply equally to goods and services

relating to funds held on trust, see Appendix 10 for delegated financial limits.

10.2.9 No verbal instructions, without an official order number, are to be given to suppliers of goods and services.

10.2.10 No orders are to be raised after goods and services have already been supplied unless in accordance with agreed procedures approved by the Director of Finance.

10.2.11 No orders to be raised with suppliers of goods and services where the authorised signatory is related to an individual who will directly benefit from that order or, the authorised signatory has a financial interest with that supplier. The Trust's Standards of Business Conduct (including NHS England Conflicts of Interest Guidance) provide further information regarding personal and business integrity and instances where a close family or personal relationship may give rise to a conflict of interest or the perception of such.

10.3 Confirmation of Receipt for Goods and Services

10.3.1 The system for receipt of goods and services shall provide for:

(a) Details of employees authorised to certify invoices (see Paragraph 4.3.2).

(b) Certification that goods have been duly received, examined and are in accordance with specification and the prices are correct.

(c) Certification that work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct.

(d) In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined.

(e) Where appropriate, that the expenditure is in accordance with regulations and all necessary authorisation has been obtained.

(f) The account is arithmetically correct.

(g) The account is in order for payment.

(h) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

10.4 Payment for Goods and Services

10.4.1 The Director of Finance is responsible for the prompt payment of accounts and claims, and these shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.4.2 The Director of Finance is responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

10.4.3 The Director of Finance is responsible for designing and maintaining procedures regarding the use and control of purchasing cards.

10.4.4 The Director of Finance is responsible for ensuring that payment for goods and services is only made once the goods and services are received unless in line with contractual terms and conditions imposed by the supplier, subject to the provisions contained in Paragraph 10.4.5.

10.4.5 Pre-payments, other than those specified by contractual terms and conditions imposed by the supplier, are only permitted where exceptional circumstances apply. In all such instances, the advice of both the Director of Finance and the Head of Procurement should be sought before entering into any contractual arrangements. In such instances:

(a) The budget holder must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments. Any proposals must be discussed with the Head of Procurement before submitting a request to the Director of Finance.

(b) The Director of Finance may approve the prepayment arrangement to progress if:

(i) The proposed arrangements takes into account the European Union Public Procurement Policy where the contract is above a stipulated financial threshold;

and

(ii) The financial advantage outweighs the disadvantages.

10.4.6 The budget holder is responsible for ensuring that all items due under a pre-payment contract are received and they must immediately advise the appropriate Director or Chief Executive if problems are encountered.

10.5 Petty Cash

10.5.1 Purchases from petty cash are restricted in value and by type of purchase as detailed in Appendix 7 and must be supported by receipt(s) and certified by an authorised signatory within their delegated limit.

10.5.2 The Director of Finance will determine record keeping and other instructions relating to petty cash.

11. TENDERING AND CONTRACTING FOR NON-PAYROLL EXPENDITURE

11.1 Delegated Authority

11.1.1 All tendering and contracting must be carried out by the Procurement Department with the exception of Pharmacy. However, the Procurement Department should still be involved to provide guidance and support, as appropriate, to ensure procurement in this area is undertaken in accordance with the requirements of these Standing Financial Instructions.

11.1.2 No employee is to enter into commercial discussions with potential or actual suppliers without the full agreement and involvement of the Procurement Department.

11.1.3 All contracts will:

(a) Be within the Trust's powers as delegated by the Secretary of State.

(b) Comply with relevant Department of Health & Social Care guidance as advised by the Head of Procurement.

(c) Incorporate the Standard NHS terms and conditions.

(d) Endeavour to obtain best value for money.

(e) Be compliant with the latest government guidance and policy regarding transparency within procurement.

11.1.4 Further details are provided in the Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy) which sets out the framework within which all procurement in the Trust should be undertaken.

11.2 Procedure for Procurement of Non-Payroll Items

11.2.1 Paragraph 10.2.2 provides for the procurement of drugs to be undertaken through the Pharmacy Department, where the Chief Pharmacist will follow similar procurement procedures to those set out below. Relevant paragraphs below equally apply to patient bespoke Orthotics procurement.

11.2.2 Authorised signatories will requisition the required goods or services. All requisitioners will be required to follow the ordering procedures set by the Procurement Department, as referred to in the Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy).

11.2.3 The Procurement Department will follow the processes outlined for the procurement of goods, services, and works in accordance with the financial limits detailed in Appendix 8.

11.2.4 Formal tendering is not required if goods and services are obtained via a framework contract put in place by a recognised body and which is open for

the Trust to utilise. This work will still be undertaken by the Procurement Department.

11.2.5 The Procurement Department will endeavour to obtain best value for money on all of its activity.

11.2.6 **Quotations – Goods, Services and Works:** A minimum of three written quotations are required where the contract value is expected to be between £10,000 and £35,000 (excluding VAT) for goods and services, and between £50,000 and £200,000 (excluding VAT) for works, unless using an already competitively tendered contract (excluding works). For spend below £10,000 for goods and services, and below £50,000 for works, then a value for money check must be completed by the budget holder along with Procurement input. Any contract entered into by the Trust regardless of value must be completed by Procurement and signed as per Paragraph 10.1.7 even those below the thresholds identified in this section. Competitive quotations should be:

(a) Obtained based on specifications or terms of reference prepared by, or on behalf of, the budget holder.

(b) Obtained in writing and published via an e-tendering platform, which includes sending the opportunity through to Contracts Finder for publication.

(c) Treated as confidential and should be retained for inspection.

(d) Evaluated by the Procurement Department in conjunction with the budget holder or delegated officer to select the quotation giving the best value for money. If this is not the lowest quotation, if payment is to be made by the Trust; or the highest, if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record. The Procurement Department will advise on which quotation should be accepted.

11.2.7 **Formal Tendering – Goods or Services and Works:** Where the likely contract value exceeds £35,000 for goods or services, and £200,000 for works, formal tendering will be undertaken.

Where a requirement for goods or services is likely to cost in excess of £35,000 and requisitions for works in excess of £200,000 is known, the budget holder will work with the Procurement Department on a formal tender process unless a framework can be used as referred to in Paragraph 11.2.4 above. The Procurement Department will lead the tendering process in conjunction with the budget holder.

11.2.8 Items estimated to be below the quotation and/or tender limits that subsequently exceed these limits shall be reported to the Director of Finance and Audit Committee along with circumstances where formal procedures have in effect been waived without approval to do so.

11.3 Procedure for Competitive Tendering

11.3.1 Trust standard tendering documentation must be used at all times unless agreed by the Head of Procurement.

11.3.2 The tender specification must be robust and impartial.

11.3.3 Trust tendering procedures must at all times adhere to the transparency agenda set by the European Union and the UK Government. All tenders will be undertaken through the Trust's electronic tendering system. This shall enable suppliers to be alerted that there is a contract opportunity available, in line with the government's transparency agenda.

11.3.4 Tenders will be returned to an 'electronic safe' locked until the due date for the receipt of bids from invited suppliers. As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the tenders shall be opened by the Procurement Department.

11.3.5 The Head of Procurement, as guardian for the e-tendering system, is responsible for ensuring all tenders are treated as confidential and retained for inspection. The system provides a register of the names of all firms or individuals invited to tender, those from which tenders have been received and the date these tenders were opened.

11.3.6 There is generally no discretion to receive tenders after the due date. In exceptional circumstances, the Head of Procurement may approve the inclusion of a late tender. This will only be approved if there is a technical reason why the tender could not be submitted and this reason must be ratified by the e-tendering system supplier.

11.3.7 Acceptance of Tender:

(a) Any clarification questions from the Trust to a tenderer that are deemed necessary to clarify technical aspects of the tender before the award of a contract must be undertaken via the Procurement Department and not directly by the budget holder. All questions must be sent via the e-tendering portal for transparency purposes.

(b) The most economically advantageous tender shall be accepted as determined by the tender evaluation criteria set by the tender project team at the start of the tender process.

(c) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive. This will be in accordance with the requirements of Paragraph 4.2 above and financial limits contained in Appendix 6.

(d) The Procurement Department will advise on the award of a contract to a supplier and provide a written de-brief to the unsuccessful bidders. Under no circumstances should an individual outside of the Procurement Department de-brief a supplier.

(e) A duly completed formal contract document (terms and conditions) shall be issued by the Procurement Department for authorisation by the Head of Procurement, or Director of Finance if the contract is related to a private finance initiative/lease agreement or its value is over £100,000.

(f) Following completion of the signed contract, an order should be raised for the goods, services or works.

11.3.8 The Head of Procurement will report to the Board on an exceptional circumstance basis as required by the Chief Executive.

11.3.9 Procurement will ensure that appropriate contract management arrangements are put in place for all accepted tenders in relation to contracts in excess of £500,000 per annum to ensure:

(a) Best value is maintained.

(b) Variations are controlled.

(c) Service continuity is maintained.

(d) Risk is managed.

11.4 Frameworks

11.4.1 The Head of Procurement will ensure the Trust's register of suppliers suitable for the supply of goods or services is kept via the Trust's contracts database. The Head of Procurement will also access such other registers available for use by the NHS.

11.4.2 The Head of Procurement will determine which register (framework agreements) may be used.

11.4.3 The Head of Procurement shall ensure all tenders provide open competition and comply with relevant Department of Health & Social Care guidance.

11.4.4 This does not preclude the assessment at either, or both, pre-qualification questionnaire or evaluation of tender stage, of contractor suitability in for example:

(a) Experience and qualifications.

(b) Understanding of the Trust's needs.

(c) Feasibility and credibility of proposed approach.

(d) Viability to deliver the goods or services.

(e) Health and safety record.

(f) Environmental considerations.

(g) Financial standing - Director of Finance responsibility.

(h) Clinical governance - Medical Director responsibility.

11.5 Waiving of Quotation and Tender Requirements

11.5.1 Quotation and tender limits are detailed in Appendix 8. Consideration of the need for a waiver of quotation/tendering requirements may occur where:

(a) In very exceptional circumstances, formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record.

(b) Specialist expertise or goods and services are required and are available from only one source.

(c) The task is essential to complete the project and arises as an unforeseen consequence of a recently completed assignment and engaging a different supplier for the new task would be inappropriate.

(d) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

(e) Permitted by Department of Health & Social Care guidance; details of which shall be documented in waiving formal tendering.

11.5.2 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure.

11.5.3 In addition to Paragraph 11.5.1 above, a waiver shall not be required under the following conditions:

(a) Turnkey costs where a tender has been compliantly run for the associated equipment and where a Quantity Surveyor has deemed the turnkey costs to be in line with market value.

(b) The payment is for non-domestic rates.

(c) The payment is for mandatory NHS related fees such as CNST payments, etc.

11.5.4 The goods purchased for equipment specific parts which must, by their nature, be from the original manufacturer and where a cost effectiveness analysis of the current equipment solution has been conducted within the last 12 months to the satisfaction of the Head of Procurement. Where it is decided that competitive tendering is not applicable and therefore, the requirements of Standing Financial Instructions should be waived, the fact of the waiver and the reasons should be documented using the waiver form obtained from the Head of Procurement. Details of both authorised and unauthorised waivers will be reported to the Audit Committee.

11.5.5 All requests to progress with waivers must receive prior approval. All such non-competitive action will require the completion of a waiver form. Waiver forms should be initially sent to the Head of Procurement to review and authorise, if appropriate. Waiver forms require authorisation as set out in accordance with the financial limits detailed in Appendix 8.

11.5.6 It should be noted that European Procurement Law applies at all times and in particular to proposed procurements in excess of the financial thresholds (Official Journal of the European Union limits) appertaining at the time. This cannot be waived and the Procurement Department will advise budget holders as to how compliance can be achieved.

11.5.7 The Audit Committee may, at its discretion, invite regular users of the waiver and non-competitive action procedures, to explain the need and to advise how this action may be avoided.

11.5.8 The Head of Procurement will provide ongoing reports to the Audit Committee detailing the use made of waivers.

11.6 Auctions

11.6.1 Should the Trust choose to access auctions (of any kind) as a process for procurement, this must be done through the Procurement Department and the Director of Finance must be assured the process complies with best practice guidelines.

12. EXTERNAL BORROWING AND INVESTMENTS

12.1 Finance & Performance Committee

12.1.1 The terms of reference for Finance & Performance Committee include overseeing all aspects of cash management as well as external borrowing (including temporary overdraft facilities and Public Dividend Capital) and investments.

12.1.2 The Finance & Performance Committee must operate within its terms of reference established by the Board.

12.1.3 The terms of reference will be reviewed annually.

12.2 Public Dividend Capital

12.2.1 The Trust must always initially seek to maximise sources of funding other than borrowing to fund its capital investment.

12.2.2 Subject to paragraph 12.2.1, the Trust must always seek to maximise the amount of public dividend capital available to it, as appropriate, prior to considering any form of external borrowing (including finance leasing) to fund its capital investment.

12.2.3 The Director of Finance must report to the Board as and when public dividend capital is to be drawn down or repaid.

12.2.4 Repayments of public dividend capital must be approved prospectively by the Board.

12.3 External Borrowing

12.3.1 The Director of Finance will advise the Board, as part of the annual financial planning process, concerning the Trust's ability to pay interest on, and repay the capital element of both public dividend capital and any other borrowing within any limits or restrictions set by NHS England.

12.3.2 All applications concerning external borrowing, either short-term or long-term must be approved prospectively by the Board. In this instance, borrowing excludes finance leases but does include planned temporary overdraft facilities with the Trust's commercial bankers.

12.3.3 All short-term borrowing must be proactively managed as part of a planned approach to monitoring and controlling total working capital with a view to minimising individual and cumulative borrowing applications.

12.3.5 All long-term borrowing must be consistent with the Trust's current financial plan and must not exceed any limits or restrictions set by NHS England.

12.3.4 Under no circumstances must long-term borrowing be used other than to

support capital investment.

12.3.5 The Director of Finance is responsible for reporting periodically, but regularly, to the Board, via Finance & Performance Committee concerning all borrowing, which as a minimum must be annually as referred to in paragraph 12.3.1 above.

12.4 Investments

12.4.1 Temporary cash surpluses must be held in such public or private sector investments in accordance with the Treasury Management Policy approved by the Board.

12.4.2 The Director of Finance is responsible for advising the Board on the investment of surplus cash and will report quarterly, as necessary, to Finance & Performance Committee and annually to the Board concerning the performance of investments held.

12.4.3 The Director of Finance will prepare detailed procedural instructions for the investment of surplus cash and on the records to be maintained.

13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

13.1 Capital Investment

13.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.

(c) Shall ensure that the capital investment is not undertaken without confirmation of commissioner(s) support, where appropriate, and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 For every appropriate capital expenditure proposal, the Chief Executive shall ensure that a business case is prepared, in line with the approved Business Case Process and Guidance document.

13.1.3 For capital schemes where the contracts stipulate stage payments, the Director of Finance will ensure that this is reflected appropriately in contractual terms and conditions that are communicated effectively between all parties involved.

13.1.4 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall approve each scheme and issue to the manager responsible :

(a) Specific authority to commit expenditure.

(b) Authority to proceed to tender.

(c) Approval to accept a successful tender, subject to the requirements of Standing Orders

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with Health Building Note 00-08 (Parts A and B) guidance and the Trust's Standing Orders.

13.1.6 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.2 Post Project Evaluation

13.2.1 Post project evaluation will be undertaken, as a minimum, on all capital investments where the business case is approved by the Board. The post project evaluation will be reviewed by the Board.

13.2.2 The project evaluation shall be produced in line with the approved Business Case Process and Guidance document.

13.3 Private Finance Initiative and Leasing

13.3.1 The Trust should normally test for private financing or leasing when considering capital procurement. When the Trust proposes to use private financing or leasing (regardless of whether the lease is an operating or finance lease), the following procedures shall apply:

(a) The proposal must obtain approval commensurate with that which is required of assets, goods or services obtained by outright purchase.

(b) The budget holder for the associated private financing/lease cost must authorise that the costs are acceptable within their managed budget.

(c) The Director of Finance shall demonstrate that the financing represents value for money and genuinely provides the desired transfer of risk.

(d) Any finance or lease document must be signed by the Director of Finance (see Paragraph 10.1.7).

(e) The proposal must comply with any guidance issued by NHS England.

13.4 Capital Delegated Limits

13.4.1 All initial allocations for capital schemes within the constraints of the Board approved programme will be set by the Director of Finance.

13.4.2 Following the subsequent tendering/quotation action and the approval of the business case the Director of Finance must give approval before any expenditure is committed in line with procedures contained in the Policy and Guidance for the Procurement of Goods, Services and Works (procurement Policy).

13.4.3 The delegated transactional financial limits detailed in Appendix 4 relate to the subsequent authorisation of all expenditure including staff-related costs, requisitions, orders and invoices. All procurement is subject to the procedures set out in Chapter 11.

13.5 Asset Registers

13.5.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted at least once a year.

13.5.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within this register shall be as determined by the Director of Finance taking account of any guidance issued by the Department of Health & Social Care.

13.5.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties.

(b) Stores, requisitions and payroll records for own materials and labour including appropriate overheads.

(c) Lease agreements in respect of assets held under a finance lease and capitalised.

13.5.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices, where appropriate, and in accordance with procedures approved by the Director of Finance.

13.5.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in the ledger against balances on the fixed asset register.

13.5.6 The value of each asset will be depreciated in accordance with methods and rates determined by the Director of Finance consistent with the requirements of relevant International Financial Reporting Standards, as interpreted by the Department of Health & Social Care within its Group Accounting Manual.

13.5.7 The Director of Finance will calculate capital charges in accordance with:

(a) Useful economic asset lives and the Trust's accounting policies for depreciation; and

(b) In accordance with the Department of Health and Social Care's Group Accounting Manual for public dividend capital dividends payable.

13.6 Security of Assets

13.6.1 The overall control of fixed assets is the responsibility of the Chief Executive.

13.6.2 Asset control procedures, including donated assets, must be approved by the Director of Finance. These procedures shall make provision for:

(a) Recording managerial responsibility for each asset.

(b) Identification of additions and disposals.

(c) Identification of all repairs and maintenance expenses.

(d) Physical security of assets in accordance with the Trust's Security Policy.

(e) Periodic verification of the existence of, condition of, and title to, assets recorded.

(f) Identification and reporting of all costs associated with the retention of an asset.

13.6.3 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Director of Finance.

13.6.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of all authorised signatories in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with the Trust's Security Policy.

13.6.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by employees in accordance with the procedure for reporting losses (See Chapter 15 and Appendix 9).

13.6.6 Where practical, assets should be marked as Trust property.

13.6.7 The Chief Executive shall be responsible for establishing and maintaining separate records for equipment on loan from suppliers and items provided through operating lease arrangements (See the Policy and Guidance for the Procurement and Payment of Goods, Services and Works (Procurement Policy)).

14. STORES AND RECEIPT OF GOODS

14.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) Kept to a minimum.

(b) Subjected to annual stock take.

(c) Valued in accordance with the Trust's accounting policies as determined by the Director of Finance taking account of the requirements of International Financial Reporting Standards.

14.2 Subject to the responsibility of the Director of Finance for the systems of control, overall control of stores shall be the responsibility of an officer delegated by the Chief Executive. The day-to-day responsibility may be delegated to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oils the responsibility of a designated Estates Officer.

14.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the officer delegated by the Chief Executive and agreed with the Director of Finance. Wherever practicable, stocks should be marked as health service property.

14.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores, losses and materials management.

14.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

14.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

14.7 The designated officer shall be responsible for a system, approved by the Director of Finance, for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also Chapter 15). Procedures for the disposal of obsolete stock shall be determined and agreed by the Director of Finance.

15. DISPOSALS, CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

15.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance.

(b) Disposed of in accordance with a Board approved policy.

(c) Recorded by the Condemning Officer, who must be an authorised signatory at budget holder level or above, in a form approved by the Director of Finance that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

15.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

15.2 Losses and Special Payments

15.2.1 Losses and special payments are divided into categories, as defined below. These categories are:

Losses (excluding family practitioner services):

1. Losses of cash.
2. Fruitless payments and constructive losses.
3. Bad debts and abandoned claims.
4. Stores losses and damage to property.

Special payments (excluding family practitioner services):

5. Compensation under court order or legally binding arbitration award.
6. Extra-contractual payments.
7. Ex-gratia payments.
8. Special severance payments.
9. Extra statutory and extra regulatory payments.

15.2.2 The Director of Finance is responsible for ensuring that suitable procedural instructions are produced for the reporting, recording and accounting of all losses and special payments in accordance with the guidance issued by the Department of Health & Social Care. The Director of Finance must also prepare a Counter Fraud, Bribery and Corruption Policy that sets out the action to be taken in the event of a suspected fraud being detected.

15.2.3 Any employee discovering or suspecting a loss of any kind must notify their line manager immediately, who will ensure the incident is reported in line with the requirements of the Incident and Serious Incident Management Policy. Where a criminal offence is suspected, involving theft or arson, the police will be informed in accordance with the arrangements set down in the Trust's Security Policy. For all suspected losses, actions should be taken without undue delay having regard to the potential seriousness of the loss in each individual case.

15.2.4 The Director of Finance must ensure that all individual losses and special payments above £50 are reported to the Audit Committee and that smaller losses are reported in aggregate. A report of losses apparently caused by theft, arson, neglect of duty or gross carelessness must be made to the Audit Committee as soon as practicable, and must also be similarly reported to the external auditor.

15.2.5 The Board shall approve the writing-off of losses and the making of special payments in accordance with the approved financial limits detailed in Appendix 9.

15.2.6 The Director of Finance shall be authorised to take necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.7 For any loss, the Director of Finance should consider whether any insurance claim can be made or any other action taken to recover some of the loss.

15.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded. Details will be entered as they are known. Where an actual value cannot be immediately determined an estimated value should be inserted. The precise format of the register will be determined by the Director of Finance.

15.2.9 Audit Committee will review updates to the Losses and Special Payments Register at each of its scheduled meetings.

16. FINANCIAL SYSTEMS AND DATA

16.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage.

(b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment.

(d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews, as he or she may consider necessary, are being carried out.

(e) Ensure, as appropriate, compliance with the requirements of the relevant Data Protection Acts.

(f) Ensure that appropriate data back-up and recovery arrangements are in place.

16.2 The Director of Finance shall satisfy hat new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

16.3 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy that:

(a) Systems acquisition, development and maintenance are in line with

corporate policies.

(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists.

(c) Finance and other appropriate staff have access to such data.

(d) Such computer audit reviews, as are considered necessary, are being carried out.

17. PATIENTS' PROPERTY

17.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

(a) Notices and information booklets.

(b) Hospital admission documentation and property records.

(c) The verbal advice of administrative and nursing staff responsible for admissions.

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.4 Where Department of Health & Social Care instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

17.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.6 Where a deceased patient is intestate and there is no lawful next of kin, details of any monies or valuables held should be notified to the Treasury solicitor.

17.7 Any funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any of that patient’s monies held by the Trust.

17.8 Staff should be informed, on appointment, by the appropriate manager of their responsibilities and duties for the administration of the property of patients.

17.9 Where patients' property is received for specific purposes and held for

safekeeping the property shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with guidance contained in The Records Management Code of Practice for Health and Social Care 2016 issued by the Information Governance Alliance.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents held in accordance with the above shall only be destroyed at the express instigation of the Chief Executive and records shall be maintained of documents so destroyed.

19. RISK MANAGEMENT & INSURANCE

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management, which will be approved and monitored by the Board.

19.2 The risk management strategy (see Risk Management Policy) shall, as a minimum, contain the following elements:

(a) The continuous identification and prioritisation of key risks.

(b) A description of actions taken to manage each key risk.

(c) The identification of how risk is measured.

19.3 The programme of risk management shall include:

(a) A process for identifying and quantifying risks and potential liabilities.

(b) Engendering among all levels of staff a positive attitude towards the control of risk.

(c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk.

(d) Contingency plans to offset the impact of adverse events.

(e) Audit arrangements including; internal audit, external audit, clinical audit, health and safety review.

(f) Arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make an annual governance statement within the Annual Report and Accounts as referred to in the Department of Health & Social Care's Group Accounting Manual.

19.4 The Director of Finance shall ensure that appropriate insurance arrangements exist in accordance with the risk management programme covering both the Trust and the Charity.

20. FUNDS HELD ON TRUST

20.1 General

20.1.1 All relevant sections of this document equally apply to funds held on trust, which are managed by the Corporate Trustee and registered with the Charity Commission under the charity name of the Rotherham Hospital and Community Charity.

20.1.2 There are, however, certain exceptions and specific requirements that only apply to funds held on trust, which are explained further in this section.

20.1.3 In all aspects of managing funds held on trust, the Corporate Trustee must be mindful of relevant legislation and best practice guidance issued by the Charity Commission.

20.2 External Audit

20.2.1 The external auditor is appointed by the Corporate Trustee and paid for from funds held on trust.

20.2.2 The Corporate Trustee must ensure a cost efficient service by periodically seeking competitive tenders for this service. Cost efficiency must not be used as a reason to compromise the quality of the external audit service.

20.2.3 Competitive tenders should be sought at least every 3 years, with an option to extend this to 5 years at the discretion of the Corporate Trustee Committee. The reasons for agreeing to any extension must be clearly documented in the minutes of the meeting when it was discussed and agreed.

20.2.4 Should there appear to be a problem with the external audit service being provided then this should be raised with the external auditor and escalated appropriately within the external audit firm to ensure that the issue is resolved promptly and to the satisfaction of the Corporate Trustee.

20.3 Budgets, Authorisation of Expenditure and Transactional Financial Limits

20.3.1 No budgets are set for funds held on trust.

20.3.2 All expenditure must be authorised and transacted in accordance with the delegated financial limits detailed in Appendix 10.

20.3.3 The Charity must manage its expenditure within its totality of income overall and commensurate with its policy on reserves.

20.4 Annual Accounts and Reports

20.4.1 The Director of Finance, on behalf of the Corporate Trustee, will:

(a) Prepare annual accounts in accordance with Financial Reporting Standards applicable in the UK, as adjusted from time to time with accounting policies and guidance issued by the Charity Commission, the Charity's own accounting policies and generally accepted accounting practice.

(b) Produce an annual report for funds held on trust, which will comply with the provisions of the latest Statement of Recommended Practice (Charities SORP (FRS102) - Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland)

(c) Prepare and submit financial returns to the Charity Commission for each financial year in accordance with the prescribed timetable.

20.4.2 The formal published annual accounts and report must be received and approved by the Corporate Trustee and cannot be delegated.

20.5 <u>Bank Accounts</u>

20.5.1 All funds shall be held in the name of the Charity.

20.5.2 Only the Director of Finance has the authority to open any bank account in the Charity's name. They have the discretion to open the number and type of bank accounts as necessary to expedite normal day-to-day business, including the investment of surplus cash.

2.5.3 No arrangements shall be made with the Charity's bankers for accounts to be overdrawn. This should not happen and any instances should be reported to the Charitable Funds Committee.

20.6 <u>Income</u>

20.6.1 All gifts, donations and proceeds of fund raising activities that are intended for the Charity's use shall be handed immediately to the Director of Finance to be banked directly.

20.6.2 All gifts and donations shall be received and held in the name of the Charity and administered in accordance with the Charitable Funds Policy, subject to the specific objects for any restricted or designated funds.

20.6.3 Where it becomes necessary for the Charity to obtain a grant of representation in order to obtain a legacy due to the Charity under the terms of a will, the Director of Finance shall be the Trust's nominee for this purpose. Where appropriate, the Director of Finance shall seek legal advice upon the liabilities and other implications for the Charity of obtaining any such grant of representation.

20.6.4 All employees of the Trust who receive enquiries regarding legacies, shall

keep the Director of Finance informed and shall keep an appropriate record. After the death of a benefactor, all correspondence concerning a legacy shall be dealt with by the Director of Finance who will be solely responsible for legally acknowledging receipt of such monies on behalf of the Charity.

20.6.5 The Director of Finance shall advise the Corporate Trustee on the financial implications of any proposal for fund raising activities that the Charity may initiate, sponsor or approve.

20.7 Terms of Service and Payment of Staff

20.7.1 Any staff working directly on behalf of the Charity will not be directly employed by the Charity. They will be employed by the Trust in accordance with the requirements of Chapter 9 above and their pay costs recharged to the Charity.

20.7.2 Any associated non-pay costs associated with their employment with the Trust will be similarly recharged to the Charity.

20.7.3 Any non-recurrent restructuring costs e.g. redundancy costs, etc. incurred by the Trust associated with staff working directly on behalf of the Charity will be similarly recharged.

20.7.4 The Director of Finance will ensure that sufficient funds are available within the Charity to be able to absorb any such costs so recharged.

20.8 Expenditure

20.8.1 All expenditure from funds held on trust, with the exception of legitimate expenses for management and administration, must be in accordance with the specific objects for individual funds, as appropriate.

20.8.2 Expenditure must not result in further commitments and or liabilities for either the Charity or the Trust unless these have been fully identified and adequately funded.

20.9 Investments

20.9.1 In order to discharge its duties as Corporate Trustee the Charity must:

(a) Know and understand its investment powers.

(b) Discharge its duties properly when it takes decisions on investments.

(c) Have proper arrangements in place for holding investments on behalf of the Charity.

(d) Follow legal requirements if it is going to use someone to manage investments on its behalf.

(e) Know what it can and cannot do if it is going to apply an ethical

approach to investments.

(f) Seek professional external advice where appropriate.

20.9.2 These duties should be undertaken in accordance with a clearly defined investment strategy for the Charity, which is kept under regular review.

20.9.3 The Corporate Trustee may choose to adopt one of several approaches to investment management - advisory, discretionary or collective – and seek appropriate advice in arriving at that decision.

20.9.4 All investment decisions must be formally reported to both the Charitable Funds Committee and the Corporate Trustee. For the latter, presentation of the minutes from the previous meeting of the Charitable Funds Committee will be sufficient.

20.10 Capital Expenditure

20.10.1 Other than in exceptional circumstances and agreed by the Corporate Trustee, any capital investment incurred by the Charity will be directly for the benefit of the Trust rather than the Charity itself and hence, will be accounted for as assets on the balance sheet of the Trust and not the Charity.

20.11 Reserves

20.11.1 The Corporate Trustee is responsible for determining a policy on reserves in accordance with Statements of Recommended Practice issued by the Charity Commission.

20.11.2 This requires the Corporate Trustee to include in the Charity's annual report information about its reserves policy and the level of reserves held. In particular, the Corporate Trustee should:

(a) Describe its reserves policy.

(b) Explain why it holds or does not hold reserves.

(c) Quantify and explain the purpose of any material restricted, designated or endowment funds and, where set aside for future expenditure, the likely timing of that expenditure.

(d) Give the level of reserves at the last day of the financial year to which the report relates.

Scheme of Delegation – Appendices 1 to 10

APPENDIX 1: LIST OF DIVISIONS[1]

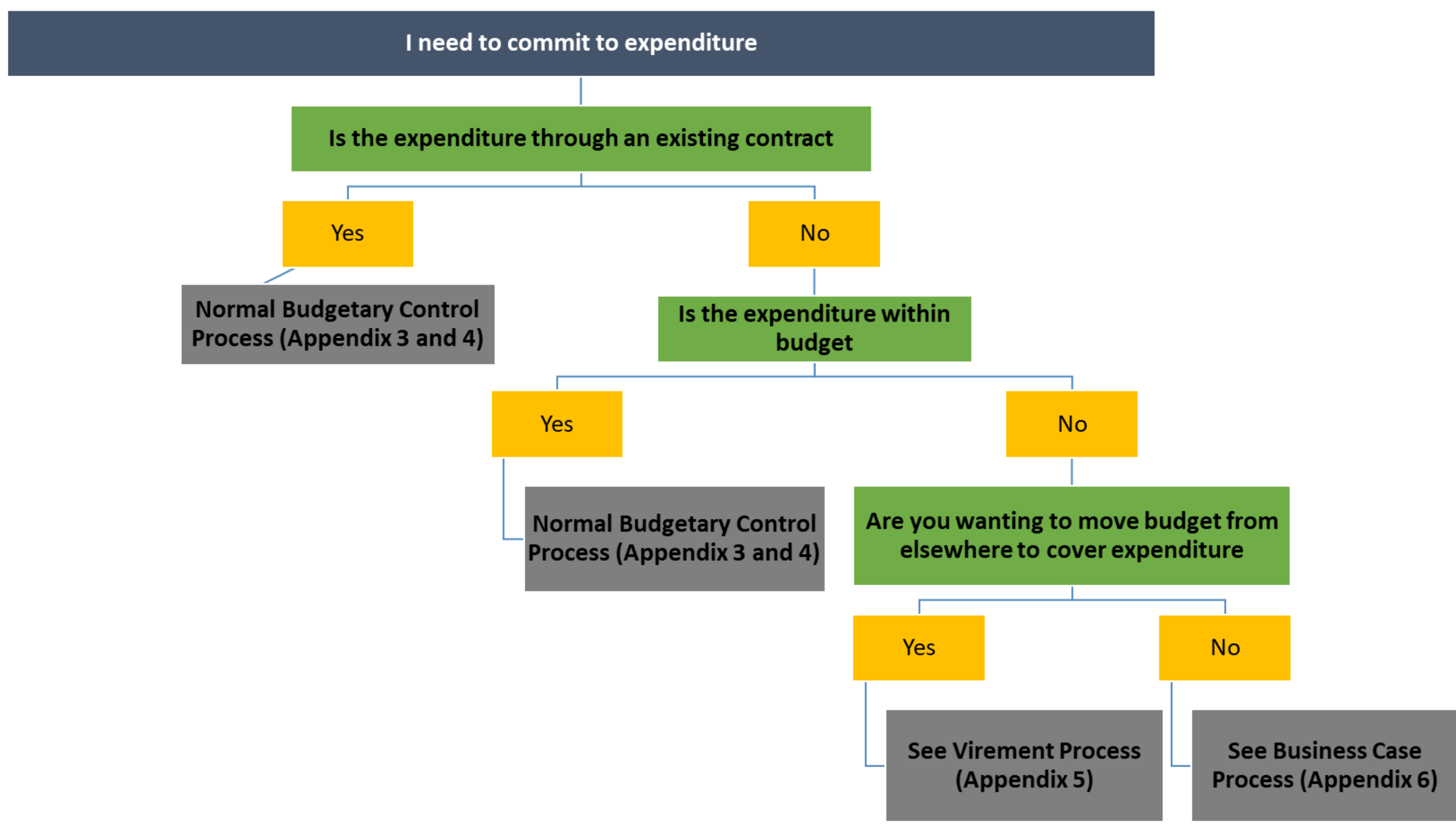
A	**:**	Care Group 1
B	**:**	Care Group 2
C	**:**	Care Group 3
E	**:**	Managing Director
F	**:**	Company Secretary
G	**:**	Director of Finance
H	**:**	Chief Operating Officer
I	**:**	Income[1]
J	**:**	Medical Director
K	**:**	Chief Nurse
L	**:**	Director of People
N	**:**	Chief Executive
O	**:**	Care Group 4
Z	**:**	Central Income & Costs[2]

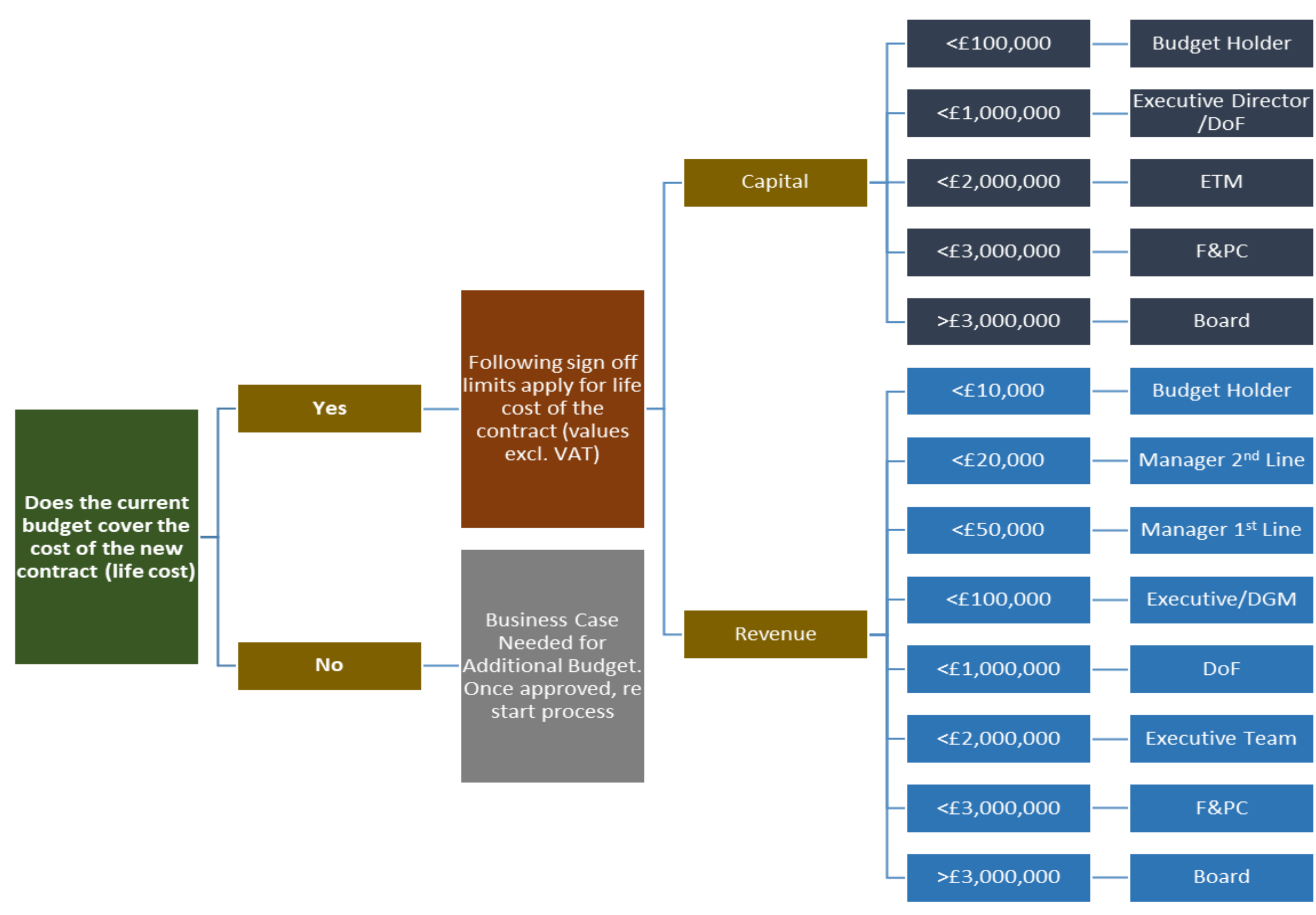
1. A Division will consist of:

   - Several cost centres that constitute a Service Unit;
   - Several service units that constitute a Management Team;
   - Several management teams that constitute a Division.
   - The sum of divisions constitutes the Trust.

2. These are managed by the Director of Finance on behalf of the Board.

APPENDIX 2: OVERVIEW OF BUDGET DELEGATION WITHIN THE BUDGETARY CONTROL PROCESS




Does the current budget cover the cost of the new contract (life cost)
Yes
No
Following sign off limits apply for life cost of the contract (values excl. VAT)
Business Case Needed for Additional Budget. Once approved, re start process
Capital
Revenue
<£100,000
Budget Holder
<£1,000,000
Executive Director /DoF
<£2,000,000
ETM
<£3,000,000
F&PC
>£3,000,000
Board
<£10,000
Budget Holder
<£20,000
Manager 2nd Line
<£50,000
Manager 1st Line
<£100,000
Executive/DGM
<£1,000,000
DoF
<£2,000,000
Executive Team
<£3,000,000
F&PC
>£3,000,000
Board

APPENDIX 3: BUDGET DELEGATION AND FINANCIAL LIMITS FOR AUTHORISED SIGNATORIES - REVENUE FUNDS

Standing Financial Instruction 4.4.1 allows the Chief Executive to delegate management of a budget to permit the performance of a defined range of activities. This appendix details the budgets so delegated on the understanding that the requirements of Standing Financial Instructions 4.4.2, 4.4.3, 4.4.5, 4.4.6, 4 . 5 . 2 , 10.2.1, 10.2.4 and 10.2.7 will be strictly adhered to.

The budgets delegated include generic subjective (income, pay and non-pay) headings referenced to the objective (cost centre) headings identified for each Service Unit and Division. The generic headings are consistent with those contained in the Trust's annual accounts as defined in the Department of Health & Social Care's Group Accounting Manual, whilst the objective headings reflect the Trust's internal management and budgetary reporting structure.

The extent of delegation to budget holders will be reviewed annually by the Chief Executive and approved by the Board.

Within these budgets, the following transactional financial limits apply:

Authorised	Limit (£)[1]
Budget Holder (Maximum of two per cost centre)	£5,000
Manager 2nd in line to an Executive or Care Group General Manager	£20,000
Manager 1st in line to an Executive or Care Group General Manager	£50,000
Executive/Care Group General Manager & Deputy Director of	£100,000
Director of Finance[2,3,4]	£1,000,000
Executive Team[2,3,4]	£2,000,000
Finance & Performance Commitee[2,3,4]	£3,000,000
Board[2,3,4]	No limit

1. Figures exclude VAT.
2. For the approval of procurement contracts before being ordered as in 3 or 4 below.
3. Transactions that need to be physically signed will be done so by the Director of Finance and/or Chief Executive.
4. Transactions that need to be approved electronically will be done so by the Deputy Director of Finance or the Director of Finance.

A detailed organisational structure populated with named authorised signatories is maintained and available on the Trust's intranet.

Some cost centres may have additional requisition points attached to them, which are not shown here. If there is any confusion about cost centres and/or requisition points please contact the Financial Management section of the Finance Department.

Cost centres may be added to the above list during the financial year to which these Standing Financial Instructions and Scheme of Delegation apply. This can only be done with the prior approval of the Director of Finance.

Responsibility for such new cost centres will be delegated to the appropriate budget holder referred to above and will be subject to the same transactional financial limits referred to above and subsequently included on the organisational structure available on the Trust's intranet.

The budget allocated to each cost centre will be consistent with the annual financial plan approved by the Board, updated for any in year changes approved by the Director of Finance, Executive Team or the Board. The total adjusted budget available will be shown in monthly budget statements issued by the Director of Finance and the monthly finance reports to Finance & Performance Committee and the Board.

Initial base budgets produced as part of the annual business plan must be signed-off at divisional or Executive Director level.

APPENDIX 4: BUDGET DELEGATION AND FINANCIAL LIMITS FOR AUTHORISED SIGNATORIES - CAPITAL FUNDS

Standing Financial Instruction 13.1.5 authorises the Chief Executive to issue a scheme of delegation for capital investment management. This appendix details the budgets so delegated on the understanding that the requirements of Standing Financial Instructions 4.4.2, 4.4.3, 4.4.5, 4.4.6, 4.5.2, 10.2.1, 10.2.4 and 10.2.7 will be strictly adhered to.

The budgets delegated include generic subjective (pay and non-pay) headings referenced to the objective (cost centre) headings identified for each Scheme Manager. The generic headings are consistent with those contained in the Trust's annual accounts as defined in the Department of Health & Social Care's Group Accounting Manual, whilst the objective headings reflect the Trust's internal management and budgetary reporting structure.

The extent of delegation to budget holders will be reviewed annually by the Chief Executive and approved by the Board.

Within these budgets, the following transactional financial limits apply:

Authorised	Limit (£)[1]
Budget Holder	£100,000
Project Director/Executive Director	£1,000,000
Director of Finance[2,3,4]	£1,000,000
Executive Team[2,3,4]	£2,000,000
Finance & Performance Committee[2,3,4]	£3,000,000
Board[2,3,4]	No limit
1. Figures exclude VAT. 2. For the approval of procurement contracts before being ordered as in 3 or 4 below. 3. Transactions that need to be physically signed will be done so by the Director of Finance and/or Chief Executive. 4. Transactions that need to be approved electronically will be done so by the Deputy Director of Finance or the Director of Finance.	

A detailed organisational structure populated with named authorised signatories is maintained and available on the Trust's intranet.

Cost centres may be added to the above list during the financial year to which these Standing Financial Instructions and Scheme of Delegation apply. This can only be done with the prior approval of the Director of Finance.

Responsibility for such new cost centres will be delegated to the appropriate budget holder referred to above and will be subject to the same transactional financial limits referred to above and subsequently included on the organisational structure available on the Trust's intranet.

The budget allocated to each cost centre will be consistent with the annual business

plan approved by the Board, updated for any in year changes approved by the Director of Finance, the Executive Team or the Board. The total adjusted budget available will be shown in monthly budget statements issued by the Director of Finance and the monthly finance reports to Finance & Performance Committee and Board.

Due to the nature of certain capital schemes that necessarily involve expenditure on building work, engineering work and/or professional fees, the Director of Estates & Facilities is authorised to commit expenditure on behalf of the budget holder.

Additionally, where services are subject to potential VAT recovery, the Director of Finance, via the Head of Financial Services will be necessarily involved in committing professional fees to identify the extent of such VAT.

Any queries regarding the budget available for any particular capital scheme should be addressed to the Deputy Director of Finance or the Head of Financial Services.

APPENDIX 5: VIREMENT RULES AND FINANCIAL LIMITS

This appendix sets down the powers of virement available, both recurrently and non-recurrently, in accordance with Paragraphs 4.2.1 and 4.4.3.

Recurrent Revenue Virement

Budget holders are authorised to vire recurrent savings and under-spends from one budget heading to offset or reduce an existing recurrent overspend on another budget heading. Thus, the impact upon the total budget will be neutral, which will be confirmed by the Director of Finance as part of the monthly budgetary control process.

Recurrent savings and under-spends cannot be utilised to develop new recurrent initiatives.

Recurrent savings or under-spends of a significant nature, as determined by the Director of Finance in discussion with the appropriate Finance Manager, must be identified and transacted as a cost improvement plan or alternatively declared to the Director of Finance for discussion about their potential use.

Non-Recurrent Revenue Virement

Non-recurrent savings or under-spends of a significant nature, as determined by the Director of Finance in discussion with the appropriate Finance Manager, must be declared to the Director of Finance for discussion about their potential use. What this means in reality is that such a saving or under-spend occurring year to date cannot be used to commit unbudgeted expenditure in a future period, unless formally approved by the relevant Executive Director, Care Group General Manager or Deputy Director of Finance (i.e. £100,000 authorised signatory as per Appendix 3). This must be in accordance with an agreed procedure for exceptional spend requests, as approved by the Director of Finance. The maximum value for individual exceptional spend requests must not exceed £5,000 plus VAT, otherwise it will need formal approval of the Executive Team in accordance with the latest Business Case Process and Guidance document.

Non-Recurrent Capital Virement

Capital scheme bids must have robust estimates prepared before funding can be allocated. This must give a clear indication of the split between the cost of works (i.e. building and engineering costs, inclusive of any professional fees) and the cost of equipment. For information technology schemes, this is likely to be split between implementation costs and the cost of equipment and intangible purchases. Any savings or under-spends on either of these two elements within a capital scheme in each case cannot be used for virement between each other unless this is necessary to:

(a) Maintain the overall scheme cost within the total scheme budget allocated;

(b) Maintain the total cost of schemes within a total portfolio budget allocated;

and is

(c) Formally approved in accordance with the limits detailed below.

Otherwise, their impact must be declared as part of year-end out-turn forecasts reported to the Board.

In this instance, a portfolio budget is considered to be the budget allocated across several schemes being managed collectively but individually by the Director of Estates & Facilities and the Director of Health Informatics.

Where a capital scheme is constituted entirely by cost of works or entirely by equipment costs, the budget must be used to fund only those items included within the original estimate. Any savings or under-spends generated from the actual costing of the original specifications cannot be used to enhance the nature of the scheme without prior approval of the Executive Team, Finance & Performance Committee or the Board in accordance with authorisation limits contained in Appendix 6. This equally applies to information technology and any other schemes per se.

Capital virement is subject to the following limits:

(a) Virement of up to 5% of the total scheme costs, up to a maximum of £50,000 is allowed at the discretion of the budget holder without any prior approval.

(b) Virement of between 5% and 10% of the total scheme costs, up to a maximum of £100,000 must be approved by the Director of Finance.

(c) Virement in excess of 10% or £100,000 of the total scheme costs, whichever is the lower must be approved by the Executive Team or the Board in accordance with authorisation limits contained in Appendix 6.

For example:

(a) Scheme Cost £200,000

- Maximum virement approved by the budget holder is 5% i.e. £10,000.
- Maximum virement approved by the Director of Finance is a further 5% i.e. £10,000 giving a total of £20,000.
- Any virement above £20,000 must be approved by the Executive Team in accordance with authorisation limits contained in Appendix 6.

(b) Scheme Cost £1,000,000

- Maximum virement approved by the budget holder is 5% i.e. £50,000.
- Maximum virement approved by the Director of Finance is a further 5% i.e. £50,000 giving a total of £100,000.
- Any virement above £100,000 must be approved by the Executive Team, Finance & Performance Committee or the Board in accordance with authorisation limits contained in Appendix 6.

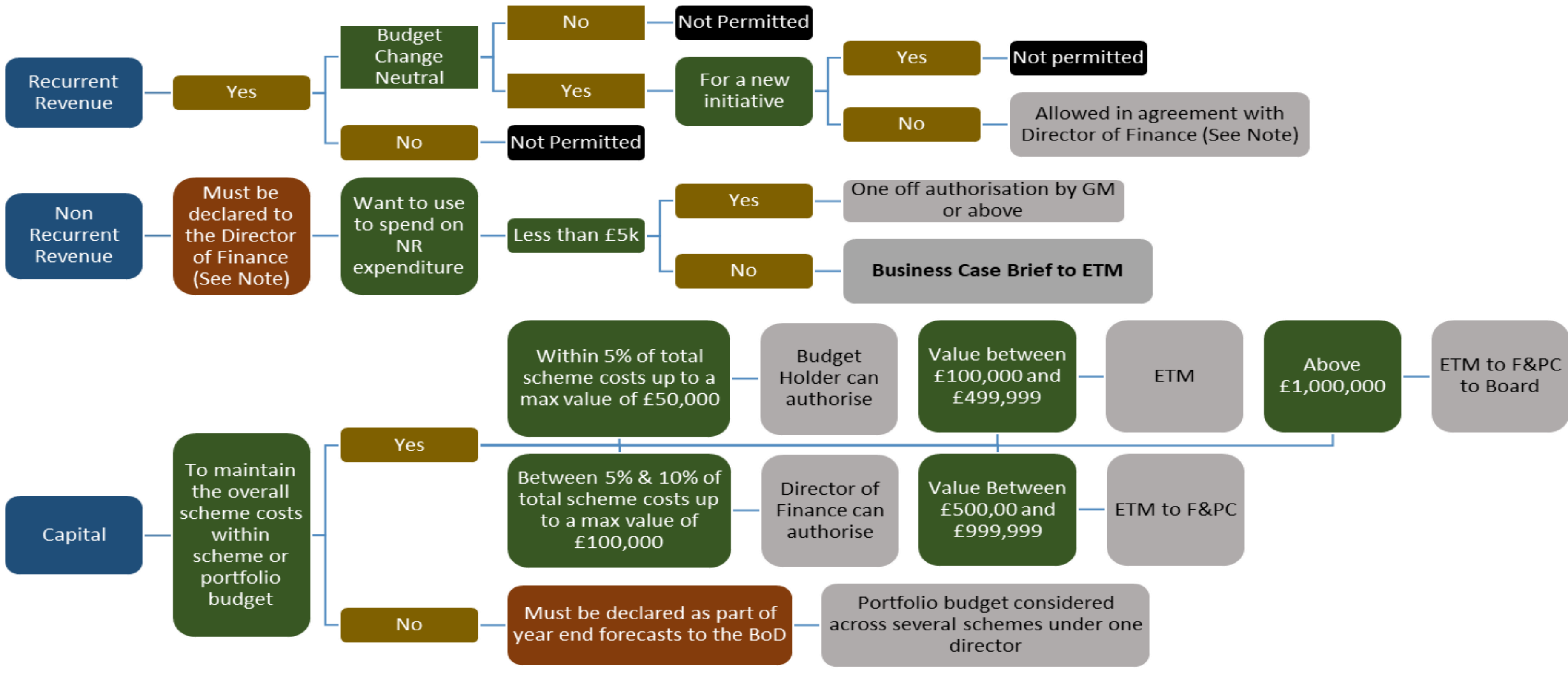
(c) Scheme Cost £2,000,000

- Maximum virement approved by the budget holder is 2.5% i.e. £50,000.
- Maximum virement approved by the Director of Finance is a further 2.5% i.e. £50,000 giving a total of £100,000.
- Any virement above £100,000 must be approved by the Executive Team, Finance & Performance Committee or the Board in accordance with authorisation limits contained in Appendix 6.

Any savings or under-spends on one capital scheme cannot be used for virement to fund additional expenditure on another capital scheme without approval of the Executive Team, Finance & Performance Committee or the Board in accordance with authorisation limits contained in Appendix 6.

Capital virement that does not need formal approval of the Executive Team will be managed and controlled via the Capital Monitoring Group.

OVERVIEW OF VIREMENT RULES AND FINANCIAL LIMITS



Note: Reference to the Director of Finance is implicit rather than explicit, by acceptance/recognition of the monthly out-turn results reported through the budgetary control process.

APPENDIX 6: FINANCIAL LIMITS FOR IN YEAR CHANGES TO BUDGETS

In accordance with paragraph 4.2.1 with the exception of budget transfers and virement (see Appendix 5), there will be no changes to budgets in year unless duly authorised. Only expenditure that has already been budgeted for can be committed by budget holders and in accordance with their delegated spending limits.

The only corporate bodies with the authority to commit additional (net) expenditure on behalf of the Trust and their authorisation limits are detailed below:

Authority	**Limit (£)[1,2,3]**
Director of Finance and Managing Director (Via Executive Team)[4]	<£250,000
Chief Executive (Via Executive Team)[4]	£250,000 & <£500,000
Finance & Performance Committee	£500,000 & <£1,000,000
Board	£1,000,000 & above
1. Figures exclude VAT. 2. Figures apply to a mix of annual recurrent and total non-recurrent transactions. 3. Figures are applied gross to income or expenditure, whichever is the greater. 4. By exception and entirely at their discretion, if authority is given in between Executive Team meetings, with such decisions being formally minuted at the next meeting of the Executive Team. Normally authority would be expected to be given following discussion at the appropriate meeting of the Executive Team and formally minuted as part of the record for that meeting.	

No other committee or group has authority to commit additional expenditure on behalf of the Trust.

It would normally be expected that any business case would be scrutinised by all levels of authority relative to the financial limit involved. For example:

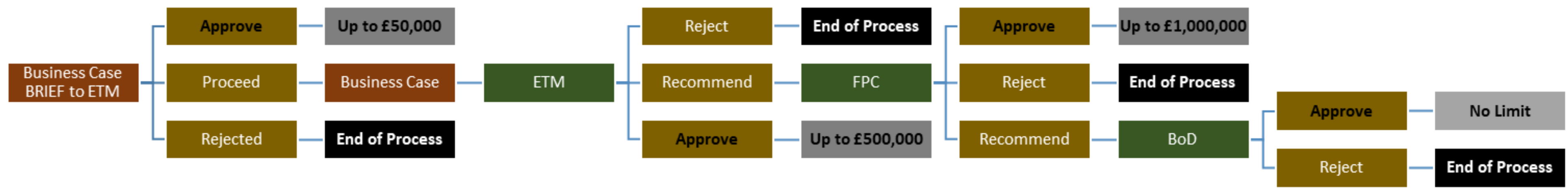
(a) A business case that requires £200,000 recurrent investment can be approved by the Director of Finance or the Managing Director following a paper presented to the Executive Team meeting.

(b) A business case that requires £300,000 recurrent investment and £250,000 non-recurrent investment to support its implementation would need to be approved by both the Executive Team and Finance & Performance Committee.

(c) A business case for capital replacement of a significant piece of medical equipment costing £1,200,000 would need to be approved by the Executive Team, Finance & Performance Committee and Board.

These limits equally apply to the virement rules contained in Appendix 5, as appropriate, income generation schemes and discontinuation of, or disinvestment in a service or operation, as referred to in paragraphs 7.2.4 and 7.2.5.

All business cases will need to be produced following the latest Business Case Process and Guidance document.



These limits are then subject to further approval externally as follows:

Where a NHS Foundation Trust is deemed to be in financial distress, as formally determined by NHS England:

Authority	**Limit (£)**[1,2]
Board	Up to £25,000,000
NHS England and DHSC Joint Investment Sub-Committee (JISC)	£25,000,001 & £30,000,000
NHS England and DHSC Joint Investment Sub-Committee (JISC)	£30,000,001 & £50,000,000
NHS England and DHSC Joint Investment Committee (JIC) and HM Treasury[3]	Above £50,000,000

1. Figures **include** VAT.
2. Figures apply to capital investment and property transactions (non-digital) and digital (self-funded), asset disposal and whole-life cost business cases.
3. Business cases exceeding £50,000,000 either capital cost or whole-life costs, will require approval from NHS England and DHSC Joint Investment Committee and HM Treasury, except for Electronic Patient Records funded by the central frontline digitisation capital.
4. In all cases the Trust should follow guidance contained in NHS England's publication "Capital Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts" published in February 2023.

APPENDIX 7: FINANCIAL LIMITS FOR PETTY CASH

In accordance with Paragraph 10.5.1, the delegated transactional financial limits for petty cash are detailed below:

Description	Limit (£)[1]
Return of patients' cash	Up to the amount of cash deposited for safe-keeping
Payment of patients' fares or funeral expenses for which the Trust is liable	Up to the amount of fares paid or funeral expense
All other petty cash payments	£100
1. Figures exclude VAT.	

Petty cash shall not under any circumstances be used for the encashment of private cheques.

APPENDIX 8: PROCUREMENT PROCESS QUOTATION AND TENDER FINANCIAL LIMITS

Goods and Services

Procedure	**Limit (£)**[1]
Obtain best value.	<£10,000
If no contract exists, obtain a minimum of 3 written quotations.	£10,000 & <£35,000
Formal tendering via the Procurement Department. Advice will be given on the process to be followed.	£35,000 & <OJEU Threshold Limit[2]
Formal tendering complying with OJEU requirements to be undertaken by the Procurement Department. If insufficient tenders are received, a further procurement exercise may be necessary.	>OJEU Threshold Limit
Procure via the use of the Trust's measured term contract or OJEU tender.	Works <£200,000
Formal tendering via the Procurement Department. Advice will be given on the process to be followed.	Works >£200,000
1. Figures exclude VAT. 2. Official Journal of the European Union. Guidance on financial thresholds for different categories of expenditure is available from the Procurement Department.	

Works

Limit (Total Contract Value) Works [1]	**Procedure**
<£50K	No quotation process: • Obtain best value
>£50K-£200K	Informal quotes: • Minimum of 3 informal quotes • Price only or cost/quality/social value evaluation • E-tendering portal not mandatory but can be used • All quotes must be submitted with the requisition • Most advantageous quote will be successful **OR** (up to £100k) Direct appointment via Measured Term Contract (MTC) if appropriate
>£200K – Find a tender (was OJEU[2])	Formal quotes: • Minimum of 3 formal quotes • One local quote where possible[3] • Cost/quality/social value evaluation • E-tendering portal mandatory; advertising optional • Most advantageous quote will be successful

Find a tender (was OJEU[2])	• E-tendering portal mandatory • Advertise on relevant portals • Cost/quality/social value evaluation • Most advantageous tender will be successful

Notes:

1. Excluding VAT.
2. Currently £5,336,937 inclusive of VAT at the prevailing rate.
3. Local to be defined as a base within South Yorkshire & Bassetlaw or with an "S/DN" post code.

Waiving of quotation and tender requirements in accordance with Paragraph 11.5 require authorisation in accordance with the financial limits detailed below:

Authority	**Limit (£)[1]**
Head of Procurement	< £50,000
Director of Finance or Chief Executive	£50,000 & <£100,000
Director of Finance and Chief Executive acting jointly	£100,000 & <£250,000
Chairman/Board	Above £250,0000
1. Figures exclude VAT.	

APPENDIX 9: FINANCIAL LIMITS FOR LOSSES AND SPECIAL PAYMENTS

Authority	Limit (£)[1]
Budget holder	< £250
Director of Finance and Deputy Director of Finance acting jointly	£250 & <£1,000
Audit Committee	£1,000 & <£10,000
Board	Above £10,000
1. Figures exclude VAT.	

These delegated spending limits only apply to the specific circumstances outlined below.

Delegated limits excluding losses and special payments in category 5 (Compensation under court order or legally binding arbitration award) and also payments relating to clinical negligence and personal injury claims within category 7 (Special severance payments).

Budget holders have authority to write-off losses and approve special payments that occur within their area of responsibility, up to a value of £250 per item. These must be approved by an appropriate authorised signatory as designated within the Trust's scheme of delegation and be forwarded to the Director of Finance for action.

All items between £250 and £1,000 will be considered jointly by the Director of Finance and Deputy Director of Finance.

All items with a value in excess of £1,000 must have completed a checklist, as appropriate, in a format prescribed by and prepared by the Director of Finance. To avoid delays in making payments to third parties, approval of losses can be agreed jointly by two executive directors, one of which must be the Director of Finance. All such approvals will be reported through to, and formally ratified by, Audit Committee or the Board at its next available meeting.

Delegated limits and procedures for Category 5 payments and payments in respect of clinical negligence and personal injury claims within Category 7.

Where preliminary analysis concludes that the claim is thought to be valid, approval will be sought to settle. For all claims, including all clinical negligence cases, the Medical Director will notify NHS Resolution in accordance with the Trust's Claims Handling Policy. The Trust will only be liable for any amount up to its agreed level of excess.

APPENDIX 10: AUTHORISATION OF EXPENDITURE AND TRANSACTIONAL FINANCIAL LIMITS - TRUST FUNDS

In accordance with Paragraph 20.3.2 the following financial limits apply for the authorisation of expenditure from funds held on trust.

Authority[1]	**Limit (£)**[2]
Head of Fundraising	<£5,000
Any Trustee acting individually	£5,000 & <£10,000
2 x Trustee's acting jointly	£10,000 & <£25,000
Charitable Funds Committee	£25,000 & <£50,000
Corporate Trustee	No limit
1. Due to timing issues, if it is not practical to defer a decision until the next meeting of the Charitable Funds Committee, approval can be given as indicated and then reported to the next meeting of the said Committee. 2. Figures exclude VAT.	

Once expenditure has been authorised, official orders can then be raised or invoices approved by any of the following authorised signatories:

Head of Fundraising
Executive Director (Excluding the Director of Finance to maintain separation of duties)
Deputy Director of Finance
Head of Financial Services
Assistant Head of Financial Services

Other expenditure will be necessarily incurred within funds held on trust, whether this is actual cash transactions or non-cash accounting entries.

Cash transactions may include:

(a) Staff and associated non-pay recharges, which will have been previously agreed by the Charitable Funds Committee.

(b) Audit fees, both internal and external, prospectively agreed as necessary by the Corporate Trustee.

(c) Investment brokers fees, as advised by the Charity's appointed investment advisor.

(d) Management costs/overheads, recharged from the Finance Department.

(e) Bank charges.

(f) Realised gains and losses on disposal of investments, as advised by the Charity's appointed investment advisor.

Non-cash transactions may include:

(a) Depreciation on any fixed assets held.

(b) Unrealised gains and losses on disposal of investments, as advised by the Charity's appointed investment advisors.

All such transactions must be authorised and/or actioned by one of the following authorised signatories.

Deputy Director of Finance
Head of Financial Services
Assistant Head of Financial Services

APPENDIX 11: LIST OF REFERENCES

Internal

- Business Case Process and Guidance (August 2022)
- Counter Fraud, Bribery and Corruption Policy (Reference number 588)
- Annual Report and Accounts (Trust-wide document)
- Claims Handling Policy (Reference number 219)
- Constitution of The Rotherham NHS Foundation Trust (Approved by the Council of Governors)
- Governance and Compliance Framework (Finance document)
- Losses and Special Payments Register (Finance document)
- Matters Reserved to the Board (Approved by the Board of Directors in December 2018 - available by contacting the Trust's Company Secretary)
- Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy) (Reference number 370)
- Incident and Serious Incident Management Policy (Reference number 25)
- Risk Management Policy (Reference number 609)
- Scheme of Delegation (Appendices 1 to 10 within Standing Financial Instructions)
- Security Policy (Reference number 27)
- Standards of Business Conduct (including NHS England Conflicts of Interest Guidance) (Version 11 approved by the Board of Directors in November 2021)
- Standing Orders (for the regulation of proceedings and business of the Board of Directors) (Approved by the Board of Directors in November 2021 – available by contacting the Trust's Company Secretary)
- Treasury Management Policy (Reference number 160)

External

- Administration of Estates (Small Payments) Act 1965
- Capital Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts (February 2023 – NHS England)
- Charities SORP (FRS102) - Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland. Code of Audit Practice (April 2020 – National Audit Office)
- Contracts Finder (government web page)
- Data Protection Act 2018
- Directive 2004/18/EC of the European Parliament and of the Council
- Government Functional Standard (GovS 013: Counter Fraud) Management of Counter Fraud, Bribery and Corruption Activity (August 2021– Counter Fraud Centre of Expertise, part of the Cabinet Office)
- NHS England's NHS foundation trust annual reporting manual 2022/23
- Group Accounting Manual (Updated annually - Department of Health & Social Care)

- The Health and Social Care Act 2012, as amended by the Health and Care Act 2022
- Health Building Note 00-08
- Off Payroll Working (IR35): Deemed employer responsibilities under off-payroll working rules
- International Financial Reporting Standards (IFRS)
- NHS Counter Fraud Manual (Available via the NHS Counter Fraud Authority Application Access Portal with appropriate username and password access)
- The National Health Service Act 2006
- NHS Foundation Trust Accounting Officer Memorandum (August 2015 Monitor)
- Code of governance for NHS provider Trusts (Applicable from April 2023 – NHS England)
- NHS Internal Audit Standards (April 2011 – Department of Health & Social Care)
- Official Journal of the European Union (Official gazette of record for the European Union)
- Public Sector Internal Audit Standards (March 2017 – Chartered Institute of Public Finance and Accountancy and the Institute of Internal Auditors)
- The Records Management Code of Practice for Health and Social Care 2021 (updated August 2023) (NHS England)
- Risk Assessment Framework and reporting manual for Independent Sector providers of NHS services (July 2023 – NHS England)
- Assuring and supporting complex change – Statutory transactions, including mergers and requisitions (NHS England)
- Who Pays? Determining which NHS commissioner is responsible for making payment to a provider (June2022 – NHS England)

Public Board of Directors' Meeting
8 November 2024

Agenda item	P183/24
Report	**Annual Review of Standing Orders**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Links with all BAF risks as the Standing Orders are related to the regulation of proceedings of the Board of Directors.
How does this paper support Trust Values	Supports all Trust values as relate to the proceedings and business of the Board of Directors.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	The Trust Standing Orders for the regulation of proceedings and business of the Board of Directors was the subject of a significant review and amendment in 2023. Following the annual review process for 2024/25, minor amendments have been made which are illustrated in blue text throughout the document. The following additions and strike outs were approved at the Audit and Risk Committee on 25 October 2024. 1. Section 6.2c be removed as this is no longer applicable; 2. Section 8 has been amended to reference the new guidance relating to the standards of business conduct issued by NHS England in September 2024; 3. Section 8.3 is new to reflect declarations of relatives of Directors or officers; and 4. Section 9 has additional narrative to reflect the Fit and Proper Person Framework in force from September 2023. The additional amendment has been made to Section 3.20a to reflect the request from the Audit and Risk Committee. 5. Section 3.20a has been amended to reflect the number of Board meetings in a calendar year and that the Board of Directors will determine which of those meetings will be strategic meetings and substantive Board meetings.
Due Diligence	The Standing Orders have been presented to the Executive Team and the Audit and Risk Committee in October 2024.

Board powers to make this decision	Within the Powers Delegated to the Board and Constitution.
Who, What and When	Subject to approval at the Board, the Standing Orders will be available on the public facing website and reviewed again in October 2025.
Recommendations	It is recommended that the Board approve the minor amendments to the Standing Orders.
Appendices	Standing Orders for the Regulation of Proceedings and Business of the Board.

Standing Orders

For the regulation of proceedings and business of the Board of Directors

Approved by the Board of Directors ~~April 2023~~

October 2024

Foreword

The National Health Service Act 2006 (as amended) and the Foundation Trust's Constitution require that all NHS Trusts are required to have Standing Orders that provide a framework within which the Board operates. The Standing Orders, Standing Financial Instructions and Scheme of Delegation provide a regulatory and business framework for the conduct of the Board, including activities relating to the Trust Charity. All Executive and Non-Executive Directors and all members of staff should be aware of the existence of these documents and where necessary, be familiar with the detailed provisions.

The Board will discharge its responsibilities by direct decision or delegation to a Committee of the Board or the Chief Executive as Accounting Officer. In acting under delegated powers, it is the duty of any Committee Chair or the Chief Executive to report to the Board any serious impediments encountered in discharging their responsibilities.

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Introduction

Statutory Framework

The Rotherham NHS Foundation Trust (the Trust) is a Public Benefit Corporation established on 1 June 2005 through the granting of Authorisation by Monitor, now NHS England.

The Trust headquarters are at:
Rotherham General Hospital
Moorgate Road
Rotherham
S60 2UD

~~For administrative purposes, Rotherham Hospital is the Trust Headquarters.~~

~~NHS Foundation Trusts are governed by the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999, the Health and Social Care Act 2001 and 2003 and the Health and Social Care Act 2012. The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 2006, to fund projects jointly planned with local authorities, voluntary organisations and other bodies~~

The statutory functions conferred on the Foundation Trust are set out in the National Health Service Act 2006 as amended and in the NHS Provider Licence issued by NHS England.

As a public benefit corporation, the Trust has specific powers to contract in its own name and to act as a Corporate Trustee. As Corporate Trustee, the Trust is accountable to the Charity Commission for those funds deemed to be charitable.

The Trust Constitution requires the Trust to adopt Standing Orders for the regulation of its proceedings and business in addition to Standing Financial Instructions as an integral part of the Standing Orders.

NHS Governance Framework

The Code of Governance requires that, inter alia, Boards of Directors draw up a schedule of decisions reserved to that Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated appropriately.

The Code also requires the establishment of an Audit Committee and a Remuneration Committee, with formally agreed terms of reference.

The Code of Practice on 'Openness in the NHS' set out the requirements of public access to information on the NHS, subject to, for example, the Freedom of Information Act 2000.

Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. These Standing Orders set out the detail of these arrangements.

Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO5), the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a Trust committee, sub-committee or joint committee appointed by virtue of Standing Order 6 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or in accordance with the Constitution and the terms of the authorisation.

Delegated powers are covered in the Standing Financial Instructions and Scheme of Delegation which is a separate document. This document has the effect as if incorporated into the Standing Orders.

Collaboration with others

Foundation Trust Boards of Directors are encouraged to move away from silo governance and develop internal integrated governance that will support authorised decision making which is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance.

However, this is being furthered with the introduction of new systems of health and social care, with many different types of organisations becoming a part of a single system.

A number of organisations in South Yorkshire and Bassetlaw ('SY&B'), have come together and established an Integrated Care System. These organisations include clinical commissioning groups, local authorities, voluntary organisations, regulatory authorities and others, including:

The Rotherham NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Sheffield Children's Hospital NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust

In parallel, Accountable Care Partnerships have been established across SY&B 'Place' localities, including those in Rotherham, Bassetlaw, Barnsley, Doncaster and Sheffield.

Collectively, the new structures will share obligations, set out in Memoranda of Understanding. National legislation is not yet in place to support collaborative governance and decision making arrangements, therefore the Trust retains legal and regulatory obligations as a stand-alone entity, at the time of writing. Appropriate amendments and updates will be made to these Standing Orders to reflect the progress made re the legal structures.

1.0 Interpretation

Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Director of Corporate Affairs/Company Secretary).

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the Health and Social Care (Community Health and Standards) Act 2003 and other Acts relating to the National Health Service or in the Financial or other Regulations made under the Acts or in the Authorisation or Constitution shall have the same meaning in this interpretation and in addition:

"Accounting Officer" means the Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. In accordance with the Act, this shall be the Chief Executive.

"Authorisation" means the authorisation of the Trust by Monitor, now under the umbrella organisation, NHS Improvement, the Independent Regulator of NHS Foundation Trusts

"Board of Directors" means the Chair, Non-Executive Directors and the Executive Directors (voting) and Directors (non-voting) appointed in accordance with the Trust's Constitution.

"Budget" means a resource, expressed in financial terms, approved by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Budget Holder" means the director or employee with delegated authority to manage finances for a specific area of the organisation.

"Chair" is the person appointed in accordance with the Constitution to lead the Board of Directors and the Council of Governors. The expression "the Chair" shall be deemed to include the Vice Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief officer of the Trust.

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"Committee" means a committee appointed by the Board of Directors.

"Committee in Common" means the collective group or representation from NHS organisations established to perform a particular function or duty.

"Committee members" mean persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"Constitution" means the Constitution of the Trust as approved from time to time by NHS Improvement, the Independent Regulator of NHS Foundation Trusts.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and

maintenance and for disposal of surplus and obsolete assets.

“Council of Governors” means the persons, elected and appointed, to fulfil the functions as laid out in the Constitution.

"Finance Director" means the Director of Finance who is the chief finance officer of the Trust.

"Executive Director" means a director who is an officer of the Trust appointed in accordance with the Constitution. For the purposes of this document, “director” shall not include an employee whose job title incorporates the word director but who has not been appointed in this manner.

“Foundation Trust” means The Rotherham NHS Foundation Trust

"Funds held on Trust" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977 as amended by S.22 of the 2006 Act. Such funds may or may not be charitable.

“ICS” means Integrated Care System

“Independent Regulator” means the Regulator for the purpose of Part 1 of the 2003 Act.

“Licence” shall mean the licence granted to the Foundation Trust under Section 88 of the 2012 Act.

“Memorandum of Understanding” (MoU) means a bilateral or multilateral agreement between two or more parties expressing an intended will and/or common line of action between the parties.

“Monitor” means the body corporate known as Monitor, as provided by section 61 of the Health and Social Care Act which is now part of NHS England.

"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-Executive Director" means a director who is not an officer of the Trust and who has been appointed in accordance with the Constitution or under the previous appointment system. This includes the Chair of the Trust.

"Officer" means an employee of the Trust or any other person who exercises functions for the purposes of the Trust other than solely as a Staff Governor or Non-Executive Director of the Trust.

“Secretary” means the Director of Corporate Affairs (Company Secretary) unless otherwise defined

"Senior Independent Director" means one of the independent Non-Executive Directors appointed by the Board of Directors, in consultation with the Council of Governors, to undertake the role in accordance with the Code of Governance

"SFI's" means Standing Financial Instructions.

"SO's" mean Standing Orders.

"SY&B" means South Yorkshire and Bassetlaw, where a collaboration between the South Yorkshire and Bassetlaw NHS providers, and others, is established to deliver the objectives of the South Yorkshire and Bassetlaw ICS.

"Trust" means The Rotherham NHS Foundation Trust.

"Vice Chair" means the Non-Executive Director appointed by the Council of Governors to take on the duties of Chair if the Chair is absent for any reason.

2.0 The Trust

a. All business conducted by the Board of Directors shall be conducted in the name of the Trust.

b. The responsibilities of the Board of Directors are set out in the Constitution.

c. The powers of the Trust established under statute shall be exercised by the Board of Directors except as otherwise provided for in SO5.

d. Directors acting on behalf of the Trust as Corporate Trustee of The Rotherham Hospital and Community Charity Charitable Funds are accountable for charitable funds held on trust to the Charity Commission.

e. The Board of Directors has resolved that certain powers and decisions may only be exercised or made by that Board in formal session. These powers and decisions are set out in the Matters Reserved.

2.1 Composition of the Board of Directors

a. In accordance with the Trust's Constitution, the composition of the Board of Directors shall comprise both Executive and Non-Executive Directors.

b. The Board of Directors shall comprise:
   1) A Non-Executive Chair
   2) No fewer than five other Non-Executive Directors
   3) No fewer than five Executive Directors including:
      - Chief Executive (and Accounting Officer)
      - Director of Finance
      - Registered Medical Practitioner or Registered Dentist (within the meaning of the Dentists Act 1984)
      - Registered Nurse or a Registered Midwife

c. The Non-Executive Directors and Chair together shall be greater than the total number of Executive Directors.

2.2 Appointment and removal of the Chair and Non-Executive Directors

a. The Chair and Non-Executive Directors are appointed and may be removed by the Council of Governors in accordance with the procedure set out in the Constitution.

b. Non-Executive Directors (including the Chair) are to be appointed by the Council of Governors using the procedure set out in the Constitution.

2.3 Terms of Office of the Chair and Non-Executive Directors

a. The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the Constitution. The terms and conditions of the office are decided by the Council of Governors at a General Meeting.

2.4 Appointment of Vice Chair of the Board of Directors

a. For the purpose of enabling the proceedings of Governors of the Trust to be conducted in the absence of the Chair, the Council of Governors will support the appointment of a Non-Executive Director to be Vice Chair for such a period, not exceeding the remainder of their term as Non-Executive Director of the Trust, as they may specify. Provision 3.6 of these Standing Orders sets out the provision if the Chair and Vice Chair are absent.

b. Any Non-Executive Director so elected may at any time resign from the office of Vice Chair by giving notice in writing to the Chair. The Council of Governors may thereupon appoint another Non-Executive Director as Vice Chair in accordance with the Constitution.

2.5 Powers of the Vice Chair

a. Where the Chair of the Trust has ceased to hold office, or has been unable to perform duties as Chair owing to illness, absence or any other cause, references to the Chair shall, so long as there is no Chair able to perform those duties, be taken to include reference to the Vice Chair.

2.6 Appointment of Senior Independent Director

a. The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be their Senior Independent Director, using the procedure set out in the Constitution.

2.7 Role of Board of Directors

a. The Board will function as a corporate decision-making body. Executive and Non-Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.8 Corporate role of the Board

a. All business conducted by the Trust shall be conducted in the name of the Trust unless otherwise resolved by the Directors.

b. All funds received in trust shall be held in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

c. The powers of the Trust established under statute shall be exercised by the Board in session except as directed by a resolution of the Board.

2.9 Lead Roles for Board Members

a. The Chair will ensure that the designation of Lead roles or appointments of Board members as required or as set out in any statutory or other guidance, will be made in accordance with the guidance or statutory requirement.

b. Additional ‘champion’ roles may also be allocated to Non-Executive Directors.

2.10 Statement of Matters Reserved

a. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the statement of Matters Reserved to the Board and shall have effect as if incorporated into these Standing Orders.

3. Meetings of the Board of Directors

3.1 Admission of the Public and Press

a. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board of Directors held in public but shall be required to withdraw upon the Board resolving as follows:

b. ‘That representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’ (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).’

c. The Chair shall give such direction as seen fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board’s business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

d. ‘That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public’ (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

e. Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided above, shall be confidential to the members of the Board.

f. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked ‘in confidence’ or minutes and papers headed ‘private’ outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

g. Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3.2 Observers at Board Meetings

a. The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust’s Board meetings, and will change, alter or vary these terms and conditions as it deems fit.

3.3 Calling Meetings

a. Ordinary meetings of the Board of Directors shall be held at such times and places as that Board may determine.

b. Meetings of the Board of Directors may be called by the Chair or the Director of Corporate Affairs (Company Secretary).

c. Meetings of the Board of Directors may be called by at least one-third of directors who give written notice to the Director of Corporate Affairs (Company Secretary) specifying the business to be carried out.

d. The Secretary should send a written notice to all directors within seven days after receipt of such a request. If the Chair, or Director of Corporate Affairs (Company Secretary), refuses to call a meeting following a requisition, such one-third or more Directors may forthwith call a meeting.

3.4 Notice of Meetings

a. Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every director, or sent electronically or by post to the agreed address of such director, so as to be available at least three clear days before the meeting.

b. A notice shall be presumed to have been served one day after posting. Lack of service of the notice on any director shall not affect the validity of a meeting.

c. In the case of a meeting called by directors in default of the Chair, those directors shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

d. Agendas will be sent to directors no less than three clear days before the meeting and supporting papers shall accompany the agenda, save in emergency.

3.5 Setting the Agenda

a. The Board of Directors may determine that certain matters shall appear on every agenda for a meeting. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders.)

b. A director who requires an item to be included on the agenda should advise the Secretary of the Board prior to the agenda being agreed with the Chair and no less than 7 working days before a meeting.

c. When a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors meeting.

3.6 Chair of Meeting

a. At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice Chair shall preside. If the Chair and Vice Chair are absent, such Non-Executive Director as the directors present shall choose, shall preside.

b. If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Director as the

directors present shall choose shall preside.

3.7 Annual Members' Meeting

a. The Trust will publicise and hold an annual members meeting, in accordance with the terms of the Constitution and in accordance with Schedule 7, paragraph 28 of the NHS Act 2006.

3.8 Notices of Motion

a. A director wishing to move or amend a motion should advise the Company Secretary prior to the agenda being agreed with the Chair and no less than 7 clear days before a meeting. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

3.9 Emergency Motion

a. Subject to the agreement of the Chair, and subject to the provision of SO 3.8, a director of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda up to one hour before the time fixed for the meeting.

b. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision is final.

3.10 Withdrawal of Motion or Amendments

a. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.11 Motion to Rescind a Resolution

a. Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the director who gives it and also the signature of 4 other directors.

b. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within 6 months. However, the Chair may do so if he/she considers it appropriate.

3.12 Motions

a. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

b. When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceeds to the next business.

- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put.
- A motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press).
- No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.13 Chair's Ruling

a. Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity, and any other matters shall be observed at the meeting.

3.14 Voting

a. Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chair of the meeting and directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

b. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

c. If at least four of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

d. If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

e. Under no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote. In exceptional circumstances (to be defined by the Chairman), with prior agreement of the Chairman and Chief Executive, up to one Director may participate in a Board of Directors meeting by telephone, video or computer link. If prior agreement has been given, participation, and voting, shall be allowed.

f. An officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director.

g. An officer attending to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

h. The Clinical ~~Divisional~~ Care Group Directors attending Board of Directors' meetings, will have no formal voting rights on a decision nor the personal accountabilities associated with Board membership.

i. No resolution shall be passed if it is opposed by all the Non-Executive Directors present, or by all of the Executive Directors present.

3.15 Minutes

a. The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

b. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

c. Where providing a record of the meeting, a set of minutes from the meeting shall be made available to the public (required by Code of Practice on Openness in the NHS and the Freedom of Information Act) and circulated to the Council of Governors. A record of items discussed in private will be maintained and approved by the Board of Directors.

3.16 Suspension of Standing Orders

a. Except where this would contravene any statutory provision or any provision of the authorisation or of the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two Executive Directors and two Non-Executive Directors, and that a majority of those present vote in favour of suspension.

b. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

c. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

d. No formal business may be transacted while Standing Orders are suspended.

e. The Audit Committee shall review every decision to suspend Standing Orders.

3.17 Variation and Amendment of Standing Orders

a. These Standing Orders shall be amended only if:
- a notice of motion under Standing Order 3.8 has been given; and
- no fewer than half of the Trust's total Non-Executive Directors in post vote in favour of amendment;
- at least two-thirds of the Directors are present; and
- the variation proposed does not contravene a statutory provision or provision of the authorisation or of the Constitution.

3.18 Record of Attendance

a. The names of the Chair and directors present at the meeting shall be recorded in the minutes.

b. The Secretary shall keep and maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors. The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link as per SO 3.14.e. Participation where agreed shall be deemed to constitute presence in person at the meeting.

3.19 Quorum

a. No business shall be transacted at a meeting of the Board of Directors unless at least one-third members of the whole number of the Directors are present (including at least one Executive Director and one Non-Executive Director).

b. An officer in attendance for an Executive Director but without formal acting up status, may not count towards the quorum.

c. If the Chair or director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7) they shall no longer count towards the quorum.

d. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting.

e. The meeting must then proceed to the next business. The above requirement for one Executive Director to form part of the quorum, shall not apply where the Executive Director is excluded from a meeting.

f. In exceptional circumstances, up to one Director may participate in Board of Directors meetings by telephone, video or computer link in accordance with SO 14.e. With prior agreement of the Chairman and Chief Executive, which shall be noted in the minutes, the Director may form part of the quorum.

3.20 Frequency

a. The Trust shall hold meetings of the Board of Directors ~~on a generally monthly basis~~, and at least ~~ten~~ 11 times in each calendar year. The Board of Directors will determine which of the 11 meetings will be dedicated to strategic sessions and substantive Board meetings.

b. The Board of Directors shall determine the dates of the board meetings in advance.

4.0 Meetings of the Council of Governors

4.1 Admission of the Public and Press

a. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Governors resolving as follows:

b. ‘That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’ (Section 1(2) Public Bodies (Admission to Meetings) Act 1960.’

c. The Chair (or Vice Chair) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council of Governors’ business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors resolving as follows:

‘That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Governors to complete business without the presence of the public’ (Section 1(8) Public Bodies (Admission to Meetings) Act 1960.’

d. Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

4.2 Calling Meetings

a. General Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine.

4.3 Notice of Meetings

a. Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted by it, shall be delivered to every Governor, or sent by post to the usual residence of such Governor, so as to be available to him/her at least three clear days before the meeting.

b. Lack of service of the notice on any Governor shall not affect the validity of the meeting.

c. Meetings of the Council of Governors may be called by seven Governors (including at least one elected Governor and one appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send out a written notice to all Governors as soon as possible after receipt of such a request.

d. Agendas will be sent to Governors three clear days before the meeting, and supporting papers, whenever possible, shall accompany the agenda. Papers may be sent by electronic means.

e. A notice shall be presumed to have been served one day after posting.

4.4 Chair of Meeting

a. At any meeting of the Council of Governors, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, one of the other Non-Executive Directors will be nominated by the Council of Governors to preside.

b. If the person presiding at the meeting of the Council of Governors has a conflict of interest in relation to the business being discussed, the Vice Chair (or nominated Chair) will chair that part of the meeting.

4.5 Notices of Motion

a. A Governor desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Secretary, who shall insert in the agenda for the meeting, all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned in the agenda.

4.6 Withdrawal of Motion or Amendments

a. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.7 Motions

a. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment of the Chair.

b. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:
- An amendment to the motion
- The adjournment of the discussion
- That the meeting proceeds to the next business
- The appointment of an ad hoc committee to deal with a specific item of business
- A motion under section 1 of the Public Bodies (Admissions to Meetings) Act 1960 resolving to exclude the public (including the press)

c. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

4.8 Chair's Ruling

a. Statements of Governors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevance, regularity and any other matter shall be observed at the meeting.

4.9 Voting

a. Every question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the person presiding at or chairing the meeting shall have a casting vote.

b. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands.

c. If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

d. If a Governor so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

e. Under no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

4.10 Minutes

a. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

b. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

c. Where providing a record of a public meeting the Council of Governors' minutes shall be made available to the public as required by the Code of Practice on Openness in the NHS.

4.11 Record of Attendance

a. The names of the Governors present at the meeting shall be recorded in the minutes, and shall be reported in the Trust's annual report.

4.12 Quorum

a. For Council of Governors meetings, the quorum is as set out in the Constitution.

b. If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO7) he shall not count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.13 Frequency of Council of Governor meetings

a. The Council of Governors shall hold meetings at least four times a year in each calendar year.

5.0 Arrangements for the exercise of functions by delegation

a. Subject to a provision in the authorisation or the Constitution, the Board of Directors may make arrangements for the exercise, on its behalf of any of its functions by
   - a committee or sub-committee of the Board;
   - appointed by virtue of SO5.c below; or
   - by an Executive Director.

b. The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by a Committee, which it has formally constituted. The constitution and terms of reference of these Committees and their specific executive powers, shall be approved by the Board

c. Each case will be subject to such restrictions and conditions as the Board of Directors thinks fit.

d. Standard exceptions to this requirement are:
   a) Approval of single tenders: Where, in the best interests of the Trust, single tendering arrangements need to be completed before the next Audit Committee meeting, the request may be considered by the Chief Executive and the Director of Finance acting jointly. Where the request is approved, the decision of the Chief Executive and Director of Finance will be reported in writing to the next Audit Committee meeting for formal acknowledgement and, if appropriate, approval.

   b) Use of the Trust's seal: Where, in the best interests of the Trust, the sealing of documents needs to be completed before the next Board meeting, the sealing may be undertaken by any two of the following acting jointly: Chairman, Chief Executive and / or Director of Finance and/or Director of Corporate Affairs.

5.1 Emergency Powers

a. The powers which the Board of Directors has retained to itself within these Standing Orders may, in emergency be exercised by the Chair, after having consulted at least two Non-Executive Directors and an Executive Director. The exercise of such powers by the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

5.2 Delegation to Committees

a. The Board of Directors shall agree, as and when it deems appropriate, to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted.

b. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

5.3 Delegation to Officers

a. Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on its behalf by the Chief Executive. The Chief Executive shall determine which functions shall be delegated to officers to undertake.

b. The Chief Executive shall prepare a Scheme of Delegation (which is set out in the Standing Financial Instructions) identifying proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

c. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors or the Director of Finance or other executive director. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

d. The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

5.4 Overriding Standing Orders

a. If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Audit Committee.

b. All members of the Board of Directors, Council of Governors and colleagues have a duty to disclose any non-compliance with these Standing Orders to the Chairman as soon as possible.

6.0 Committees

6.1 Appointment of Committees

a. Subject to the authorisation and the Constitution, the Board of Directors may appoint committees of the Board, consisting wholly or partly of the Chair and Executive or Non-Executive Directors of the Trust, or wholly of persons who are not Executive or Non-Executive Directors of the Trust which is likely to contribute to or assist it in the exercise of its powers.

b. A committee or joint committee appointed under this regulation may, subject to such directions as may be given by the Independent Regulator of the Trust, and in accordance with the Constitution, appoint sub-committees consisting wholly or partly of directors of the committee or joint committee (whether or not they are directors of the Trust); or wholly of persons who are not directors of the Trust or the committee of the Trust.

c. The Scheme of Delegation does not discharge accountability to Non-Executive Directors to provide information and advise the Board of Directors in accordance with any statutory requirements.

d. The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair of the committee as the context permits, and the term "director" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold any meetings of committees established by the Trust, in public.)

e. Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation and regulation.

f. Such terms of reference shall have effect as if incorporated into the Standing Orders.

g. Where Trust committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

h. Committees, sub committees, or other groups, will not use the designation 'Board' in its name.

i. The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and regulations permit, those persons, who are neither directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the authorisation and the Constitution.

j. The committees and sub-committees established by the Trust are:
- Audit and Risk Committee
- Nomination and Remuneration Committee (made up of Governors)
- Nomination and Remuneration Committee (made up of majority Non-

Executive Directors and relating to the appointment / removal of Executive Directors);

- Finance and Performance Committee
- Quality Committee
- People and Culture Committee
- Charitable Funds Committee
- The Rotherham NHS Foundation Trust Committee in Common

k. Membership of the Trust's Committee in Common is defined by its Terms of Reference, as agreed by all the parties. The Board of Directors, together with other SYB ICS partners, has agreed not to delegate any of its statutory functions to the Committee in Common.

l. Such other committees may be established, as required, to discharge the Board's responsibilities.

m The committee established by the Council of Governors is the Nomination Committee, made up of Governors, save for the Committee Chair, being the Trust Chairman. Travelling and other allowances for Non-Executive Directors shall be determined by the Committee.

n. A Charitable Funds Committee has been established by the Corporate Trustee of The Rotherham Hospital and Community Charity.

6.2 Confidentiality

a. A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

b. A Director of the Trust, a member of a committee or attendee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if that committee shall resolve that it is confidential.

~~c. The Board of Directors may facilitate the attendance of up to two Governors at certain Board Committee meetings. The purpose of Governors attending the Committees is to allow them to observe the Non-Executive Directors. This provides Governors the opportunity of fulfilling their duty of holding Non-Executive Directors to account for the performance of the Board, and to participate in Non-Executive annual appraisals. To ensure the integrity of Board Committee governance, Governors will not participate in the meetings, unless directly invited to so by the committee Chairman. No actions shall arise as a result of Governors' invited participation. Attending Governors shall acknowledge their duty of confidentiality of matters discussed, by providing a signed declaration to this effect.~~

7.0 Declarations of Interests

7.1 Members of the Board of Directors

a. Pursuant to Section 20 of the Schedule 7 of the National Health Service Act 2006, a register of Director's interests must be kept by each NHS Foundation Trust.

b. All Directors (including for the purposes of the standing order, Non-Executive Directors) should declare relevant and material interests to the NHS Board of which they are a member. This should take place on appointment.

c. Interests may be financial or non-financial (i.e. political or belief-based). Interests which should be regarded as 'relevant and material' and which, for the avoidance of doubt, should be included in the register are:

(a) Any directorship of a company;
(b) Any interest (excluding a holding of shares in a company whose shares are listed on any public exchange where the holding does not exceed 5% of the total issued share capital, or the value of such shareholding does not exceed £25,000) or position in any firm or company or business, which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;
(c) Any interest in an organisation providing health and social care services to the National Health Service; or
(d) Position of authority in a charity or voluntary organisation in the field of health and social care;
(e) Any affiliation to a special interest group campaigning on health or social care issues (this includes political parties).
(f) To the extent not covered above, any connection with an organisation, entity or company considering entering in to, or having entered into financial arrangement with The Rotherham NHS Foundation Trust, including but not limited to, lenders or banks.

d. Reference should also be made to ~~the Monitor *NHS Foundation Trust Code of Governance*~~ NHS England Code of Governance for NHS Provider Trusts and the Trust's Constitution in determining whether other circumstances or relationships are likely to affect, or could appear to affect, the director's judgement.

e. Each Board agenda will contain at the beginning, an agenda item relating to declaration of interests. During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority vote will resolve the issue with the Chair having the casting vote.

f. At the time that interests are declared, they should be recorded in the Board of Director's minutes. Any changes in interests that should arise between Board meetings, should be advised to the Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest.

g. It is the responsibility of the director to inform the Secretary of changes in their interests, within the appropriate timelines.

h. A register of directors' interests shall be maintained and held by the Secretary and presented bi-annually to the Board of Directors. This will be formally recorded in the minutes. Any changes in interests should be officially declared to the Secretary where an appropriate amendment is required.

I There is no requirement for the interests of directors' spouses or partners to be declared; however, in accordance with the Nolan Principles of integrity, accountability and openness, good practice suggests that such declarations are strongly advisable (as are declaring the interests of other immediate family members and co-business partners).

j. If directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or Secretary.

k. For the avoidance of doubt, any remuneration, compensation or allowances payable to the Chair or a Non-Executive Director in accordance with the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.

l. The Register of Directors' Interests will be available for inspection by the public free of charge. Copies or extracts of the Registers must be provided to Members of the NHS Foundation Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-Members for copies or extracts of the register.

8.0 Standards of Business Conduct

8.1 Policy

a. The Trust's Standards of Business Conduct Policy provides guidance for all colleagues in the Trust who may or may not be Members of the Board of Directors, and who may have conflicts of interest that should be declared. The policy has been updated to reflect new guidance published by NHS England in September 2024 which takes account of the changes introduced by the Health and Care Act 2022.

b. ~~There is an obligation on the Trust, through its incorporation with the NHS Standard Contract pursuant to General Condition 27, that 'Managing Conflicts of Interest in the NHS' statutory guidance (publications gateway reference 06419) and superseding the Standards of Business Conduct for NHS staff (HSG(93)5), is complied with by all colleagues.~~

c. All Trust colleagues should familiarise themselves with the contents of the Standards of Business Conduct policy, and should seek advice if in doubt as to whether a potential interest should be declared.

8.2 Canvassing of, and Recommendations by, Directors in Relation to Appointments

a. Canvassing of Directors of the Trust, or members of any Committee of the Trust directly or indirectly for any appointment under the Trust, shall disqualify the candidate for such appointment.

b. A Director shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

c. Informal discussions outside appointment panels or committees, whether solicited or unsolicited, will be declared to the panel or committee.

8.3 Relatives of Directors or Officers

a. Candidates for any staff appointment shall, when making the application, disclose in writing whether they are related to any Director or employee of the Foundation Trust. Failure to disclose any relative/relationship shall disqualify a candidate and, if appointed, render the candidate liable to instant dismissal.

b. Where the relationship of an officer or another Director is disclosed, the Standing Order 7, Declarations of Interests shall apply.

9.0 Compliance with Fit and Proper Persons Regulations

a. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all NHS Trusts to ensure that all Executive and Non-Executive Director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Persons Regulations ('FPPR'). The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights at Board meetings.

b. The regulations stipulate that Trusts must not appoint or have in place an Executive Director or a Non-Executive Director unless they meet the standards set out in the Regulations.

c. Guidance issued by the CQC in January 2018 places ultimate responsibility on the Trust Chair to discharge the requirements of the FPPR.

d. The Chair must assure themselves that new applicants and existing post holders meet the fitness checks and do not meet any of the unfit criteria. Responsibility also falls on the Chair to decide whether an investigation is necessary and, at the end of the investigation, to consider whether the director in questions remains fit and proper.

e. ~~The Chair will be notified by the CQC of any non-compliance with the FPPR, and holds responsibility for making any decisions regarding action that needs to be taken.~~ The Fit and Proper Person Test Framework issued by NHS England became effective from 30 September 2023 and is applicable to both Non-Executive and Executive Directors (irrespective of voting rights) and those individuals called directors' with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

10.0 Custody of Seal and Sealing of Documents

10.1 Custody of Seal

a. The Trust's Seal shall be kept by the Chief Executive, or officer appointed by them, in a secure place.

10.2 Sealing of Documents

a. The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or where the Board of Directors has delegated its powers.

b. The affixing of the Seal shall be attested and signed by the Chief Executive Director (or officer nominated by them) together with one other Executive Director.

c. Before any building, engineering, property or capital document is sealed, it must be approved and signed by the Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them).

d. For contracts, other than building and engineering, contract management teams and Departmental Heads are required to consider the enforceability of rights which may accrue by virtue of breaches of such contracts.

e. Where the contract management team or Departmental Head believes that the contract should be entered into under seal, that contract should be submitted to the Director of Finance for review. If the Director of Finance agrees that the contract should be completed under Seal then appropriate processes set out in the SFI's for building and engineering contracts, should be followed.

10.3 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors when required and at least bi-annually. (The report shall contain details of the seal number, the description of the document and date of sealing). The book will be held by the Secretary.

11. Signature of documents

a. Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

b. For the purpose of defence documents in legal proceedings, the Director of Corporate Affairs (Company Secretary) or in their absence, any Executive Director, shall be authorised to sign the necessary documentation on behalf of the Trust.

c. The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which that Board has delegated appropriate authority.

d. Where electronic documents have been 'signed' with electronic signatures, details pertaining to the document, shall be maintained in a register and presented to the Board of Directors, for ratification where necessary, on a bi-annual basis.

12. Freedom to Speak Up

a. In accordance with the Public Interest Disclosure Act 1998, the Board of Directors is required to prepare and update, as necessary, procedures for receiving and investigating disclosures, internally or externally, as well as illegal acts or omissions at work.

b. The Board of Directors is responsible for ensuring that all senior leaders, are knowledgeable about Freedom to Speak Up (FTSU), and can readily articulate the Trust's FTSU requirements and policy.

c. The Chief Executive is responsible for appointing the FTSU Guardian and ultimately, for ensuring that FTSU arrangements meet the needs of colleagues.

d. The Chief Executive and Chair are responsible for ensuring the annual report contains information about FTSU and that the Trust is engaged with both the regional Guardian network and the National Guardian's Office

13. Miscellaneous

13.1 Standing Orders to be given to Directors and Officers

a. It is the duty of the Chief Executive to ensure that existing directors and officers are notified of and understand their responsibilities within Standing Orders and SFIs.

b. Updated copies shall be issued to staff in e-mail format through the Trust's Colleague Bulletin.

c. New designated officers shall be informed in writing and shall receive e-copies where appropriate of Standing Orders.

13.2 Documents having the standing of Standing Orders

a. Standing Financial Instructions and the Scheme of Delegation shall have effect as if incorporated into Standing Orders.

b. Reservation of Powers to the Board and Scheme of Delegation shall have the effect as if incorporated into these Standing Orders.

13.3 Review of Standing Orders

a. Standing Orders, and all documents having effect as if incorporated in Standing Orders, shall be reviewed annually by the Audit and Risk Committee on behalf of the Board of Directors.

Public Board of Directors' Meeting
8 November 2024

Agenda item	P184.24
Report	**Reservation of Powers to the Board of Directors and Schedule of Delegation**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Not applicable
How does this paper support Trust Values	Supports all Trust values
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	In accordance with the NHS Act 2006 and the revised Code of Governance, the Trust is required to have a Board approved document setting out the reservation of powers to the Board of Directors in addition to a schedule of decisions and duties delegated by the Board of Directors. The following document is a full review and re-draft of the current Matters Reserved to the Board to bring in line with the Code of Governance and approved Terms of Reference for the Board Committees.
Due Diligence	The document is a matter for Board approval.
Board powers to make this decision	Powers as set out in the NHS Act 2006 (as amended).
Who, What and When	Subject to approval, the document will be made available on the public facing website. This will be subject to annual review.
Recommendations	It is recommended that the Board approve the Reservation of Powers to the Board of Directors and the Scheme of delegation to the Board Committees.
Appendices	

Reservation of Powers to the Board of Directors and Schedule of Delegation to Board Committees

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Section 1 – Introduction

1.1 The NHS 2026 (as amended) and NHS England's Code of Governance for NHS Provider Trusts (October 2022), effective from 1 April 2023 requires there to be a formal document setting out the Reservation of Powers to the Board of Directors in addition to a schedule of decisions, duties delegated by the Board of Directors.

1.2 The purpose of this document is to provide details and define those powers specifically reserved to the Board and those delegated to the appropriate level of Board Committee or individual. However, the Board of Directors remains accountable for all its functions, including those that have been delegated to the Chair of the Trust, individual directors or officers of the Trust. The Board of Directors would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.3 All matters that are not reserved to the Board of Directors or delegated to its Committees shall be exercised on behalf of the Board of Directors by the Chief Executive. The scheme of delegation identifies those functions which the Chief Executive shall perform personally and those which are delegated to other Directors or Officers. All powers delegated by the Chief Executive can be reassumed by him/her should the need arise.

1.4 It should be noted that in accordance with the provision of emergency powers within the Standing Orders and Constitution, in an emergency the powers that the Board of Directors has retained to itself may be exercised by the Chief Executive and the Chair after having consulted at least two other Non-Executive Directors; the exercise of such powers by the Chief Executive and the Chair of the Trust shall be reported to the next formal meeting of the Board of Directors.

1.5 Powers are delegated to Directors or Officers on the understanding they will not exercise delegated powers in a manner which is likely to be a cause for public concern.

1.6 A Director's delegated power may be delegated to designated deputies.

1.7 In circumstances where the Chief Executive has not nominated a Director or Officer to act in their absence, the Board of Directors shall nominate an Officer to exercise the powers delegated to the Chief Executive in their absence.

1.8 This document should be read in conjunction with the Standing Orders and Standing Financial Instructions.

Section 2 – Reservation of Powers to the Board of Directors

The Board of Directors must determine those matters on which decisions are reserved to itself and these matters are set out below

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
General Enabling Provision The Board of Directors shall exercise all powers of the Trust as set out in the NHS Act 2002 (as amended), subject to any restrictions by its Licence, or as delegated in accordance with the following scheme. The Board at a full session may determine any matter it wishes within its statutory powers and has the right to determine that it is appropriate to resume its delegated powers.	
1. Regulations and Controls	
1.1	Approve Standing Orders (SOs), Standing Financial Instructions (SFIs) Schedule of Powers Reserved to the Board.
1.2	Suspend the Standing Orders pertaining to the Board of Directors.
1.3	Approve variations or amendments to the Constitution in conjunction with the Council of Governors.
1.4	At the next formal meeting of the Board of Directors ratify any urgent decisions taken by the Chair and the Chief Executive.
1.5	Require and receive, at any point during the Board of Directors meeting, the declaration of interests of any member of the Board of Directors irrespective of voting rights that may conflict with those of the Trust; and determining the extent to which the Board member may remain involved with the matter under consideration.
1.6	Approval of the format for the Declarations of Interests form.
1.7	Determine the independence of the Non-Executive Directors.
1.8	Regularly review, and at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services as per the Provider Licence.

1.9	Establish and dis-band Committees of the Board that are directly accountable to the Board of Directors. Appoint and remove members of all Committees of the Board or the appointment of a Trust representative to third party organisations.
1.10	Receive reports from the Board Committees including those that the Trust is required to establish and take appropriate action.
1.11	Confirm any recommendations from the Board Committees where they do not have the power to make such decisions (where Board Committees make a decision which is within their delegated power, this will be regarded as having been made by the Board of Directors).
1.12	Ratify the Terms of Reference and reporting arrangements of all Board Committees that are formally established by the Board of Directors.
1.13	At the next available formal meeting, receive a report on the application of the Trust seal since the last report to the Board of Directors and at least bi-annually in the event of nil return.
1.14	Ratify or otherwise, instances of non-compliance with the Board of Director's Standing Orders and the justification of any non-compliance.
1.15	Approve the wording of any statement of the Board of Directors pertaining to a dispute between the Council of Governors and the Board of Directors.
1.16	Decide whether the Trust will insure through the risk pooling schemes administered by the NHS Resolution.
1.17	Make any arrangements it considers appropriate to the provision of indemnity insurance or similar for the benefit of the Trust or directors to meet all or any liability which are properly the liability of the Trust recognising Public Benefit Corporation status.
1.18	Approve any recording by members of the public at any Board of Director's meeting held in public.
1.19	Resolve to exclude members of the public from any meeting or part of the meeting.

1.20	Determine that certain matters appear on each agenda of the Board of Director's meeting.
1.21	Provide permission that Directors, Officers or any employee or representative of the Trust in attendance at a meeting held in private or part of a meeting in private may disclose the contents of the papers or any discussion.
1.22	Send a copy of the agenda of the meeting of the Board of Directors to the Council of Governors.
1.23	Send a copy of the minutes of the Board of Directors meeting held in public to the Council of Governors.
1.24	Determine the times and places for the meetings of the Board of Directors.
1.25	Approve the Trust's banking arrangements.
1.26	Approve arrangements relating to the discharge of the Trust's responsibilities as a Corporate Trustee for funds held on Trust.
1.27	Approve the arrangements relating to the discharge of the Trust's responsibilities as Bailee for patient monies.
1.28	Grant delegated authority to the Chair or other Directors to carry out actions on its behalf.
2. Appointments/Dismissal/Terms and Conditions	
2.1	Ratify any changes to the overall number of Non-Executive Directors and Executive Directors.
2.2	Appoint one of the independent Non-Executive Directors as the Senior Independent Director.
2.3	Appoint one of the independent Non-Executive Directors as the Vice-Chair.
2.4	Appoint and Dismiss the Trust Company Secretary.
2.5	Consider and approve proposals presented by the Chief Executive for setting remuneration and conditions of service for those employees and officers not covered by the Nomination and Remuneration Committee.

2.6	Approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service for employees.
2.7	Approve the Director's Code of Conduct.
3. Strategy, Business Plans, Budgets and Statutory Returns	
3.1	Define and set the aim, goals and strategic objectives of the Trust (the Trust Strategy).
3.2	Approve any supporting strategies (People, Quality, Estates, Digital, Clinical)
3.3	Approve and monitor the Trust's policies and procedures for the management of risk - approve key strategic risks.
3.4	Approve the Trust's forward plan and budget in respect of each financial year setting out the application of available financial resources.
3.5	Approve the capital programme.
3.6	Approve any business case for capital investment of £1m or more (or a linked series of projects for which the combined value would exceed £1m.
3.7	Approve any long term borrowing and ensure this is consistent with the plans outlined in the annual plan.
3.8	Ratify proposals for acquisition, disposal or change in the use of land and/or buildings of £1m or more (or a linked series of acquisitions, disposals or change of use of land for which the combined value would exceed £1m. If significant transaction, in conjunction with the Council of Governors.
3.9	Approve proposals in individual cases for the write-off of losses or making of special payments of £500K or more and all those of a novel or contentious nature.
3.10	Approve the introduction of discontinuance of any significant activity or operation relating to the areas of responsibility of those Committees in Common established by the Board.
3.11	Approve the level of non-pay expenditure on an annual basis.

3.12	Approve the Care Quality Commission Registration Declaration.
3.13	Approve the Trust's Quality Report.
3.14	Approve any monitoring returns to NHS England ensuring these are submitted at such frequency as is required.
3.15	Approve the Trust's forward plan prior to submission to NHS England, ensuring that it has regard to the views of the Council of Governors.
3.16	Approve the Annual Accounts and Annual Report.
3.17	Receive reports from the Director of Finance on financial performance against budget and plans.
3.18	Approve proposals for ensuring equality and diversity in both employment and the delivery of services.
3.19	Approve the Trust's Investment Policy and authorise institutions with which cash surpluses may be held.
3.20	Approve the Annual Reports relating to: ➢ Safeguarding ➢ Health and Safety ➢ Infection Prevention and Control
3.21	Approve the following policies: ➢ Health and Safety Policy ➢ Safeguarding Policy ➢ Risk Management Policy
4. Audit	
4.1	Receive reports from the Audit and Risk Committee and take action as appropriate.
4.2	Approve the Annual Letter of Representation to the External Auditor.

5. Monitoring	
5.1	Receive such reports as the Board sees fit from Board Committees in respect of their exercise of delegated powers, including an annual report of activities undertaken by the Board Committee.
5.2	Continuous appraisal of the Trust affairs by receipt of reports as the Board sees fit from members of the Board of Directors, Committees and Officers of the Trust. All monitoring returns required by the Regulator and the Charity Commission shall be reported to the Board of Directors.
5.3`	Receive performance reports against agreed internal, local, contractual and national targets and standards.
5.4	Receive and approve key reports as required including reports to and from NHS England in regard to compliance.
6. Schedule of Delegated Powers to the Board Committees	
6.1	**Audit and Risk Committee** The Audit and Risk Committee has delegated authority from the Board of Directors to seek assurance on: a) The adequacy of the Trust's system of internal control, including audit arrangements (internal and external), financial systems, financial information, assurance arrangements including governance, risk management and compliance with legislation. b) The Trust policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any relating to self-certification including the NHS Code of governance and NHS provider Licence. c) Approve the policies and procedures relating to counter fraud, bribery and corruption as required. d) Approve any other policies or procedures relevant to the Committee's remit. e) Approve the Internal Audit plan. f) The effectiveness of the governance framework for monitoring and continually improving the quality of health care provided to service users to enable the Trust's strategic objectives to be achieved. g) Operate within the remit of its approved Terms of Reference.

<table>
<tr><td>6.2</td><td>Quality Committee
The Quality Committee has delegated authority from the Board of Directors to take the following actions on its behalf:

a) Approve specific policies and procedures relevant to the Committee’s purpose, responsibilities and duties.
b) Engage with the Trust auditors in cooperation with the Audit and Risk Committee.
c) Seek any information it requires from within the Trust and to commission independent reviews and studies if it considers this necessary in order to discharge its function.
d) Operate within the remit of its approved Terms of Reference

The Quality Committee has delegated authority from the Board of Directors for oversight and scrutiny of:

a) Performance against the following domains of quality, safety, effectiveness and patient experience.
b) Compliance with essential regulatory and professional standards, established good practice and mandatory guidance.</td></tr>
<tr><td>6.3</td><td>Finance and Performance Committee
The Finance and Performance Committee has delegated authority from the Board of Directors to take the following actions:

a) Approve specific policies and procedures relevant to the Committee’s remit.
b) Approve the recommendations from the Accountable Emergency Officer for Emergency Preparedness, Resilience and Response via the annual self-assessment submission.
c) Recommend to Board the submission of the Trust’s annual plan to the regulator.
d) Review the finance report on a monthly basis and approve any submissions of monitoring reports to the Regulator.
e) Seek any information it requires from within the Trust and to commission independent reviews and studies should these be considered necessary.
f) Make any recommendations to the Board of Directors in relation to capital and other investments, cost improvement plans and business development opportunities.
g) Approve business cases in accordance with delegated authority limits as described with the Standing Financial Instructions.
h) Operate within the remit of its approved Terms of Reference.</td></tr>
</table>

6.4	**People and Culture Committee** The People and Culture Committee has delegated authority from the Board of Directors to take the following actions: a) Operate within the remit of its approved Terms of Reference. b) Approve the Integrated Equality and Diversity Plan. c) Approve specific policies and procedures relevant to the Committee's remit.
6.5	**Nomination and Remuneration Committee** The Nomination and Remuneration Committee has delegated authority from the Board of Directors to; a) Appoint or remove the chief Executive. b) Set the remuneration and allowances and other terms and conditions o office of the Chief Executive. c) Appoint or remove the other Executive Directors and set the remuneration and allowances and other terms and conditions of office of the Executive Directors, in collaboration with the Chief Executive. d) Consider any activity within the approved terms of reference. e) Identify and appoint candidates to fill posts within its remit as and when they arise. f) Keep the leadership needs of the Trust under review at Executive level to ensure the continued ability of the Trust to operate effectively in the health economy. g) Sponsor the Trust's leadership development and talent management programmes. h) Ensure appropriate succession plans are in place for members of the Executive Team. i) Evaluate the balance of skills, knowledge and experience on the Board of Directors.
6.6	**Charitable Funds Committee** The Charitable funds Committee has delegate authority on behalf of the Corporate Trustee to: a) Ensure funds held on Trust (charitable funds) are managed in accordance with the Trust's approved Standing Orders and Standing Financial Instructions. b) Approve specific policies and procedures relevant to the Committee's remit. c) Review the Annual Report and Accounts prior to formal submission to the Corporate Trustee.

	d) Ensure the requirements of the Charities Act and the Charity Commission are met and approve submissions required by regulators and auditors.
7. Non-Executive Director Champion Roles delegated to Board Committees The Board of Directors have delegated the following issues (previous NED Champion roles) to the relevant Board Committees in line with guidance from NHS England:	
7.1	**Quality Committee** ➢ Hip fractures, falls and dementia ➢ Palliative and End of Life Care ➢ Resuscitation ➢ Learning from Deaths ➢ Health and Safety ➢ Safeguarding ➢ Safety **Audit and Risk Committee** ➢ Counter Fraud ➢ Risk **Finance and Performance Committee** ➢ Emergency Preparedness ➢ Procurement ➢ Cyber Security **People and Culture Committee** ➢ Violence and Aggression – Management of

Board of Directors' Meeting
08 November 2024

Agenda item	P185/24
Report	**Application of the Company Seal Report**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Not applicable for this report.
How does this paper support Trust Values	This report supports the core value of Ambitious ensuring the Board complies with the requirements it sets out in its Constitution in relation to the signing and sealing of documents with third parties
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Executive Summary	The following register of use of the Trust Seal is presented to the Trust Board in accordance with Section 10.3 of the current Standing Orders. Following the last report to the Trust Board in July 2024, the Trust Seal has been applied on three occasions.
Due Diligence	This report has not been, and is not required to be considered by any other Committee.
Board powers to make this decision	No decision is required by the Trust Board, however, the Board will note that the current Trust Standing Orders (Section 10.3) requires a report to be made to the Board when the Seal has been applied.
Who, What and When	No additional action is required. The Director of Corporate Affairs will be charged with compliance with the relevant procedures and will be supported by the Deputy Director of Corporate Affairs during this process.
Recommendations	It is recommended that the Board receives and notes the content of the report.
Appendices	Register of application of the Seal since the last report to Board in July 2024.

Register of Use of the Trust Seal

1. Introduction

1.1 In accordance with Section 10.3 of the current Standing Orders.

“An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.”

1.2 The last report to the Board on matters relating to the Trust Seal was July 2024.

2. Use of the Trust Seal

2.1 Since the last report, the Trust Seal has been applied on three occasions as follows:

Document Sealed	Date of Sealing	Officers Attesting the Seal
Under lease and licence to underlet part of the Medical Centre at Quarry Lane, Greenlands Park, North Anston.	11/09/2024	Steve Hackett Alan Wolfe
Licence to underlet to underlet part of the Medical Centre at Quarry Lane had not been executed in the correct place on 11/09/20234	18/10/2024	Steve Hackett Alan Wolfe
Lease renewal of Lloyds Pharmacy Unit 10, Rotherham General Hospital.	18/10/2024	Steve Hackett Alan Wolfe

3. Recommendations

The Board is asked to note the contents of the report.

Board of Directors' Meeting
08 November 2024

Agenda item	P186/24
Report	**Nominations and Remuneration Committee 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 Nominations and Remuneration Committee carried out a review of its Terms of Reference during July 2024 and these were approved at the August Committee for presentation to the Board. The following approved Terms of Reference are presented to Board for final ratification: • Nominations and Remuneration Committee Terms of Reference
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	• Nominations and Remuneration Committee Terms of Reference

Nominations & Remuneration Committee Terms of Reference

Name and Designation of Author	Angela Wendzicha, Director of Corporate Affairs
Approved by	Nominations and Remuneration Committee Trust Board
Approving evidence	
Date approved	July 2024
Review date	July 2025
Review frequency	Annual
Target audience	Nominations and Remuneration Committee Members and Attendees
Links to other Procedural Documents	Trust Board Terms of Reference and Trust Constitution
Protective Marking Classification	Subject to the FOI Act

Version Control

Date	Version	Author Name & Designation	Summary of amendments
August 2022	1.0	Angela Wendzicha, Director of Corporate Affairs	New Terms of Reference following amalgamation of the Nomination Committee and Remuneration Committee
July 2024	1.1	Daniel Hartley, Director of People	Review and update

Title	Nomination and Remuneration Committee
Constitution	1.1 The Nomination and Remuneration Committee ("the Committee") is a standing Committee of the Trust's Board of Directors ("the Board").
Authority	2.1 The Committee is authorised by the Board to act and investigate any activity within its terms of reference. 2.2 It is authorised to seek any information it requires from any member of staff and those members of staff are directed to co-operate with any request made by the Committee. 2.3 The Committee is authorised to instruct external professional advisers and request the attendance of individuals with relevant experience to attend if necessary.
Purpose & Duties	**Nomination Duties** 3.1 The Committee shall identify suitable candidates to fill Executive Director vacancies as required. 3.2 Review on a regular basis the structure, size, diversity and composition (including skills, knowledge and experience) required of the Executive Directors and agree any changes. 3.3 Give full consideration to and make plans for succession planning at Chief Executive and Executive Director level. 3.4 Keep the leadership needs of the Trust under review at Executive Level to ensure the continued ability of the Trust to operate effectively within the health system. 3.5 Where a vacancy is identified, prepare and agree a role description and person specification required for the particular post. In identifying suitable candidates, the Committee shall use open advertising and, if appropriate, the services of external advisors to facilitate the search. 3.6 Consider whether suitable candidates meet the "fit and proper persons test" criteria set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 3.7 Be responsible for identifying and agreeing for appointment, candidates to fill posts following the recruitment process. 3.8 Be responsible for identifying and agreeing a suitable candidate for the position of Chief Executive (this post is subject to the support of the Council of Governors).

Performance Duties

3.9 Receive reports on the performance of the Chief Executive and other Executive Directors against their agreed objectives and agree the performance assessment frameworks for individual Executive Directors and the Board of Directors as a whole.

3.10 Receive confirmation from the Chair in respect of the Chief Executive and from the Chief Executive in respect of the other Executive Directors on completion of their annual appraisals and of any issues that may have been identified.

3.11 Consider any matters relating to the continuation in office of any Executive Director at any time including the suspension or termination of service, subject to the provisions of law and their service contract.

Remuneration Duties

3.12 Review the ongoing appropriateness and relevance of the Trust's Remuneration Policy.

3.13 Set the remuneration for all Executive Directors within the terms of the agreed Remuneration Policy and following consultation with the Chief Executive. This will include basic salary, pension rights (insofar as these fall within the Committee's powers), any benefits of any kind, any incentive arrangements and compensation commitments on early termination arrangements.

3.14 Consider the performance criteria and any upper limits for annual bonuses and incentive schemes including in the remuneration of Executive Directors.

3.15 Ensure the Committee is adequately informed of comparative levels of remuneration for Executive Directors and other Trust employees who may be contracted on terms which are not part of the national NHS terms and conditions such as 'agenda for change'.

3.16 Establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the Trust successfully.

3.17 Ensure compliance with the requirements of HMRC and regulators such as NHS England with regard to severance pay and or other payments outside of contractual obligations. The Committee must be satisfied that such payments are in the best interest of the Trust and represents value for money. The Committee must therefore:

- Satisfy itself that is has the relevant information before it, to make a decision to approve a submission for payment outside of contractual obligations;
- Consciously discuss and assess the merits of the case;

	➢ Consider the payment or payment range being proposed and addressing whether it is appropriate, taking into account the issues set. The Committee should only approve such payment which it considers to be in the public interest and in accordance with HMT guidance "Managing Public Money". ➢ Keep a written record summarising its discussions and decision; and ➢ Monitor redundancy/capitalised pension costs for all staff groups and to approve any redundancy/capitalised pension costs in excess of £100,000. 3.18 To monitor compliance with IR35/ off payroll requirements.
Membership	The Committee members shall comprise: ➢ Chair of the Trust (Chair of the Committee) ➢ All other Non-Executive Directors
Attendees	The following will be in attendance at the Committee: ➢ Chief Executive (is a member when appointing or appraising other Executive Directors) ➢ Executive Director of People
Quorum	The quorum shall be made up of three members of the Committee including the Chair or nominated Deputy.
Observers	Meetings are not open to the public or members of the Council of Governors. Observers may be invited to attend from time to time for specified matters with the express approval of the Chair of the Committee.
Frequency of Meetings	The Committee will meet at least twice per year with ad hoc meetings as required by the business.
Meeting administration	Notice of the meetings will be given at least seven working days in advance of the meeting unless exceptional circumstances ensue. The Executive Director of People will support the Chair and the Chief Executive in the management of the Committee's business.
Operational Groups which report into the Committee/Group	There are no operation groups which report into the Committee.
Monitoring and review	The Terms of Reference will be subject to annual review. 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 Trust Board

Board of Directors' Meeting
08 November 2024

Agenda item	P188/24
Report	**Audit & Risk Committee 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 Healthcare Financial Management Association (HFMA) published a revised edition of the handbook in March 2024. The revised edition takes account of recent learning from governance failings and has been developed with input from NHS England. The Audit and Risk Committee carried out a review of the current Terms of Reference to ensure they aligned with any recommendations from the revised HFMA handbook during October 2024. The Terms of Reference were largely in line with the HFMA handbook and approved by the Audit and Risk Committee.
Due Diligence	The Terms of Reference were presented and discussed at the Audit and Risk Committee on 25 October 2024.
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	• Audit & Risk Committee Terms of Reference

Audit and Risk Committee
Terms of Reference

Name and Designation of Author	Angela Wendzicha, Director of Corporate Affairs
Approved by	Audit Committee Trust Board
Approving evidence	Minutes of the meeting Oct 2024 Minutes of the Board meeting held on November 2024
Date approved	Board of Directors
Review date	October 2024
Review frequency	Annual
Target audience	Audit and Risk Committee Members and Attendees
Links to other Procedural Documents	
Protective Marking Classification	Subject to the Freedom of Information Act

Date	Version	Author Name & Designation	Summary of amendments
February 2021	1		
July 2022	2	Angela Wendzicha, Director of Corporate Affairs	Full review following feedback on suggested amendments October 2021
October 2023	3	Angela Wendzicha, Director of Corporate Affairs	3.5.2 – removed reference to Improvement in NHSI 3.5.4 – removed this section as repeated in section 3.5.5 Observers – included observers only with prior approval of the Chair of the Committee.
October 2024	4	Angela Wendzicha, Director of Corporate Affairs	Minor amendments in line with HFMA Handbook (March 2024) 3.5.7 additional paragraph re requesting additional reports 12. Additional paragraph re behaviours and conduct.

Version Control

Title	Audit and Risk Committee Terms of Reference
Constitution	1.1 The Audit and Risk 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 by the Board to obtain 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 a Non-Executive Committee of the Board 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 Section 17.7.
Purpose & Duties	3.1 The Board has approved the establishment of the Committee for the purpose of advising the Board of Directors and providing an independent and objective review on the adequacy of Trust’s system of internal control, including audit arrangements (internal and external), financial systems, financial information, assurance arrangements including governance, risk management and compliance with legislation.

	The Committee will discharge this purpose through the following duties: <u>3.2 Governance, Risk Management and Internal Control</u> 3.2.1 On behalf of the Board, the Audit Committee shall review the adequacy and effectiveness of the establishment and maintenance of an effective system of risk management and internal control, across the whole of the Trust's activities (including those of any subsidiary, either currently in existence or to be established) that support the achievement of the organisation's strategic objectives. 3.2.2 In particular, the Committee, will review the adequacy and effectiveness of: • the Trust's general risk management structures, processes and responsibilities, including the production of all risk and control related disclosure statements, (in particular, the Annual Governance Statement) together with any accompanying Head of Internal Audit Opinion, prior to endorsement by the board; • the risk management strategy, structures, processes and responsibilities for identifying and managing key risks facing the organisation; • the Board Assurance Framework and ensure its presentation at the Board at intervals determined by the Board in addition to ensuring the Board Assurance Framework is adapted to recognise the impact of the Covid-19 Pandemic on the Strategic Priorities; • the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements; • the policies and procedures for all work related to anti-fraud, bribery and corruption as set out by the NHS Counter Fraud Authority; • the work of counter-fraud services; to ensure that there is an effective LCFS established by management that meets mandatory requirements and provides appropriate independent assurance to the Committee, Chief Executive and Board; • the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications including the NHS Code of Governance and NHS Provider Licence as set out in regulators' standards and guidance; • the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFS; • the operational effectiveness of policies and procedures; and • the financial control systems. 3.2.3 In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions,

	but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. 3.2.4 These will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it. 3.3 <u>Internal Audit</u> 3.3.1 Internal Audit primarily provides an independent and objective opinion to the Accountable Officer, Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust priorities. 3.3.2 The Committee shall ensure that there is an effective Internal Audit function established by management that meet the Public Sector Internal Audit Accounting Standards 2017, that utilises an independent risk based approach. 3.3.3 In addition, the Committee will: • consider the appointment of the internal audit service, the internal audit fee and any questions of resignation or dismissal and make appropriate recommendations to the Board; • following consultation with all executive and Non-Executive Board members, approve the internal audit programme and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework; • consider the major findings of internal audit investigations (and management's response) and report progress on material matters to the Board; • ensure co-ordination and co-operation between the Internal and External Auditors to optimise the use of audit resources; • ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; • review and approve the Internal Audit Plan, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework; • receive and review the annual report of the Internal Auditor and agree actions in response to this; • review annually the effectiveness of Internal Audit; and • meet in private with the internal auditor to discuss issues or matters arising. 3.4 <u>External Audit</u> 3.4.1 The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit

	process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by: • A report by the Committee to the Council of Governors in relation to the performance of the External Auditors, including details such as the quality and value of the work, and the timeliness of report and fees, to enable the Council of Governors to consider whether or not to re-appoint them. The Committee should also make recommendation to the Council of Governors about the appointment, re-appointment and removal of the External Auditor and approve the remuneration and terms of engagement of the External Auditor; • discussion and agreement with the External Auditor, before the annual audit commences, of the nature and scope of the audit, as set out in the annual plan; • reviewing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; • review and monitoring of External Audit reports, including the report to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses; • review and monitor the External Auditor's independence, objectivity and effectiveness, particularly with regard to non–audit services that may be provided to the Trust; • developing and recommend to the Board as required, the Trust's formal policy on the provision of non-audit services by the External Auditor, including approval of non-audit services by the Committee and specifying the types of non-audit service to be pre-approved, and assessment of whether non-audit services have a direct material effect on the audited financial statements ; • satisfy itself that there are no relationships between the auditor and the Trust (other than in the course of business) which could adversely affect the auditor's independence and objectivity; and • meet as required in private with the external auditor to discuss issues or matters arising. 3.5 <u>Other assurance functions</u> 3.5.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. 3.5.2 These could include any reviews undertaken by regulators (such as NHSE and the Care Quality Commission), and professional bodies with responsibility for the performance of staff or functions (such asthe General Medical Council and Nursing and Midwifery Council..

	3.5.3 The Audit Committee will also receive and review annual reports from the board's committees in support of the annual governance statement prior to them being submitted to the Board. 3.5.5 The Committee will provide assurance to the Board that the Trust is properly managing its cyber risk including any appropriate risk mitigation strategies. The Committee will receive reports that controls are in place for, protect from, and respond to cyber-attacks including management of the consequences of a cyber-security incident. In doing so, the Committee will satisfy itself that there is capable management resource in place to deal with cyber security matters. The Committee will receive assurance that the Trust has an incident response plan in place to deal with cyber security matters and that the workforce have been briefed and trained about cyber security. 3.5.6 The Committee will review the complete Board Assurance Framework (BAF) document on a quarterly basis prior to its submission to the Board. 3.5.7 The Committee shall request and review reports, evidence and assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the organisation (for example compliance reviews or accreditation reports). 3.6 Financial Reporting 3.6.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. 3.6.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. 3.6.3 The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on: • the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee; • changes in, and compliance with, accounting policies, practices and estimation techniques; • unadjusted mis-statements in the financial statements; • significant judgments in the preparation of the financial statements; • significant or proposed adjustments resulting from the audit; • letters of representation; • explanations for significant variances; • qualitative aspects of financial reporting; and • the rigour with which the Auditor has undertaken the audit.

	3.7 Counter Fraud 3.7.1 The Committee shall satisfy itself as to having adequate arrangements in place for counter fraud that meets the NHS Counter Fraud Functional Standards. 3.7.2 The Committee will refer any suspicions of fraud, bribery, and corruption to the Trust's Counter Fraud Specialist or the NHSCFA. 3.7.3 The Committee will regularly review the impact of actual, suspected or alleged fraud, bribery or corruption. 3.8 Annual Report 3.8.1 The annual report shall include a separate section to cover the work of the Committee in discharging the responsibilities outlined above. The annual report should : • explain the significant issues that the Committee considered in relation to the financial statements, operations and compliance, and how these issues were addressed; • explain, if the auditor (internal / external) provides non-audit services and how auditor objectivity and independence is safeguarded; • the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • include details of the full auditor (internal / external) appointment process where relevant. • The annual report shall also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed. 3.9 Whistleblowing Policies 3.9.1 The Committee shall review the Trust's arrangements for its employees to raise concerns, in confidence, about possible wrongdoing in financial reporting and control, clinical quality, patient safety or other matters. 3.9.2 The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action, and reassure individuals raising concerns that they will be protected from potential negative repercussions. 3.10 Collaborative Working 3.10.1 The Audit Committee will:

	• seek clarity and understanding around what the local arrangements are for collaborative working having regard for the Trust as the sovereign organisation • in seeking clarity, the Committee will understand the shared decision making arrangements; • will seek clarity on the accounting arrangements being put in place and; • will seek clarity on any proposals to agree risk appetites and tolerances. 11. <u>Other matters</u> The Committee shall: • review the appropriateness of single tender actions which have been approved by the Executive; • give due consideration to laws and regulations, and the provisions of The NHS Foundation Trust Code of Governance; and • committee members shall receive the development and training that they need to fulfil their role on the Committee. The Committee will also: • Review the BAF risks delegated to the Committee for review, and make recommendations to the Board for any required changes of risk score or content. 12. <u>Behaviours and Conduct</u> 12.1 Members will be expected to conduct business in line with the Trust values and objectives. 12.2 Members of, and those attending the Committee shall behave in accordance with the Trust's constitution, standing orders and standards of business conduct.
Membership	12.1 The Committee members shall be appointed by the Board and shall comprise three Non-Executive Directors, one of whom must have relevant and current financial experience. 12.2 The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors. 12.3 The Trust Chair shall not be a member of the Committee.
Attendees	13.1 Attendees to include: • Director of Finance who will be the Lead Executive • Chief Nurse • Director of Corporate Affairs • Representatives from Internal and External Audit

	• Attendance at least two meetings per annum (to be agreed with the Committee Chair) will be required by the Trust's Counter Fraud Specialist. 13.2 The Chief Executive may be invited to attend the Audit Committee, at least annually to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement. 13.3 Other Executive Directors or their colleagues may be invited to attend for specific agenda items.
Quorum	14.1 A quorum shall be made up of two members. 14.2 No business shall be transacted by the Committee unless a quorum is present. 14.3 Those in attendance or observing do not count towards the quorum.
Observers	15.1 Meetings are not open to members of the public. 15.2 Observers may only attend with the prior approval of the Chair of the Committee.
Frequency of Meetings	16.1 Meetings will take place at least five times per financial year, but may be held more frequently should circumstances require (which will be determined by the Chair of the Committee). 16.2 At least once a year, the Committee shall meet privately with both Internal and External Audit without the presence of management. 16.3 The Committee must consider the frequency of meetings needed to allow it to discharge all of its responsibilities.
Meeting administration	17.1 Notice of meetings will be given at least seven working days in advance unless members agree otherwise. 17.2 The Chair of the Committee, Lead Executive and the Director of Corporate Affairs will meet to agree the agenda for each meeting based on the Annual Work Plan and any other urgent business. 17.3 Administrative support to the Committee will be provided by the Corporate Governance Department. The agenda and papers will be circulated three working days prior to the meeting. Any amendments to the agenda can only be carried out with the agreement of the Committee Chair and Lead Executive. 17.4 Draft minutes and action log will be circulated by the administrative support within five working days of the Committee and approved by the Committee Chair within fifteen working days of the meeting.

	17.5 It is an unusual for business to be required to be carried out outside of scheduled Committee meetings. For business that is required to be carried out by the Committee, outside of the scheduled meetings an extra ordinary Committee will be convened.
Operational Groups which report into the Committee/Group	Risk Management Committee is the operational group reporting into the Committee. The Chair from the Risk Management Committee will provide a quarterly report the Committee.
Monitoring and review	The Committee's Terms of Reference will be subject to annual review. The Committee will undertake and annual review of its performance, via a self-assessment by its members with any agreed actions reported to the Board.

Board Planner

Event/Issue

Action	TRUST BOARD MEETINGS		2024							2025	
			Jan	March	May	June	July	Sept	Nov	Jan	March
			12	8	3	11	7	8	1		
			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	COO								•	
	Winter Plan	COO							•		
	Digital Strategy	CEO					•dfd		•		
	Estates Strategy	DoF	•				•dfd			•	•
	People and Culture Strategy	DoW			•						
	Quality Improvement Strategy.	CN							•		
	Fire Safety Strategy (via ETM)	DOE			•					•	
	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	Public Health		•				•			
	CULTURE										
	Patient Story	CN		•			•		•		•
	Staff Story	DoW	•		•			•		•	
	Annual Staff Survey	DoW		•							
	Staff Survey Action Plans	DoW			•						
	Freedom to Speak Up Quarterly Report	CN	•		•			•dfd	•	•	
	Gender Pay Gap Report and Action Plan	DoW		•							•
	Integrated EDI Plan - WRES, WDES, PSED	DoW						•			
	Patient Experience and Inclusion Annual Report	CN					•				
	End of Life Annual Report	DCN					•				
	PERFORMANCE										
	Integrated Performance Report:	COO	•	•	•		•	•	•	•	•
	Maternity including Ockenden	CN	•	•	•		•	•	•	•	•
	Safe Staffing & Establishment Nurse review (6 monthly)	CN	•				•			•	
	Safe Staffing & Establishment Nurse review	CN		•							
	Reports from Board Assurance Committees	NEDs	•	•	•		•	•	•	•	•
	Finance Report	DoF	•	•	•		•	•	•	•	•
	Car Parking Review (via ETM)	DOE			•		•				
	Summary of review on Laboratory safety prior to TUPE of staff	MD		•							
	ASSURANCE FRAMEWORK										
	Governance Report	DoCA	•	•	•		•			•	•
	Board Assurance Framework	DoCA	•	•	•		•	•	•	•	•
	Quarterly Risk Management Report	DoCA		•	•			•		•	
	Corporate Risk Register	DoCA	•	•	•		•	•	•	•	•
	Annual Review of risk appetite	DoCA					•	•			
	Assurance Board Committee ToRs - Audit & Risk Committee	DoCA							•		
	Assurance Board Committee ToRs - FPC, QC, PC	DoCA		•							
	Health and Safety Annual Report	DoE								•	
	Quality Assurance Quarterly Report	CN		•	•			•	•		•

	SIRO Annual Report	DCEO						●dfd	●			
	Safeguarding Annual Report	CN							●			
	Infected Blood Inquiry	MD							● dfd			
	Organ Donation Annual Report	HC						●				
	POLICIES											
	Health and Safety Policy (review date August 2026)	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 February 2026)	DoF										
	Risk Management Policy (due April 2026)	DoCA										
	REGULATORY AND STATUTORY REPORTING											
	Annual Report and Audited Accounts	DoF					●					
	Audit & Risk Committee Annual Report	Com Chair					●					
	People & Culture Committee Annual Report	Com Chair					●					
	Finance and Performance Committee Annual Report	Com Chair					●					
	Quality Committee Annual Report	Com Chair					●					
	Nomination and Remuneration Committee Annual Report	Com Chair					●					
	Annual Quality Account (approval)	CN					●					
	Data Security and Protection Toolkit Recommendation Report	SIRO						●dfd	●			
	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 ●			●			Q2 ●	Q3 ●		
	ANNUAL Report from the Guardian of Safe Working	MD				●					●	
	Learning from Deaths Quarterly Report	MD		●		●		●		●		●
	Learning from Deaths Annual Report	MD							●			
	Emergency preparedness, resilience and response (EPRR) assurance process sign off/Annual Report	COO						●				
	Controlled Drugs Annual Report	MD							●			●
	NHSE Self-Assessment for Placement Providers 2024	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				●					●	
	Review of Board Feedback	DoCA									●	
	Review of Board Assurance Terms of Reference	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 (ad hoc)	DoCA								●		
	Constitution	DoCA									●	
	Annual (re)appointment of Senior Independent Director	Chair							●			
	Annual (re)appointment of Board Vice Chair	Chair							●			
	Annual Board Meeting dates - approval	DoCA							●			
	Fit and Proper Person	DoCA							●			
	Escalations from Governors	Chair							●	●	●	●
	Nomination & Remuneration Committee Chair Assurance Report	Chair									●	
	Annual Planner	Chair	●	●		●		●	●	●	●	●
	Annual Refresh of Committee membership (part of Chairs Report)	Chair				●						
	Audit & Risk Committee minutes	Chair	●			●		●			●	
	Quality Committee minutes	Chair	●	●		●		●	●	●	●	●
	People & Culture Committee	Chair	●	●		●		●	●	●	●	●
	Finance & 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		•								•
	Ad Hoc Business Cases for consideration by Board value in excess of £1m											
	Out-patient Pharmaceutical Dispensing Services	COO				•						
	Board feedback		RS	SH		HW		JBe	MT	MW	RS	SH
	NED Review of complaints files (Quarterly)		KM			JB		HW		MT	New NED	
	CORPORATE TRUSTEE (AD HOC)											
	Approved Minutes (Oct 23, Jan, 24, Mar 24 plus confidential)							•				
	Chair's Logs (Oct 23, Jan 24, Mar 24, May 24)							•				
	Terms of Reference							•				
	Summary of Performance Against Objectives							•				
	Objectives to f24/25							•				
	Financial plan and budget 24/25							•				
	Cancer Appeal							•				
	Legacy Giving							•				
	Annual CFC Report							•				