The Rotherham NHS Foundation Trust

Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 2 May 2025, 9:00 AM — 12:30 PM BST
Venue	Boardroom, Level D
Organiser	Claire Rimmer

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P56/25.	Chairman's welcome and apologies for absence For Information - Presented by Dr Mike Richmond
	P57/25.	Quoracy Check For Assurance - Presented by Dr Mike Richmond
	P58/25.	Declaration of interest For Assurance - Presented by Dr Mike Richmond
	P59/25.	Minutes of the previous meeting held on 07 March 2025 For Approval - Presented by Dr Mike Richmond
	P60/25.	Matters arising from the previous minutes (not covered elsewhere in the agenda) For Assurance - Presented by Dr Mike Richmond
	P61/25.	Action Log For Decision - Presented by Dr Mike Richmond
	OVERVIEW AND CONTEXT	

9:10 AM	P62/25.	Board Committees Chairs Reports - Committee Chairs (TO FOLLOW) 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 Assurance
9:40 AM	P63/25.	Board Assurance Framework For Decision - Presented by Peter Walsh
	P64/25.	Risk Management Report For Information - Presented by Peter Walsh
	P65/25.	Risk Management Policy For Decision - Presented by Alan Wolfe
9:50 AM	P66/25.	Report from the Chairman - Verbal For Information - Presented by Dr Mike Richmond
9:55 AM	P67/25.	Report from the Chief Executive For Information - Presented by Dr Richard Jenkins
10:00 AM	STRATEGY & PLANNING	
	P68/25.	TRFT Five Year Strategy - 6 month review For Assurance - Presented by Bob Kirton
	CULTURE	
10:20 AM	P69/25.	Staff Story - Hashim Din, Alicia, Falzal, Scarlett (T Level Students) For Information - Presented by Daniel Hartley

	P70/25.	NHS Staff Survey 24/25 and next steps 25/26 For Assurance - Presented by Daniel Hartley
10:40 AM	P71/25.	Freedom to Speak Up Quarter 4 Report & Annual Report 2024/25 For Information - Presented by Helen Dobson
10:50 AM	SYSTEM WORKING	
	P72/25.	National, Integrated Care Board and Rotherham Place Update For Information - Presented by Bob Kirton
10:55 AM	BREAK	
11:00 AM	PERFORMANCE	
	P73/25.	Finance Report For Assurance - Presented by Steve Hackett
	P74/25.	Integrated Performance Report For Assurance - Presented by Bob Kirton
	REGULATORY AND STATUTORY REPORTING	
	P75/25.	Maternity and Neonatal Safety Report Presented by Sarah Petty For Assurance
11:30 AM	P76/25.	Guardian of Safe Working Hours Quarterly Report: Gerry Lynch in attendance For Assurance
11:40 AM	P77/25.	Mortality & Learning From Deaths Quarterly Report For Assurance - Presented by Jo Beahan

BOARD GOVERNANCE

P78/25. Board Committee Terms of Reference Annual Review
For Ratification - Presented by Peter Walsh

P79/25. Escalations from Governors - No Escalations
For Discussion

P80/25. Board Annual plan
For Noting

P81/25. Any Other Business
For Discussion

P82/25. Questions from Members of the Public on the Business of the Meeting
For Discussion

P83/25. Date of next meeting - Friday 04 July 2025

CLOSE OF MEETING

Draft until approved at the 2nd May 2025 meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING
Friday 7th March 2025, 09:00 – 12:00 pm
Boardroom

Present:
Dr M Richmond, Chairman
Dr R Jenkins, Chief Executive
Mrs H Craven, Non-Executive Director
Mrs H Dobson, Chief Nurse
Dr J Beahan, Medical Director
Mr S Hackett, Director of Finance
Mrs S Kilgariff, Chief Operating Officer
Mr M Temple, Non-Executive Director
Mr B Kirton, Managing Director
Ms J Burrows, Non-Executive Director
Professor S Congdon, Non-Executive Director
Mr D Hartley, Director of People
Dr R Shah, Non-Executive Director
Mr K Malik, Non-Executive Director

In attendance:
Mr A Mondon, Associate Non-Executive Director
Mrs J Roberts, Director of Operations/Deputy COO
Mrs E Parkes, Director of Communications
Mr S Dickinson, Director of Estates and Facilities
Mr J Rawlinson, Director of Health Informatics
Mr A Wolfe, Deputy Director of Corporate Affairs
Ms C Rimmer, Corporate Governance and Risk Manager (minutes)
Mr A Turvey, Public Health Consultant (for item P40/25)
Ms H Khaira, Freedom To Speak Up Lead (for item P41/25 & P42/25)
Mrs S Petty, Head of Midwifery (for item P47/25)

Observers: None

Apologies:
Ms H Watson, Non-Executive Director
Ms A Wendzicha, Director of Corporate Affairs

Item	Procedural Items	Action
P27/25	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE** Dr Richmond welcomed everyone to the meeting and noted apologies for absence.	
P28/25	**QUORACY CHECK** The meeting was confirmed to be quorate.	

P29/25	**DECLARATIONS OF INTEREST** Dr Jenkins' interest in terms of his joint role as Chief Executive of both the Trust and Barnsley Hospital NHS Foundation Trust was noted. Mrs Parkes' interest in terms of her role as Director of Communications and Marketing of both the Trust and Barnsley Hospital NHS Foundation Trust was noted.	
P30/25	**MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 10th JANUARY 2025** The minutes were approved as a correct record.	
P31/25	**MATTERS ARISING** There were no matters arising which were not covered by either the action log or agenda items.	
P32/25	**ACTION LOG** The Action Log was received and log numbers 20 and 3 were agreed to be closed with further discussions in the agenda items. All other items were agreed to remain open.	
	OVERVIEW AND CONTEXT	
P33/25	**Board Committees Chairs Reports** i. Quality Committee (QC) Ms Burrows presented the chairs report and highlighted the key points including: - IPR reporting had shown a decrease in combined positivity score for which the committee were monitoring and further information would be provided by the Chief Nurse - Presentation from Care Group 4 and the success with virtual ward, particularly around patients choosing to be referred there. Ms Burrows raised the need to further maximise the use of this resource - Volunteering as an area to consider for expansion - Strategic session at the last meeting around the Quality Strategy and the view to incorporate further strategic sessions into the work planner. Dr Beahan provided further information on the never event regarding a small piece of equipment that had broken. The level of impact to the patient was not yet known due to the complexities involved. Dr Beahan reassured that the Patient Safety Investigation (PSI) was ongoing and the correct processes worked through. Dr Richmond endorsed the future award opportunities and pressed for further ambition in putting forward subject matters. Mrs Dobson detailed that information had been circulated to Care Groups and a short list of options would be presented to the Executive Team Meeting (ETM). Ms Parkes noted the work in the Communications team to publicise and encourage awards.	

On the inspection on the Radio-Pharmacy facilities, Mrs Craven posed that it was incumbent on the Trust to ensure services are fit for purpose and this oversight should be reflected on and built into processes. Dr Jenkins concurred but raised that the Medicines and Healthcare products Regulatory Agency (MHRA) had increased the levels required. There had been new protocols and need to ensure Standard Operating Procedures (SOPs) were correct.

Dr Shah put forward concerns of the rising sickness rates in Care Group 4 and the stretch on services, noting the decline in pressure ulcer care in the community as an indicator of impact. Mrs Dobson raised that sickness rates were an issue in all areas and regarding pressure ulcers, there were difficulties in the measurements but that community was less of a concern than the acute setting. Mrs Dobson detailed that will be some leadership changes that could lead to improvements and a step change for the Care Group.

Dr Shah queried whether the Virtual Ward data could report on the effectiveness of reducing demands on the acute or whether it was just delaying admissions. Mrs Dobson explained that there was a performance dashboard behind the high-level data and that it was difficult to identify specifics due to the links and work with social care. Mrs Dobson raised that there was need for a deep dive to ensure Virtual Ward was not picking up other work outside of its remit and commission. Mrs Kilgariff added that it can be difficult to step patients down from Virtual Ward which could have impact on the service and it would be worth reviewing. Mr Kirton commented that the plan for 2025/26 involves a review of community services with the view to change the model and the relationship between the different models of services; this was being led with Commissioners.

Prof. Congdon posed that more triangulation was needed between committees, particularly in regard to the IPR and areas of concern or static nature, and join up with the risk register to provide more assurance and joined up reporting. Prof. Congdon raised that the IPR fails felt tenuous and an area of concern. Mrs Dobson referred to the Board Assurance Framework (BAF) and the level of assurance and triangulation regarding quality; driving discussions had been the long waits in UECC however, reviewing the data, did not show direct harms. Mrs Dobson highlighted the vast amount of underlying information and evidence that feeds into the reviews and data sets, such as the Exemplar Accreditation Programme, but accepted that there would always be more that can be done. Mr Kirton commented that there will be further work led by the Executive Team to ensure there is focus and accountability through Performance Meetings, leading to the accountability from Executives at Board and Board Committees.

Dr Richmond concluded that the Board looked forward to receiving the Quality Strategy which would identify the ambitions moving forward. The Board would look for an update as soon as possible and on a regular basis thereafter.

ii. People & Culture Committee (P&CC)

Dr Shah introduced the chair's report and updated the Board on the following:

- The positive work on the Band2/3 consultations and the learning gained to be recorded and reflected on in future

- Benefits from the Wellbeing trolley rounds, bringing dialogue not gathered otherwise
- Care Group 1 presentation and the challenges in acuity, pressure on staff, sickness rates, staffing levels and gaps. Dr Shah updated that the committee had actioned a deep dive into the absence rates and Health and Wellbeing support, and would like to see more innovation in this area and a look to wider incentives for people

Prof. Congdon reflected on the care group presentation and the feelings portrayed, considering whether it was stress, culture, engagement or leadership issues. Mrs Kilgariff concurred with the observations and updated that there had been follow up conversations and reflections. Mr Hartley added that his team would be putting in extra support to the care group and put specific actions in place to ensure compliance with policies and consideration to the support and challenge required to deliver the best care for patients through the staff at work. Dr Jenkins noted the extra pressure on teams from the March A&E targets and Mrs Craven raised that it was timely to initiate a deep dive and noted the national reporting on the difference in workforce attitude and mental health issues.

Dr Richmond concluded that there should not be normalisation of high sickness rates and the Trust should reflect on what the best of the best are doing in the NHS.

iii. Finance & Performance Committee (FPC)

Mr Temple presented the report and raised that volume, sickness absence and the consequence on performance targets had been key elements of the discussions. Mr Temple raised that there were targets not being met however, the Trust was in the top quartiles for some performance metrics, concluding that some areas were coping with the challenges better or worse than others. It was reported that the Trust will meet its financial plan but Mr Temple detailed that the committee were incredibly mindful of the next year.

On risk management, Mr Temple updated on the focus on static risks and the action plans in place and that this will be a key area of focus moving forwards.

Mrs Craven raised that the ability to meet next year's plan is a largely dependent on CIP and big transformational schemes, however, there was a lack of multi-year schemes. Mrs Craven referred to earlier comments on better triangulation, including the BAF and the risk levels, with more focus on the controls and gaps of the BAF to be addressed not just in year, but a multi-year viewpoint.

iv. Audit and Risk Committee (ARC)

Mr Malik was pleased to hear and see the conversations on risks and shared that the Trust is recognised by 360 Assurance as a reference point for good practice. Mr Malik reported that the committee had discussed more dynamic risk management which had been a theme of conversations during the meeting;

	static risks can lose meaning and there is need to incorporate environmental changes and areas of focus moving forward. Mr Malik updated that the new Risk Management Strategy was approved and that is took a further view on skills, capabilities and system-wide risk reviews. An action was taken to circulate the Risk Management Strategy for Board approval outside of the meeting. Regarding Standards of Business Conduct, Mr Malik detailed that this had been an area of focus and there was movement in the right direction. On internal audits, Mr Malik clarified that the split assurance on bank and agency was specifically around the ordering process and the issue was on the segregation of duties. An action plan to address was in place and monitored and Mr Hackett confirmed that there had been response to the recommendations with immediate mitigations put in place. The issue had been flagged to other organisations as it is a common area of weakness.	**Mr Wolfe**
P34/25	**Board Assurance Framework (BAF)** Mr Wolfe presented the BAF report, reflecting on the input from Executive Leads and the recommendation for the BAF risk scores to remain the same. For BAF risks R2 and R3, AMW confirmed that these would be fully reviewed and refreshed with the new Managing Director, with integration of previous comments around the work with Place. There would also be a full BAF refresh with all Executive Leads for 2025/26. AMW reminded that a significant assurance opinion had been given by 360 Assurance on the BAF and would strive to remain or surpass this in the next year. Dr Richmond reflected on a Barnsley and Rotherham Governor to Governor meeting earlier in the week and the discussions on shared services, governance and board assurance; whether this was separate or jointly agreed and to be mindful of this for shared endeavours. Mr Kirton updated that it was a principle that was being worked towards, to have one joint report and all work to the same version. There were already local examples of this in train. Mrs Kilgariff detailed the governance layers for MEOC and the joined up reporting to FPC to link up to Board.	
P35/25	**Corporate Risk Register Report** Mr Wolfe introduced the report which gave a high level review of the risk management processes and compliance in the Trust. Mr Wolfe feedback on the recent Risk Management Committee and the discussions around static risks and in-depth reviews to progress the risks, and the number of highly rated risks in relation to the UECC which were raised as requiring more corporate ownership or input. Mr Wolfe also detailed the conversations around risks out of the Trust's control to mitigate and triangulating the risk score with the risk and incidents of harm and effects on a daily/weekly/monthly basis to be reflected in the rating. Lastly, Mr Wolfe drew attention to the emerging risks and the changes reported. Dr Shah queried Risk 6421 and SH updated that the funding had been agreed but not yet received. There is an action plan in line with the programme and would lead to a reduction in the risk.	

P36/25	**Report form the Chairman - Verbal** Dr Richmond had no further comments and would provide a brief update in the confidential meeting.	
P37/25	**Report from the Chief Executive** Dr Jenkins updated the Board on the recent introduction of ANPR cameras, transitioning to a new parking management system and confirmed that Trade Unions had been cited on this and were in support of the changes. Mr Malik commended the achievements in the DM01 performance and queried how, in general, the Trust ensures good practice is shared. Mrs Kilgariff detailed that this is through oversight and understanding of positioning alongside other aspects, such as collective improvement work. Mrs Kilgariff agreed that there is opportunity to further showcase the work done, for example in Cancer Services, to the wider organisation and ensure clinicians are sighted on it. Mr Malik pushed on whether there is something more formal; acting on rather than sharing, and Mrs Kilgariff linked to national best practice, GIRFT work, upskilling of service managers and inclusion of colleagues in improvement work. Dr Shah raised that Dermatology and Gastroenterology were fragile services and had been for some time, and questioned how this is being addressed as well as the other risks to patients waiting. There was link to the Quality Priority on Delayed Diagnosis and Dr Beahan updated on the positive recruitment in Gastroenterology which should have impact and that there were conversations with Barnsley on partnership working. Dr Beahan detailed that Dermatology is a challenge across the ICB and the ICB are leading on plans to address fragility, alongside the Trust doing its own review.	
	STRATEGY AND PLANNING	
P38/25	**Draft Annual Operational Plan - Verbal** Mr Kirton updated the Board that the work is ongoing, following the updates provided at the Strategic session. There was some incongruence between the local and national ask and there are ongoing discussions. Mr Kirton shared the difficulties to finalise a plan as issues are live national debates and noted the aim to submit to March FPC and then Board. Mrs Craven put forward that the Board should be behind the parameters set so that the pressure is shared and suggested a series of meetings to understand the construction and viability of the plan. There would be a CEO and Chairs meeting next week and Dr Jenkins raised concern regarding timetables and the time required to outline figures. Dr Jenkins also raised that there is an expectation that the Trust Board supports a system plan but there were still questions on how this would be delivered. Dr Richmond summarised that there were still various gaps in the information and apparent deadlines and the Non-Executives agreed on the benefit of a series of meetings to understand the parameters and balance required, in the lead up to final submission.	

P39/25	**Fire Strategy** Mr Dickinson introduced the report, noting that it had been to the Executive Team and FPC last year and amended accordingly. Mr Dickinson summarised that strategy on fire safety was around the leased estate, including in the community, to maintain high standards of control. Remarks were made on the building descriptions to ensure there was reference to the fire alarm systems in each space. Further remarks were made on references to other buildings, both on site and off, Trust owned and leased, and the clarity on the duty of care. Prof. Congdon queried the documentation on compliance, how it is implemented internally and whether there is external auditing. Mr Dickinson explained that, for the Health and Safety aspects, the premises insurance model is used and the team were looking at benchmarking utilising SPC charts to provide assurance. For Fire Safety, this was national guidelines and reporting including assessments on fire systems and fire risk assessments from all sites used to give an overall scoring and this could also form a new reporting dashboard. Mr Dickinson added that there is work ongoing with an external assessor but reassured that there was no evidence towards non-compliance. It was suggested that this was reflected in the strategy. Mr Temple put forward that the next steps are how the strategy will be used and reported against, and supported the introduction of SPC charts and that it would be useful as part of the IPR. Dr Jenkins raised that the assurance processes to Board had not been successful here and needed further work. Further clarity was requested in the strategy and consideration of comments from Board members. The strategy was not approved and would be brought back again for final approval.	
	CULTURE	
P40/25	**Patient Story** The Board welcomed Mr Turvey to the meeting, who gave a presentation on a patient's interaction with the Healthy Hospital Team stop smoking service and the impact it made. Mr Turvey explained more about the service, their roles, the circa 4,000 conversations with patients about smoking in the last year and the good links with community services to ensure ongoing support. Mr Turvey presented the positive feedback given by the service user following interactions as an inpatient and the positive impact of the follow up to initiate reengagement with the stop smoking service. Mrs Dobson raised that there is learning from this and benefits of the follow up interactions. It was also just a snapshot as the community offer is also very meaningful. Mr Turvey detailed that the focus is to help people use the services across the whole system; all inpatient attendances are screened for smoking status and the team is working hard to reach patients identified. There is training for champions across the Trust to support spotting the signs and making every interaction count.	

	Ms Burrows highlighted that the follow up call had been really important in this case and whether there was scope for this as part of the service. Ms Burrows also queried how the effectiveness of referrals to other systems is reviewed. Mr Turvey explained that they were working with the strategy team to stratify the risk of not achieving outcomes and utilise algorithms to analyse the data, similar to that of the missed appointments in cancer services. The community teams had also been good at giving feedback to the service. On the digital weight management pilot, as part of waiting well, Mr Turvey updated the Board that the national evaluation was more focused on engagement and acceptance, but the Trust evaluation would hope to share more information on outcomes in due course.	
P41/25	**<u>Freedom to Speak Up Quarter 3 Report</u>** The Board welcomed Ms Khaira to the meeting who presented the Freedom To Speak Up (FTSU) report. Ms Khaira highlight the following key points: - The number of concerns raised had increased from nine to twenty three in the last quarter. Whilst there was not the view to focus on the numbers, it showed that there are concerns from staff groups across the Trust and Ms Khaira raised that the quarter had seen an increase regionally as well as nationally. It could also correlate with the FTSU Week in October and the awareness raised - 50% of concerns had been raised in Care Group 1, with two grouped concerns. There is work to introduce FTSU Champions here and the Heads of Nursing were looking into this - Actions for Quarter 4 including increasing the number of FTSU Champions from twelve to twenty Dr Beahan commended the work Ms Khaira had been doing to raise awareness and posed that the engagement and visibility could bring more historic concerns forward. Dr Richmond queried the closing of the loop for concerns raised and Ms Khaira detailed the simpler completion for some, and the regular updates provided for more complex cases. Mrs Dobson confirmed the close working with Ms Khaira and the Executives to provide updates and recognised that it was a good process. Dr Shah posed whether there was triangulation here with the information on the ability to come to work and feel valued; was the service counselling or creating change. Ms Khaira acknowledged that there were elements of counselling, however, was looking to change this, and noted the correlation between the staff survey from the previous year, and areas where concerns were ongoing. HK – yes but trying to change. Mr Hartley reported that some concerns do lead to investigations and would pick up further at People and Culture Committee, as is a key part of the People picture.	
P42/25	**<u>Freedom to Speak Up Annual Report 2023/24</u>**	

	Ms Khaira presented the annual report, which was a summary of quarterly reporting to Board, for completeness.	
P/43/25	**Gender Pay Gap** Mr Hartley presented the report and detailed that the overall statistics were static in the main, reflecting on the previous year, and the gaps were multi factorial. Mr Hartley drew attention to the difference in the consultant workforce and that he was working with the Medical Director and team to look further here. There were historic awards that had contributed, which had been stopped with the new contracts, and the medical training timeline to consultant also had impact. There would be actions ongoing to close the gap relating to the ability to attract and retain female medics to more senior roles, looking at what can be done proactively locally as well as nationally. Dr Jenkins highlighted the difficulties, due to historic pay patterns, however, there can be current change and focus now on ensuring people are treated equally. Dr Beahan detailed that she would take the findings back to Medical Workforce as well. The report was approved and actions would be taken forward in line with the EDI plan.	
	SYSTEM WORKING	
P44/25	**South Yorkshire Bassetlaw Integrated Care System and Integrated Care Partnership report** Mr Kirton reflected on previous Board conversations about the role in Place and there would be a fuller report coming forward. Mr Kirton updated on the South Yorkshire pathways work including the Growth Accelerator, and the co-created Rotherham Social Value Vision. Ms Burrows commended the work on social value as a positive step. Ms Burrows put forward that, in the context of the current system, the ICB's update/ newsletter was surface level and lacking depth and Mrs Craven requested more information on the outcomes and the next steps, rather than meetings that have taken place. Mr Kirton confirmed the commitment to bring a fuller update to Board. Dr Richmond queried the levels of accountability for joint plans and Mr Kirton acknowledged that it can be difficult, however, there was a tangible successful example with the CDC funding and the system working together to shape the submissions and influence to secure investment.	
	PERFORMANCE	
P45/25	**Finance Report** The Finance report was presented by Mr Hackett, detailing the Month 10 position. Mr Hackett drew attention to the significant improvements and the achievability of the financial plan. There was ongoing work around capital expenditure to ensure the proper and full use of resource made available for the year. On Cost Improvement Programmes (CIP) Mr Hackett outlined the circa	

	80% delivery in year and the challenges and risk that will carry over into next year; this will inevitably add to the financial challenges. Following FPC feedback, the Back to Balance work would include a different approach and integration of multi-year approaches to mobilise schemes. Mr Kirton commented that there had already been positive sessions with the Executive Team, looking at multi-year approaches, tactical savings and productivity work.	
P46/25	**<u>Integrated Performance Report</u>** Mr Kirton introduced the report and referred to the discussions throughout the meeting and reports presented that link with the data. Mr Kirton reminded that it was high level reporting and the operational context would come through in the Board Committees. Ms Burrows shared frustrations on elements within the Trust's gift to control and achieve, for example appraisal rates. Mr Hartley agreed and detailed the work to challenge and support colleagues and hold Care Groups to account. Mrs Dobson updated on the C Difficile rates and actions; the Infection, Prevention and Control Committee and the Quality Committee monitor this closely and there had been work with external agencies, ICB and NHSE to see whether there were any further or different actions that should have been taken. Dr Richmond raised that the deep cleaning profile had been highlighted to Board previously and Mrs Dobson reported that she was working with the Director of Estates and Facilities on a joint proposal to move forward with routine deep cleans, instead of reactive and as required. Mrs Dobson also detailed that each case was reviewed and cases were a reflection of what is in the community, linking to themes around antibiotic prescribing. Dr Jenkins linked to the focus on getting Antimicrobial Stewardship right and to test and isolate quickly. Mrs Craven suggested that more focus should be given on actions planned and outcomes, as well as comments to focus attention on points of concern. Mr Temple referred to earlier discussions in that the addition of Estates and Fire Safety would be useful in the report. Mrs Kilgariff agreed to discuss with the Data Insights team to provide extra detail and context on the data and changes. On SHMI data, Dr Beahan informed that there had been a lot of work with the coding team and the medical teams to record co-morbidities. Dr Richmond queried, in the pursuit of excellence, what more can be done to be better than expected. Dr Beahan explained the parameters of the data, either under achieving or an outlier outside of the internal expectations to remain at a pass, and the rationale behind the static nature. Ms Burrows raised that, following the ambition of continuous improvement, the patient experience data showed a clear deterioration and there was work to do on the action plans moving forward. Dr Richmond reflected on the Board commitment to reduce 52 week waiters by half by March. Mrs Kilgariff reported that this had been brought to FPC with acknowledgement that the target would not be met. It had been eliminated in some specialities but there had been significant challenges, for example, in Gynaecology, TNO and OMFS, with patterns consistent in other organisations in	**Mrs Kilgariff**

	terms of challenges and specialities. Dr Richmond posed that there is clearly good work in areas, but that it was important from a Board perspective that there is clarity here to understand the positive positions as well as the challenges and the actions to address. Mrs Kilgariff would enable more linkage with the quarterly deep dives reported to FPC to Board. Looking at the year ahead, Dr Jenkins signalled that the expectations should be set alongside the annual plan, analysing success with the current reality, rather than constitutional standards. Dr Jenkins also suggested the IPR report should be refreshed and have clear focus on the key areas.	**Mrs Kilgariff**
	ASSURANCE	
P47/25	**Maternity and Neonatal Safety Report** The Board welcomed Mrs Petty to the meeting who provided key updates from the report: - The overview of the thematic reviews regarding the cluster of still births - The internal and external reviews conducted had identified no overarching safety concerns however, there were some learning opportunities that had been identified by teams - Audio recording of triage calls had now been implemented which was a recommendation from a national CQC report into maternity services - MBRRACE report and the comparison with other trusts - CNST sign off and submission, thanking the Board for their support Mr Hackett drew attention to the increase in smoking data, correlating with the public health funding withdrawal and the challenge passed to NHS commissioners. Mrs Petty noted that when the funded work was in progress, that percentage was closer to 7%. Dr Shah pressed that the breast feeding accreditation needed to achieve outcomes and shift the dial. Ms Burrows linked with the Rotherham Place plan and breast feeding targets to feed in here. Dr Shah also drew attention to the increase in massive PPH. Mrs Petty detailed that the service is reviewing the trends and had not seen a step change. Thematic reviews were in progress, similar to the reviews into still births and the service was also part of a research study. Dr Richmond sought clarification for the board on the independency of the thematic reviews reported and Mrs Petty outlined that the internal review and external review by LNMS were conducted separately to avoid bias and then shared following completion. Dr Richmond also raised the concerns from maternity safety champions on the capacity in theatres and Mrs Petty concurred that it was a priority for 2025/26. The rates of Caesarean sections had increased and there was inability to meet demands, but the service was maintaining as much as safety as possible within their control.	
P48/25	**Health and Safety Annual Report 2023/24**	

	Mr Dickinson presented the report and highlighted the scope and purpose of the report and the underpinning compliance, assessments and data. Mrs Craven questioned where the addendum was presented and it was agreed for this to be re-circulated to the Board as it addressed further comments on Fire Safety works. Comments were made against the clarity of the report, with further detailed need on works completed and that for the following year, and on the fire door survey and completed works. Questions were raised on the scope of the report and Mr Dickinson explained that it included multi-disciplinary team compliance, RIDDOR reporting and further focus depending on the current themes and trends and high profile risks and issues. There was a request for more detail and benchmarking for the claim data. This raised further discussions on the scope of the report and general reporting to ensure areas of concern and issues are sighted by the Board. Mr Kirton, as the new Chair of the Health and Safety Committee, detailed that there would be work done here to re-develop the report which is compiled from reporting to the committee, including a review of the terms of reference, alignment to national requirements, audits, commissioned reports and other aspects. Dr Jenkins summarised that there was learning to capture from today for the next annual report.	
	REGULATORY AND STATUTORY REPORTING	
P49/25	**Controlled Drugs Annual Report** Dr Beahan introduced the report, noting that it was a statutory requirement and had been presented at Medication Safety Committee and Quality Committee. Dr Beahan detailed that a new Chief Pharmacist was in post, the patient harm from controlled drugs was low, there are tenable monthly checks and the audit findings correlated to the spikes in data. Dr Shah raised that if there are spikes as a result of audits, there is question of the monthly reporting and tracking and this was important assurance to attain. Dr Beahan commented that the audits would be every quarter for greater visibility and cross referencing with other audits and would pick up with the Chief Pharmacist. Mr Malik queried whether the avoidance of harm was from systematic controls and whether there were any significant issues or themes in 'other medication incidents'. Dr Beahan explained that these conversations were picked up at the Medication Safety Committee and with the Chief Pharmacist.	
P50/25	**Guardian of Safe Working Hours Quarterly Report** This item was deferred.	
	BOARD GOVERNANCE	

P51/25	**Register of Sealing** Mr Wolfe explained that, as the report details, the register had not been used since the last report to Board	
P52/25	**Register of Interests (bi-annual review)** Mr Wolfe informed the Board that this would be published on the Trust website and the out of date declaration was now completed.	
P53/25	**Escalations from Governors - No Escalations** There were no escalations from the Council of Governors.	
P54/25	**Board Annual plan** The Board noted the annual planner.	
P55/25	**Any other business** There were no other items of business.	
P56/25	**Questions from Members of the Public** No questions were received.	
P57/25	**Date of next meeting** Friday 2nd May 2025	
	CLOSE OF MEETING	

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								
19	08.11.24	Action Log	P158.24	The new Director of Estates and Facilities, when commenced in post, should undertake a further review of the fire safety position and a report should be brought back to the Board in early 2025	DofE&F	Jul-25	Action update is the paper is to be completely re-written to be a strategy, with underpinning policy and procedures backed up by evidentiary documentation. However this then needs to go the appropriate forums as it had previously been commented by the CEO that we had failed in our governance to board.	**Open**
2025								
1	10.01.25	Board Committees Chairs Reports	P7/25	Consider how the Board has oversight of Research, as well as Medical Education, in the context of the objective around Teaching Hospital Status.	Jbe	Jul-25		**Open**
2	10.01.25	Board Assurance Framework	P9/25	Review and clarify wording in regard to data collection gap.	AMW	Jul-25	To be included in annual review of BAF 2025/26 which will take place following approval of Organisational Priorities	**Open**
4	10.01.25	IPR	P17/25	To address concerns over number of metrics presenting red and ensure all data sets are included. A request was also made to include further clarification on the growth and maximisation of virtual ward.	BK	May-25	To include in annual review. The data quality work is work in progress, coming to FPC SK has updated the narrative in her report re progress with virtual wards.	**Recommended to close**
5	07.03.25	Board Committees Chairs Reports - Audit and Risk Committee	P33/25	Circulate the Risk Mangement Strategy to Board Members for virtual approval.	AMW	May-25	Strategy on agenda for approval	**Recommended to close**
6	07.03.25	IPR	P46/25	Provide further comments to focus attention on point of concerns, and detail and context of the data and changes.	SK	Jul-25	SK has discussed with Deputy Director – Data and Insights to include in the IPR for the new financial year	**Recommended to close**
7	07.03.25	IPR	P46/25	Ensure more linkage to quarterly deep dives at FPC to Board.	SK	Jul-25	Ensure key issues and escalations from the deep dives are included in the chairs log for FPC.	**Recommended to close**

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: 26th March 2025**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Care Group 2 Presentation	The Committee received the presentation from Care Group 2 which focused on patients that were waiting and the roads to improvements, linking operational performance with quality outcomes including patient safety and experience. On Mexborough Elective Orthopaedic Centre of Excellence (MEOC), it was reported that patient feedback was extremely positive and the quality metrics were impressive with low numbers of incidents, low Length of Stay, no formal complaints and 100% Friends and Family Test (FFT). The committee recommended that MEOC is put forward for a Board Visit.	Board of Directors
2	Quality Priorities 2025/26	The Committee agreed the Quality Priorities for 2025/26, welcoming the in-depth report and substance behind the priorities. The three priorities for the year are: • Diabetes Management (a continuation of the 2024/25 Quality Priority) • Antimicrobial Stewardship • Reducing delays in Cancer Diagnosis and Treatment Each priority has an Executive Lead, SRO, oversight committee and are supported by the Quality Improvement Team.	Board of Directors
3	Paediatric Audiology Peer Review	The Committee were updated that the Paediatric Audiology team underwent an external peer review and that there is increased scrutiny of paediatric audiology services given the national concerns and patient safety incidents.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		The feedback was exceptional with only one risk highlighted. Feedback highlighted the positive team culture and leadership and robust local practice. Formal feedback will be received in 2-3 weeks.	
4	Quality Strategy Development	The Committee continued their input into the Quality Strategy and suggested further areas for development, drawing out particular elements such as equitable care, as a key aspect for the quality agenda. Members also noted the importance of local leadership, education and evidenced-based practice to shift the dial on QI for continuous improvement. The Quality Strategy would be presented at Strategic Board in April.	Board of Directors
5	Clinical Effectiveness and Risk Management	From discussions on both the Clinical Effectiveness Committee and Risk Management Report, the Committee considered the Trust-wide culture and ownership towards these aspects. It was suggested that there is clearer expectations on Care Groups attending and presenting to ensure rigour, accountability and triangulation.	Board of Directors
6	Board Assurance Framework	The Committee agreed for the score of BAF Risk P1 to increase from 8 to 12, following reflections on the financial constraints and pressures on the front door, the number of risks that are beyond the trusts control due to financial limitations and the number of risks around acuity pressures.	Board of Directors

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: 30th April 2025**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Chief Nurse and Medical Director Highlight Report	The Committee were updated on the recent improvements in performance, noting that attendance remains high however patient flow was in a much better place. The Committee will triangulate with key quality metrics over the coming months to monitor the impact on patient outcomes.	Board of Directors
2	Care Group 1 (Medicine and UECC) presentation	The Care Group raised the impact of additional beds and pressures and celebrated the positive work done one Ward and Board rounds, linking to Quality Improvement. The Committee recognised the quality metrics included in the presentation with triangulation of risks, clinical effectiveness, learning from deaths and the open and honest approach to breaking down the staff survey results to inform in depth work on culture and leadership.	Board of Directors
3	IPR	The Committee received the IPR and noted the assurance for quality metrics were all pass or static. The Committee were mindful that the static nature should not lead to complacency and discussed dynamism of the report to ensure valuable insights and focus on areas requiring more scrutiny. The Committee were also updated on the partnership working with Barnsley on a business case for acute inpatient mattress replacements.	Board of Directors
4	Quality Priority: Diabetes Management	As highlighted to the Board previously, the quality priority for Diabetes Management has been continued for another year. It was raised that there had been significant benefit getting the foundations right and would take this learning forward to secure the basics to then push forward with ambition.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
5	Legal Affairs Annual Report	The Committee received the annual report and discussed the increase in the number of inquests and the impact on clinicians due to the demands on their time for statements and attendance at court. This was having an impact on staff wellbeing and morale as well as affecting patients when resource is diverted.	Board of Directors
6	Board Assurance Framework	The Committee agreed for the score of BAF Risk P1 to remain at a score of 12. Once the organisational priorities for 2025/26 have been agreed, the BAF will be updated and refreshed to include these objectives.	Board of Directors
7	Maternity and Neonatal Safety Report	This report is presented to Board and the Committee wished to draw attention to the increase in C-section rates, which is reflected nationally, and the emerging impact and risk in terms of resources.	Board of Directors

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

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

Committee / Group: People and Culture Committee	Date: 25th April 2025	Chair: Ms Hannah Watson

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	HWB and Attendance Deep-Dive	The Committee received extensive information on the HWB and attendance programme, which feeds into the general concerns around sickness absence in the organisation. The committee was assured that the work demonstrated a comprehensive approach to HWB in the organisation.	Board of Directors
2	Care Group 3 (Children and Young People's Services, Obstetrics & Gynaecology and Integrated Sexual Health) Presentation	The Committee recognised this is a leadership team who are working well together, developing and challenging each other and with some novel approaches. This is all having a positive effect on appraisal rates and sickness absence rates and this team is committed to sharing some best practice elsewhere.	Board of Directors
3	IPR, Trust wide People Performance report and Organisational Priorities 2024/25	The Committee discussed the repetition of the data within these reports, with elements to be a wider conversation at Board to ensure clear insights from the data and that committees and the Board are receiving the key information and feedback on objectives.	Board of Directors
4	Board Assurance Framework	The Committee agreed for the BAF Risk score to remain at 12. Once the organisational priorities for 2025/26 have been agreed, these will be integrated into the framework.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
5	Freedom to Speak Up Quarterly Report	The Committee received the quarterly report and noted the referral from Audit and Risk Committee to consider more triangulation. The committee discussed the triangulation with quality assurance and other information to support concerns and would make this more explicit in future reports.	Board of Directors
6	Safe Staffing and Quality	The Committee reviewed the report and highlighted the level of training and development in the context of our aspirations for Teaching Hospital status. Further details were also given on engagement with colleges and universities to be the employer of choice to mitigate the subsequent risk to the organisation for the short fall of applications to universities.	Board of Directors
7	Equality Delivery System (EDS)	The Committee approved the EDS for publication and submission to NHSE, noting that the actions and priorities align with the People & Culture Strategy and the EDI Plan.	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:** 26th March 2025	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Financial, Activity and Performance Planning 2025/2026	Financial, Activity and Performance Planning 2025/26 plan approved	Board of Directors
2	Procurement Policy	The policy was approved	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:** 30th April 2025	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Multiyear Financial Improvement Plan	The Committee agreed to acknowledge that it had seen an initial version of the Multiyear plan and intend to work further on it with an action for it to come back to the May 2025 FPC.	Board of Directors
2	4 Hour Delivery Plan	The Committee received the 4 Hour Delivery Plan.	Board of Directors
3	Board of Directors Action Plan	There was an action on the March 2025 Board of Directors minutes for more linkage to quarterly deep dives to be linked to the Board from the FPC. The Committees wished to confirm that there had been discussions regarding the deep dives at the Committee; and following advice from the Trust Chair, going forward key points would be included in the Chair's Log for Board insight.	Board of Directors
4	Care Group 1	The Committee agreed that it wished to advise the Board of Directors on the impact sickness absenteeism is having an the Care Groups, and further agreed that it a session could be held at the Board Strategic Forum to discuss further and formulate trust wide actions.	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 April 2025	Chair: Kamran Malik

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Standards of Business Conduct:	The Committee noted that due to the poor compliance of Trust staff with the Standards of Business Conduct declarations, as such SoBC has been downgraded from green to amber on the Draft 2024/25 Counter Fraud Functional Standard Return. Work continues to improve Trust wide compliance and will be reported back to the next Committee.	Board of Directors
	Legal Report	The Committee discussed ways in which the data produced in the Legal Report could best be benchmarked and triangulated in order to provide significant assurance. The Interim director of Corporate Affairs was going to investigate the benchmarking data further and report back to the Committee.	Board of Directors
	Internal Audit Progress Report	The Committee noted the limited assurance for the Patient Flow audit which demonstrates the cross over between Board Committees, as it was not initial raised as a quality issue when there is a clear effect on quality, as well as expenditure and staff. The Committee agreed to advise the Board that visibility was required at Board level of cross Committee topics. The Committee also noted the moderate assurance given to the Cyber Governance audit and the work ongoing in this area.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
	Internal Audit Interim Opinion 2024/25	The Committee welcomed the interim opinion of significant assurance that there is a generally sound framework of governance, risk management, and the first to follow up rate of medium and high risks of 76%.	Board of Directors
	Internal Audit Draft 2025/26 Plan	The Committee approved the plan.	Board of Directors
	Counter Fraud 2025/26 Work Plan	The Committee approved the plan.	Board of Directors
	Single Tender Action Report	The Committee agreed to advise the Board that in regards to the Single Tender Action Report, there were two schemes relating to the SDEC/UECC that had not gone through the mini completion process due to restricted time frames but had been assessed as value for money for the Trust by the independent assessor.	Board of Directors
	Draft Annual Accounts	Accounts have been submitted on time	Board of Directors

The Rotherham NHS Foundation Trust

Agenda item	P63/25
Report	**Board Assurance Framework**
Executive Lead	Peter Walsh, Interim 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	We are presenting the Board Assurance Framework for Quarter 4 2024/25. The development of the 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 February 2025 Committee. **Finance and Performance Committee:** Discussed and approved the position in relation Strategic Risk D5 and D8 relating to future financial risk at the February and March 2025 meetings. **Quality Committee:** Discussed and approved the position in relation to Strategic Risk P1 at the February and March 2025 meetings. The Board has previously reviewed and approved the recommended scores for Strategic Risks R2 and O3. These were fully reviewed by the Managing Director and Deputy Director of Corporate Affairs at the beginning of Quarter 1 2025/26 and details will follow in the next BAF paper to the Committee covering the first financial quarter of 2025/26. These Strategic Risks R2 and O3 will be monitored by the Finance & Performance Committee from April 2025 onwards.

Due Diligence	The relevant sections of the Board Assurance Framework have been discussed at the relevant Board Committees during February and March 2025.
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 12; ➢ The rating for BAF Risk R2 to remain at 8; ➢ The rating for BAF Risk O3 to remain at 8; ➢ The rating for BAF Risk U4 to remain at 12; ➢ The rating for BAF Risk D5 to remain at 15; and ➢ The rating for BAF Risk D8 to remain at 20.
Appendices	Appendix 1: Overall Board Assurance Framework for Quarter 4 2024/25

1. Introduction

1.1 The development of the Board Assurance Framework (BAF) to align with the 5 Year Strategy was commenced during Quarter 1 2022/23 following which monthly reviews have taken place with the relevant Executive leads, Board Committees and Board. The BAF was further reviewed as a result of the Strategy refresh in July 2024.

1.2 The BAF has now ended its third year in 2024/25 and a new BAF for 2025/26 will be developed in line with approval of the Trust Strategic Objectives. These will then continue to be monitored 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 February and March 2025.

1.4 In terms of target scores, the Board will note that the following risks are currently at target score despite having gaps in controls and mitigations; detailed review of the scoring took place in February and March 2025:

- R2: Leadership within the system currently at the target of Seek
- O3: Collaboration with our partners currently at the target of Seek

1.5 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 February and March.

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

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 Gap G3 relating to challenges around sufficient workforce to support recovery plans continues to be largely mitigated, with external GIRFT Faster Further team on site since December 2024. With regards to G4 initial discussions have taken place between TRFT and Barnsley to look at commencing a peer to peer process in QI.

2.4 Review of the Risk Score relating to P1

2.5 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).

2.6 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.

2.7 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, in addition to improvements in Mortality Rates. The risk was discussed further at the March 2025 Quality Committee where it was agreed that due to continued pressures on UECC and financial constraints the scoring should be increased from 8 to **12**.

2.8 Taking the above into consideration, it was recommended the risk score remains at **12** at the end of Quarter 4**.** Additional focused review around the scoring will take place in May 2025.

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 risk was fully reviewed by the Managing Director at the beginning of April 2025 and will be presented in the next paper to the Committee that covers Quarter 1 2025/26. There have been a number of changes to the controls and gaps which will be highlighted in red in the BAF report

3.2 Review of the Risk Score relating to R2

3.2 It was recommended at month 3 of Quarter 4 2024/25 that the score remained at **8** which the Committee will note was at target score, the risk was reviewed in April and will be further reviewed in May 2025.

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 The risk was fully reviewed by the Managing Director at the beginning of April 2025 and will be presented in the next paper to the Committee that covers Quarter 1 2025/26. There have been a number of changes to the controls and gaps which will be highlighted in red in the BAF report.

Review of the Risk Score relating to O3

3.4 It is recommended that the score remains at **8** and in line with the other risks at target score will be further reviewed in May 2025.

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 in Quarter 4 to review the risk, the last being in February 2025.

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 was 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 review and further discussions at the People & Culture Committee in February 2025 it is recommended that BAF Risk U4 remains at **12.**

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 4.

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 Consequence should be raised to 4 and 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**. The risk rating was then reduced at the July 2024 Finance & Performance Committee to **16**, it was then reduced to **12** at the October 2024 Committee as the Consequence was reduced to 3, following the end of Industrial Action.

5.3 The risk was further discussed at the November 2024 Finance & Performance Committee for discussion and approval. Following the discussion it was agreed that the Likelihood should be increased to 5 due to the sustained capacity demand the Trust was experiencing and the risk rating was increased from 12 to **15**. The risk continues to be reviewed on a monthly basis and following review in February and March 2025 recommended to remain at **15**.

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.

6.1 BAF Risk D8 covered the financial situation for the Trust during the financial year 2024/25, this risk is an annual risk covering the current financial year only. As with previous years BAF Risk D8 will be closed once the year-end accounts have been signed off and a new BAF Risk D9 which will cover the financial situation for the Trust, 2025/26 will be opened.

Update to the Controls and Mitigations

6.2 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

6.3 There were no changes to the gaps, the Director of Finance continues to monitor these gaps and those that are still applicable will be reviewed again at the May meeting under the new D9 risk.

Review of the Risk Score relating to D8

6.3 The risk had been graded at **20** and was monitored on a monthly basis to the 31st March 2025. The year-end financial position will be reflected in the next presentation of this paper when it will be reported in Quarter 1 of 2025/26 financial year.

6.4 As with previous years BAF Risk D8 will be closed once the year-end accounts have been signed off and a new BAF Risk D9 which will cover the financial situation for the Trust, 2025/26 will be opened.

Recommendations

The Board of Directors is asked to:

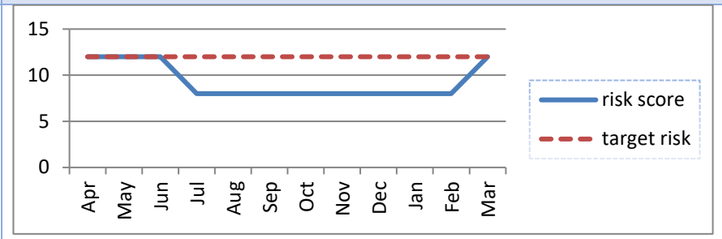
- Discuss and note the outcomes of the 2024/25 BAF following review of the BAF Risks with the individual Executive Leads.

Alan Wolfe

Deputy Director of Corporate Affairs

April 2025

Ambition	Strategic Risk			Origin al Score LxC	Score Q1	Score Q2	Score Q3	Score Q4	Target Risk Score	Movement	Risk Appetite/
	There is a Risk that….	Because…..	Leading to…..								
Patients: *We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them.*	P1: we will not embed quality care within the 5 year plan	..of lack of resour ce, capacit y and capability	..poor clinical outcomes and patient experience	4(L)x 4(C)=16	12	8	8	12	3(L)x4(C) =12	↑	Cautious
Rotherham: *We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the*	R2:we will not establish ourselves as leaders in improving the lives of the population we serve	..of insufficient influence at PLACE	..increased ill health and increased health inequalities	2(L)x4(C)=8	8	8	8	8	2(L)x4(C) =8	⇔	Seek
Our Partners: *We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient*	OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system	..of lack of appetite for developing strong working relationships and mature governance processes	..poor patient outcomes	3(L)x4(C)=12	8	8	8	8	2(L)x4(C) =8	⇔	Seek
Us: *We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.*	U4: we do not create and maintain a compassionate and inclusive culture	..	.. to an inability to retain and recruit staff and deliver excellent healthcare for patients	3(L)x4(C)=12	12	12	12	12	2(L)x4(C) =8	⇔	Seek
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	15	15	5(L)x4(C)=20	⇔	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	20	1(L)x4(c)= 4	⇔	Cautious

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)**~~ **12** **3(L)X4(C)**	~~**3(L)x4(C) =12**~~ **8** **2(L)X4(C)**	~~**Very Low (1-5)**~~ **CAUTIOUS**		**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**	**12**	
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6623, RISK5761, RISK6809, RISK6800, RISK6630, RISK6762, RISK6627, RISK6886, RISK6284, RISK5238, RISK6723, RISK6958, RISK6857, RISK6801, RISK6888, RISK6718 and RISK6421**				**Assurance Committee & Lead Executive Director**	
P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.										**Quality Committee Chief Nurse and Medical Director**		
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**		**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*						
C1	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 Dec24 - QC requested a replacement for the QA paper as it remained CQC based. An overarching quarterly update from QC to Board to be developed, see Gap G9.	November 2024 Board January 2025	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.	March 2025 Monthly	QC		L1				Chief Nurse		

		From October 24 added in subject matter expert and senior nurse review to tenderable audits - monthly rota through to March 2025 with increased visibility of Senior Nurses.							
		Exemplar Accreditation Programme established for adult inpatient areas. Completed adults, paediatrics and maternity. The update on progress made at QC Jan25 and ETM Feb25; also shared with CQC Jan 25	January 2025	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. Subject specific presentation shared with CQC on a monthly basis providing assurance around key areas - Dec24 = falls, Jan25 = Accreditation and Feb25 = Tissue Viability, will also be presented to QC.	January 2025	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.	February 2025	PSC QC ETM					Chief Nurse

		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. PSIRF Plan and Policy completed	November 2024						
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 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. QI review to thematic analysis to identify quality improvement priorities 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. Learning from Deaths report to go to Board in January 25	January 2025 November2024 ~~January 25~~ - delayed January 2025 QC - December 2024 January 2025	CEC QC Board					Medical Director

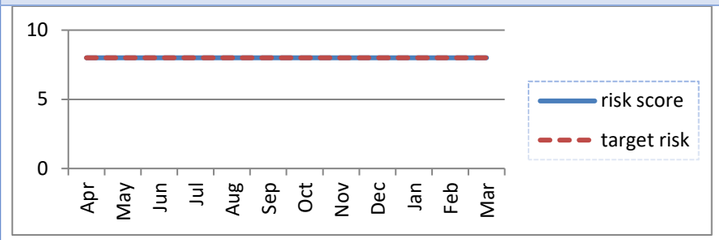
C4	Ongoing monitoring of the effectiveness of the newly implemented Clinical Effectiveness Strategy by the Clinical Effectiveness Committee.	The Care Groups report details of their Clinical Audits, Getting it Right First Time Programme (GIRFT), National Clinical Audits - Quality Accounts (NCAPOP & Other) 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	November 2024 Next is January 2025	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 All on track	November 2024 QC January 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	February 2025	QC	L1				Chief Nurse
		Report on Complaints including volume, themes and learning reported at Patient Experience Committee and Quality Committee quarterly	February 2025	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) now published by CQC. Improvement plans developed and progress monitored quarterly through Patient Experience Committee and Quality Committee	February 2025 November 2024 - public - Inpatients Q1 25/26, UECC Nov24, Maternity Nov24. CYPS Currently under embargo	In 2025	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,	March 2025	QC	L1				Chief Nurse

		supported by Qi, Effectiveness and Data Analysis teams							
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	QC - February 2025	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	February 2025	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	February 2025	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	January 2025 ARC January 2025	QC	L3				Chief Nurse

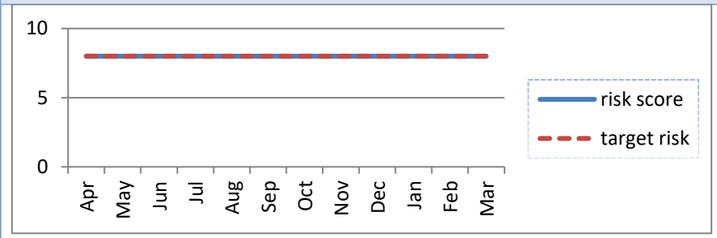
Gaps in Controls or Assurance Quarter 1 2023-24		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Lack of assurance regards quality of end of life care	Completion of action plan that has been created in response to 360 assurance report and 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.	

								Exec Team to Exec Team meeting TRFT and Rotherham Hospice held in January 2025.	
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. Completed further areas to be explored such as UECC.	
G3	Challenges around sufficient workforce to support the recovery plans around staff absence in theatres and anaesthetics. 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**				Tighten up controls around NHSP due to financial position and monitoring any impact. Proven grip and control with savings been seen. Care Group asked to escalate to Execs prior to cancelling any patients requiring a HDU bed. IA has now not a risk, however there are ongoing issues with anaesthetics and external support has been introduced with the introduction of the GIRFT Further Faster team.	
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 and plan to be presented at next Safeguarding Committee November 2024 Awaiting report	
		Benchmarking Data will be reviewed to enable relevant services to compare quality and learn from exemplar organisations. Reporting will be through relevant subcommittee and to Quality Committee quarterly. Reports to include increased comparison of data with external organisations and all associated actions.	Chief Nurse	**July 2024**	May 2025			Initial discussions have taken place between TRFT and Barnsley to look at commencing a peer to peer process in QI.	
G5	Development of Trust Quality Strategy	Development and publication of Trust Quality Strategy	Chief Nurse/Head of Quality Improvement	**November 2024**	April 2025			To include as agenda item at QC February 25 and April 2025 Board	
G6	Medicines Management Limited Assurance at 360 Assure internal audit	Development and completion of action plan which will be monitored through the Medication Safety Committee and the QC	Medical Director	**November 2024**				Plan has been developed and is now being monitored through the MSC. New Chief Pharmacist started 20 January 2025. CQC visit to Pharmacy November 2024, awaiting formal report and development of associated action plan.	

G7	CDiff rates	Development and completion of an antimicrobial action plan	Chief Nurse	**November 2024**				For further development. Rates have started to plateau over last few months. Policies in process of review. Identified as a Quality Priority for 25/26. Meeting happened with external partners in Feb 25 to expand key actions for 2025/26.	
G8	QC report for Board	Development of report to cover areas including Patient Safety, Patient Experience and Clinical Effectiveness	Chief Nurse/Medical Director	**Bi-monthly** **April 2025 - QC** **May 2025 Board**					
G9	360 Audit Care Group governance with a focus on PSIRF governance	Just agreed ToR for 360 Audit, to commence Q4	Chief Nurse/Medical Director	**Monthly QC** **Commenced April 2025, completion DATE TBC** **PSC - QC - ARC**					
G10	Quality Priorities 2025/26	Agreed 3 priorities, metrics and key objectives, currently being discussed and agreed Proposed: Diabetes Antimicrobial Stewardship Cancer Delayed Diagnosis	Chief Nurse	**Monthly QC** **March 2026**					
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**		**Previous score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***R2: Ensure equal access to services***							**8**	**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		**January 25**	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		**January 25**		Level 1				**Control remains ongoing**	
C3	Trust is a member of the Health and Wellbeing Board			**January 25**		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.		**January 25**		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		**Actions Required**		**Action Owner**		**Date Action Commenced**	**Date Action Due**			**Progress Update**	

Quarter 1 2022-23									
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	
G2	Non-elective activity continues to increase	To continue to work with PLACE with demand reducing initiatives	Managing Director	Ongoing	End of Quarter 4				
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**		**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**	**8**

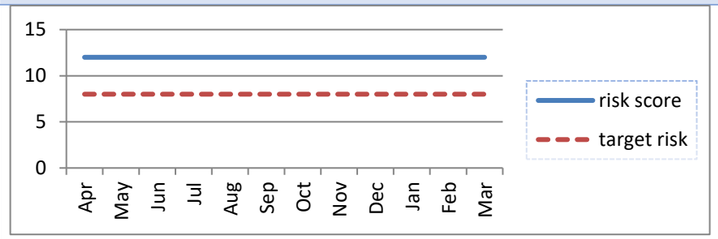
BAF Risk Description	Linked Risks on the Risk Register & BAF Risks				Assurance Committee
O3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working 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	**January 25**		Level 1				
C2	Existing collaboration with Barnsley on some clinical services	Gastro service up and running, Haematology service in progress MEOC now embedded.	**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.	**January 25**	**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 3 2024/25		**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. SYPB Management meeting January 2025 - There has been engagement with medical directors and chief nurses who have agreed that a cohesive approach is required and SYPB are now in the process of creating a new POCT policy across the network and agreeing SLA's to reduce risk and strengthen governance relating to procurement/ training/QA and IQA. Going forward, the POCT will eventually be managed by SYPB. UKAS inspection – TRFT Pathology services. UKAS inspectors will be on site from the 20/1/25 and will undertake the elements of their assessment over a number of days until approximately 3rd week in February. There are no expectations of any problems but should any concern arise, SYPB will inform the Trust. With respect to the Fuller enquiry (mortuaries), as the HTA are now undertaking unannounced inspections of mortuaries, the SYPB will be rolling out a peer review process across the region from April 2025 to support partners to prepare for such inspections happening. Dates to follow.	
	Pathology Partnership model	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	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. In an improving position, activity reviewed weekly at ETM and now past 70%		

	leading to increased reputational and financial risk to TRFT								
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

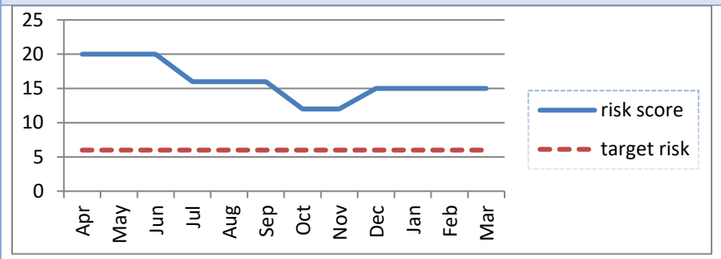
BAF Risk U4

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)**~~ **Seek**		**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** ⟷	**12** ⟷
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6888, RISK7182 and RISK6723**				**Assurance Committee**	
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. 6 month review completed	October 2024 and April 2025 P&CC	P&CC Oct24 12 month review at April 25		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 2024/27 underpins WRES and WDES signed off at Board	EDI Plan to P&CC in October 2024 and Board November 2024	P&CC Dec 24 Board Nov24		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'. Regular Corporate Bulletins sent via Communications. July 24 launched trust wide 'we said, we did' 2024/25.	October 2024 and March 2025 At Care Group P&CC presentations	P&CC Oct 24 Ongoing confirmation from Care Groups		Level 1					

		NHS Staff survey outcomes and scores to be presented at People Committee and then the March 2025 Board of Directors.	P&CC February 2025 P&CC Board Mar25		Level 3					
C4	Health wellbeing and attendance work	Went to ETM w/c 15/07/24 and P&CC in October 2024. 360 audit gave limited assurance on how managers manage long term sickness, audit to be rerun late 2024/25 5 working groups supporting work Out to tender for Occupational Health contract.	End of Quarter 3 2024/25 Quarter 4 2024/25	P&CC Feb25 and Apr25 updates	Level 1 Level 2					
C5	Development of the Trust Workforce Plan	Current Workforce Plan 2020-24 in place, new plan to be in place from April 2025. Focus groups and 1 to 1 stakeholder meetings happening	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					Value Circle completed programme of work, formal evaluation and feedback awaited. Formal Leadership Programme completed update to Feb25 P&CC

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 Group 3 Care Group 4 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. No Industrial action at this time, but situation monitored	Divisional Leads & FPC	As per each risk, further details can be found in the P&CC Risk Report				This Gap relates to three outstanding risks rated at 15 or above, please see Risk Report for further details: Care Group 1 - Risk7182 - 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. Rated 15 Corporate Services - Risk6888 - Lack of clinical psychology support for all services for which it is required. Rated 15	
G2	Joint Leadership Programme	Programme of work to be completed with feedback report						Formal evaluation and feedback awaited	

G3	Development of the Trust Workforce Plan	Development of Plan for introduction in April 2025	Director of People						
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***		**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.** **5(L)X3(C)=15**	**2x3=6**	~~**Very low (1-5)**~~ **MINIMAL**		**Previous Score Q4 2023-24**	**Q1**	**Q2**	Q3	Q4
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.***								**20**	**20** ↔	**16** ↓	**15** ↓	**15** ↔
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		**Mar25** **Mar25 IPR**	**Minutes** **Chair's Log**	Level 1						Managing Director

		Care Group Performance meetings with each CSU							
	PERFORMANCE: Executive Team oversight via IPR	Weekly receipt of Performance IPR	**Mar 25**	**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	**Mar 25**	**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	**Mar25 IPR** **Mar25 IPR** **Mar25 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)	**Mar25**	**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	Elective Delivery Group Weekly Access Meetings Care Group PTL Meetings	**Mar25**	**Monthly** **Weekly** **Weekly**	**Level 1** **Level 3 - 360 Assurance audit report - July24**				COO Ass Director of Operations

	for elective recovery schemes	To include financial allocation from ERF reserve. New weekly PTL for Elective and Cancer week commenced 27/11/2023. Outpatient, Theatre & Endoscopy Transformation Programmes External review of Trust PH processes via FF20 Programme - feedback report received		**Weekly** **Monthly Highlight Report**					Ass Director of Operations
C4	**CANCER:** Cancer PTL	Rotherham Cancer Strategy & Performance Meeting Cancer Services Quality, Governance & Business Meeting Cancer PTL Meetings. Cancer Improvement Programme	**Mar25**	**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 Winter Plan supported at November Board. Some elements of Winter Plan enacted early due to high levels of demand.	**ETM and FPC mins** **Commenced August 24** **24/25 plan went to September FPC, ETM and Nov Board**	**Evaluation – FPC mins May 2024**					COO Dir Ops
C6	**CYBER**	Monthly / Quarterly/Yearly Updates to F&PC Internal Audit programmes with finding to audit and risk Information Governance Committee with minutes chaired by SIRO DSPTK national submissions Monthly IT Security Group, with minutes 24x7 Carecert alert monitoring by NHS England Cyber teams	**Feb25** **Dec25** **Mar25**	**Minutes** **Audit** **Minutes** **Minutes** **tbc**					Director of Health Informatics

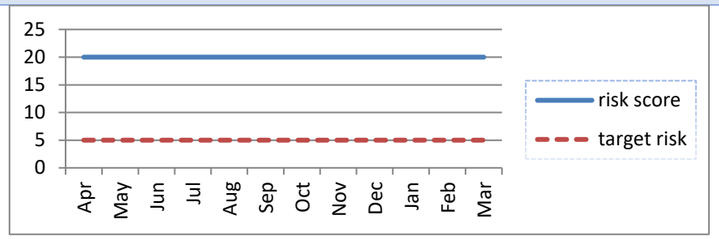
Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Insufficient funding to support increased levels of non-elective demand – both attendances at UECC and emergency admissions	Discussions with commissioners 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 **Pressure continued in February with all additional capacity remaining open.** March attendances remain high, above 2023/24 levels and above the contract plan for the year. Escalation bed capacity has remained open at peak times.	
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 ring-fence 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 in place for SDEC to remain on B6 during winter - trolley capacity is being ring-fenced from patient beds. Revised Capital Bid submitted to regional team September 2024 - still awaiting response from regional and national teams. Medical SDEC functional; on B6 and ring-fenced from inpatients. Funding for capital scheme approved. Jan SDEC capacity impacted by inpatients. Capital scheme for new SDEC progressing well. February and March capacity continues to be impacted by inpatients due to increased demand. Capital scheme continues to progress. Work on new SDEC pathways is in train. 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	Associate Director of Operations, Planning and Performance	Q2	Q4			360 Assure audit undertaken and actions agreed and in process of full implementation	

		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						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. Review of validation resource within the Trust has been undertaken with proposal to strengthen arrangements and increase capacity being developed. Currently mobilising options for increased validation capacity. Support to cleanse waiting list as part of an initial diagnostic from external; provider is underway and due to be completed in Feb25 Just completed and awaiting feedback.	
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 No further IA planned for Trust staff awaiting confirmation of any collective actions GPs will take. Continue to monitor impact of GP collective action on UECC attendances.	

								New contract potentially ends GP collective action, yet to understand impact.	
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. Request for anaesthetic expertise being sought from national GIRFT team. Anaesthetic expertise from Clinical Leads via GIRFT programme agreed - dates scheduled in December. Initial review undertaken in Dec 24 with verbal feedback (awaiting report). Dates for clinical leads to review workforce and processes with anaesthetic team scheduled in January 2025. Initial meetings with national clinical leads have been undertaken with some early feedback received and dates for on-site reviews in February 25 progressing. Work with GIRFT team continues to progress starting to see impact of early actions in terms of reduction in lost sessions. Further recruitment to anaesthetic posts in in progress.	
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. Q4 activity expected to be in line with forecast at month 8. Activity continues to deliver in line with ERF funding due to year end.	
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***		**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**	**20**
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks** **RISK 7130, RISK6755 and RISK6801**				**Assurance Committee**	
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	**Mar25 Board**		Level 1
C2	CIP Track and Challenge in place		**Mar25 Board**		Level 1
C3	Contingency of £3m in place.		**Mar25 Board**		Level 1
C4	Winter funding allocated in reserves of £1.2m.		**Mar25 Board**		Level 1
C5	Elective recovery fund £6.0m		**Mar25 Board**		Level 1
C6	Financial plan submitted to NHSE by 08/05/2024	Submitted on time, still awaiting sign off by NHSE	**Mar25 Board**		
C7	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee	**Mar25 Board**		Level 1

C8	System wide delivery of Recovery On plan with mitigations in place to manage winter pressures.	Director of Finance attends South Yorkshire DoF Group	**Mar25 Board**		Level 1				
		Monthly Finance Report to CEO Delivery Group	**Mar25 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	Situation acceptable currently, future risk	Director of Finance					For Gaps G4-G7 awaiting further national guidance to fully assess the position.	

	to suppliers. Impact to invest in capital projects.							The Trust will run out of cash at some point during the second half of the financial year 2024/25. **The Trust has received £5.7m additional income as part of South Yorkshire agreed £49m deficit plan. This means the Trust has improved its cash position. The Trust will now likely have to borrow cash in Qtr 1 or Qtr 2 of 2025/26 depending on the financial settlement in that year.**	
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					Month 11 - Trust is £0.2m adverse to plan, requiring remedial action plans from all Care Groups and Corporate areas.	
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
2nd May 2025

The Rotherham NHS Foundation Trust

Agenda item	P64/25
Report	**Risk Management Report - Including the Risk Register (with risks scoring 15 and above), and all Care Group risks rated 8+ with review date and action plans**
Executive Lead	Peter Walsh, Interim 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 "Use and Evaluate Information to improve". By having up to date information on the Trust's risks we can use and evaluate this information to take actions and decisions that improve both patients' and staff experience.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Summary (including reason for the report, background, key issues and risks)	This report provides an update to the Board of Directors 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 11th April 2025 there are 26 risks out of a total of 251 Trust-wide Approved risks that are out of review date. This shows a compliance rate of 90% with the majority (22 out of 26) of the risks overdue by less than one month. • 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 • Three high level risks were approved for a reduction in score at April Risk Management Committee (RMC) (see Section 4) • Section 5 provides further details on the strengthening of the risk management process and the outcomes from the work • There is one issue identified on the Issues Register. All issues are previously registered as risks on the Trust Risk Management database. • There are three areas of emerging risks identified 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 required and • Support in principle the developments highlighted within the report
Appendices	1. Corporate Risk Register - 15 and above risks 2. Issues Register

1. Introduction

1.1 The following report to the Board of Directors is to provide assurance that the Care Groups, and wider Trust teams are considering their risks, issues and emerging risks. The following information provides an update to the Committee 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 11th April 2025; any updates or changes subsequently within the database, may 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 11th April 2025 the Trust had a total of 251 Approved risks recorded on Datix, these are risks rated between 8 and 25, as follows:

High Risks: rated 15 - 25 and RMC Approved: = 17

Moderate Risks rated 8 - 12 and Care Group Approved = 234

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 = 414

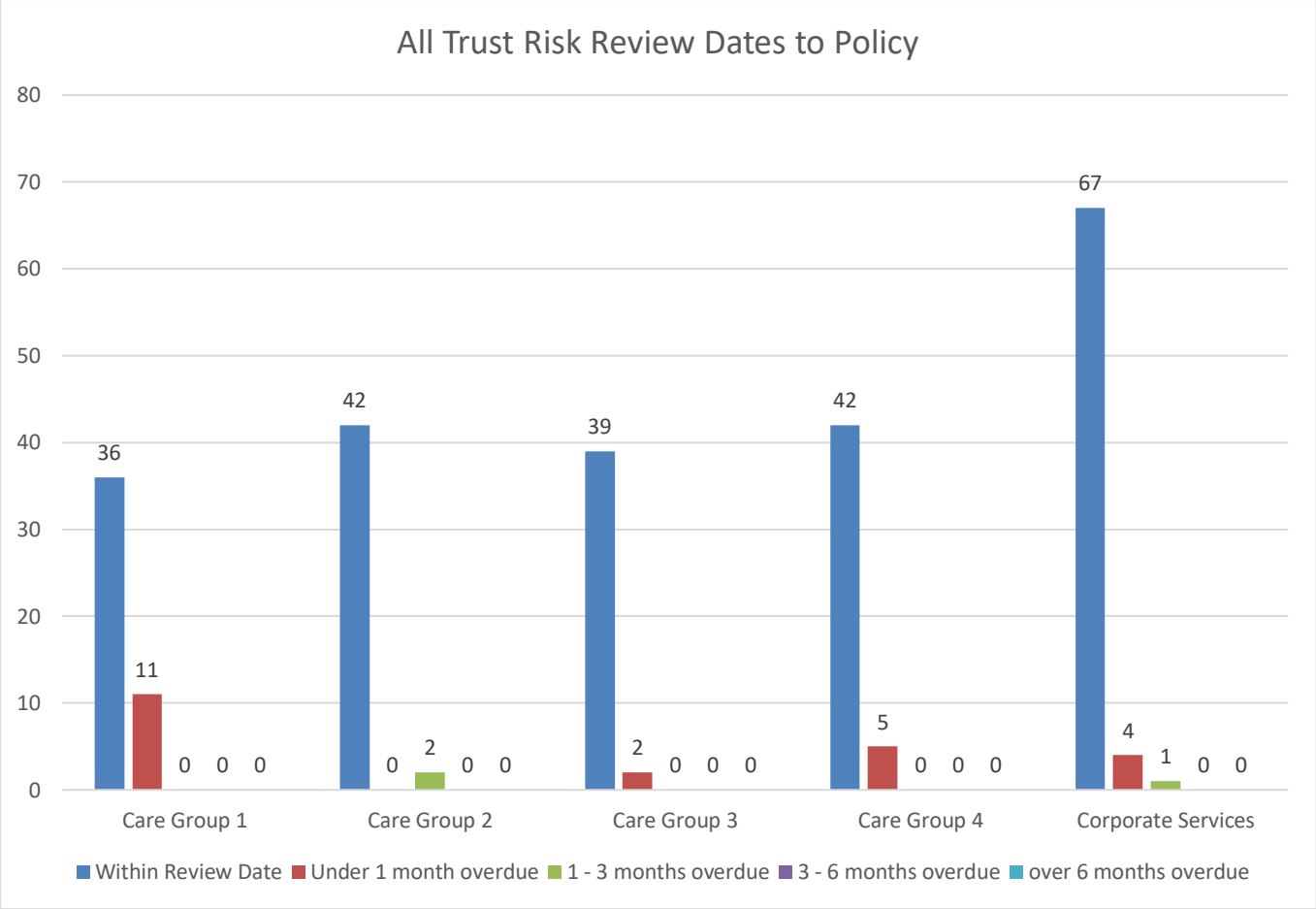
1.4 The following report illustrates the overview and analysis of the risks by review dates, action plans, Emerging Risks and the Issues Log.

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 reports a strong position at 90%; this is slightly lower than the 92% compliance rate presented to the previous Board of Directors in March. Care Group 1 had the lowest individual compliance at 77%, and Care Group 2 and Care Group 3 the highest at 95%. Care Group 3 have had consistently good compliance rates, reporting 100% compliance to review dates to Quality Committee and Finance & Performance Committee in March, as well as RMC in April. Feedback from Care Group 3 and their approach to Risk Management was shared at April RMC to the other Care Groups and Corporate Services, detailing the cross-service working, deep dives and governance leads learning from each other to coordinate the work.

2.3 There were no risks that were out of date for review for between three and six months, however, there were three risks overdue for between one and three months and further details regarding these risks and their risk ratings can be found below in section 2.4

3 Risk Action Plans

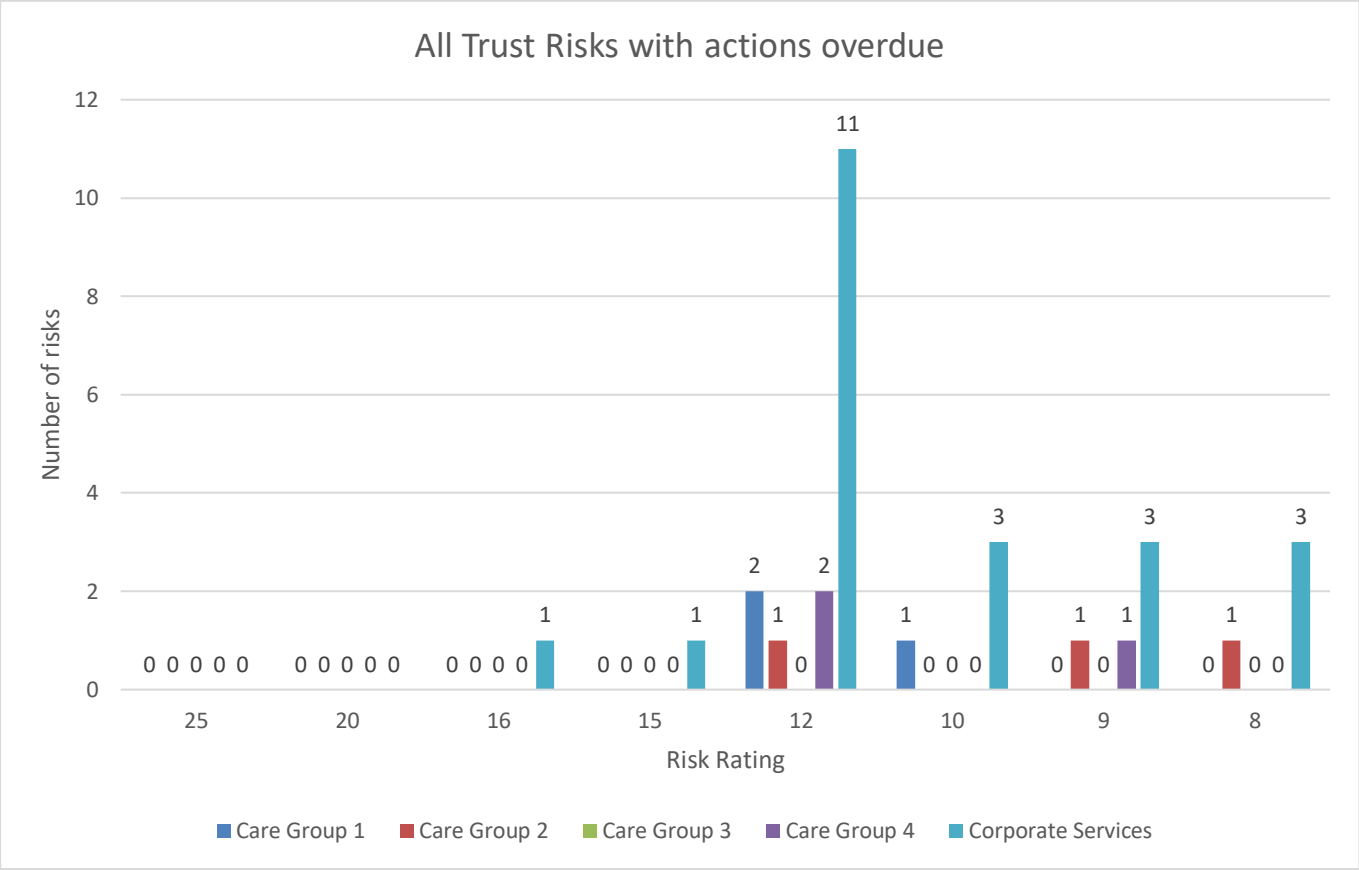
3.1 The scrutiny of action plans now includes focus on action plans in place that have all actions marked as completed, action plans that are out of date, as well as risks with no action plan in place.

3.2 Work continues to strengthen this aspect of risk management with further scrutiny on areas of action plans that need to be addressed:

- Risks 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.

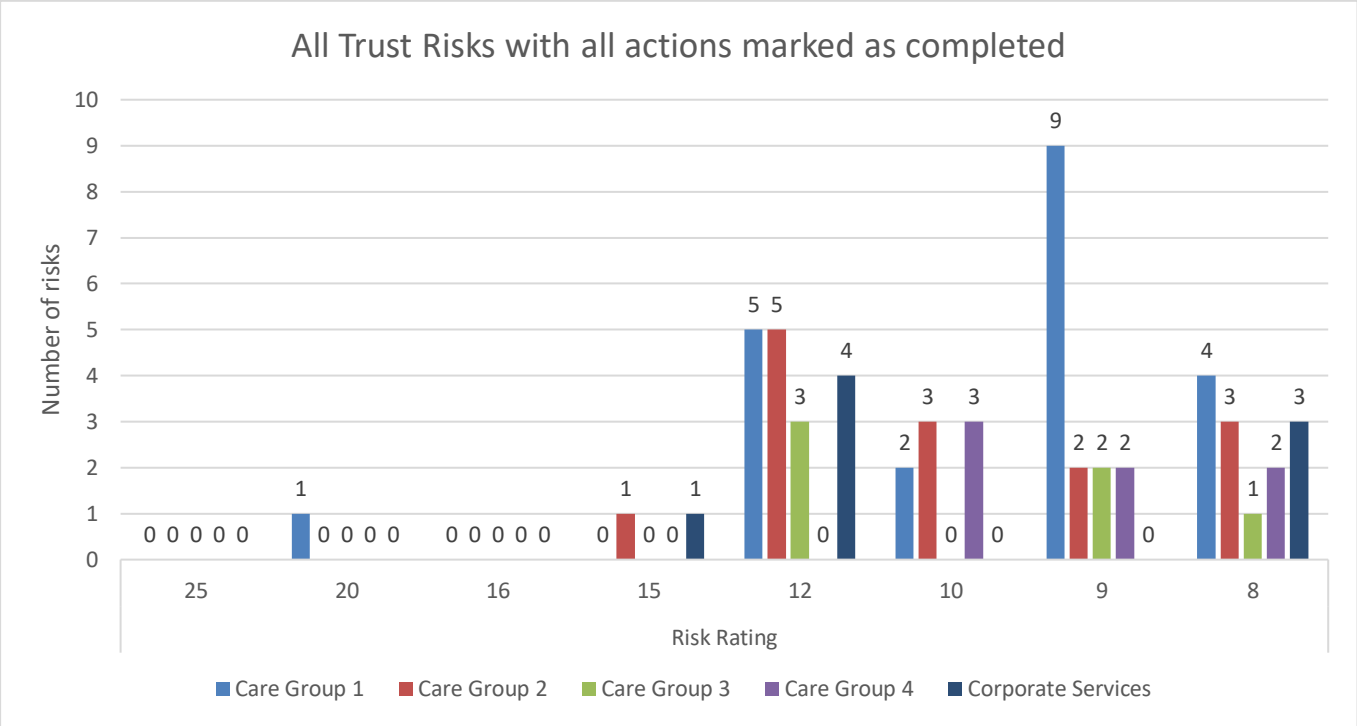
Overdue action reminders have been switched on in the Datix system which has prompted more action plan reviews and updates.

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 **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.



4 Strengthening of the overall risk process – Updates & Outcomes

5.1 The risk management function has been developing and the outcomes are visible through various layers of the organisation.

5.2 For Board Committees, triangulation between the risk reports and other reporting has been initiated, as well as through the Care Group presentations to prompt linkage of challenges and issues with the risk register, more in depth discussions and scrutiny in meetings, and use of the risk register and emerging risks for horizon scanning.

5.3 At Care Group level, there has been more interaction with governance leads and senior leaders to increase awareness of the risk register functionality and develop a mature approach to risk management. Compliance to review dates has improved, particularly for risks over 1 month overdue, and compliance with action plans, ensuring they are active and in date.

5.4 At non-Board Committees, risk registers are becoming a more focused standard agenda item, with support from Corporate Affairs to export the data in line with Board Committee reporting. Information Governance Committee have a regular risk report including approved risks and managed risks, Medical Device Safety Group has initiated a deep dive into their risks with each Care Group attending to provide further information and the

Clinical Effectiveness Committee has prompted risk register inclusion (relevant to the committee) for their template for Care Group presentations. These are all steps to increase the use, awareness and maturity of the risk register as a key tool throughout the organisation.

5.4 These actions has also prompted risk owners to review historic risks with increased scrutiny on whether or not the risk is still relevant. There is also additional scrutiny on 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.

5.5 Furthermore, based on a review of risks closed in the last quarter on Datix by Corporate Affairs, 33 risks had been closed and all risks had a relevant closure update, showing a positive audit trail and appropriate consideration given to the closure of risks.

6. Risk Management Committee

6.1 Since the last report, the Risk Management Committee met in February, March and April.

6.2 All meetings were quorate with good attendance and engagement from members and attendees.

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.

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 Following a review and refresh, the list below details the issues identified. All of these risks have been registered on the risk management database as at 11th April 2025:

1. Risk 6762 relates to the ASU trolley area not operating as surgical SDEC due to unfunded inpatient beds in both bays. This prevents flow from UECC for non-ambulatory surgical patients to be managed in ASU, which prevents SDEC operating due to inpatients in non-funded beds and there are increased admissions to hospital due to all patients managed in waiting area sometimes for long periods. The risk is rated at 15 and is an Issue Priority rating 3.

   It was reported at April RMC that the risk still remains a challenge despite having additional trolleys and a bed modelling workshop was scheduled. Discussions are ongoing regarding business cases and estates facilities.

7.4 The current issues have been transferred to an Issues Register (Appendix 2) which is monitored by the RMC and presented to all Board Committees for additional scrutiny in relation to their business agenda.

8 Emerging Risks

8.1 The emerging risks have been identified by the Care Groups at the Risk Management Committee and also during Board Committees. None of these risks have been registered on the risk management database as at 11th April 2025. Those identified were as follows:

- 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.

- The Assisted Dying Bill could significantly impact the NHS by potentially causing resource strain due to the need for additional assessments, complex ethical decision-making processes, and potential staff concerns, while also raising questions about whether it would lead to improved or diminished access to quality palliative care, depending on how it's implemented and funded.
- Risks to the Trust related to the recent Government announcement on NHS England reducing the workforce by 50%.

9 Moving forward

9.1 Risk Management training and support continues with the Care Groups, led by the Corporate Affairs Team. This quarter included support meetings with UECC, Infection Prevention and Control, the Charity, Clinical Effectiveness and several 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. As well as the monitoring at the RMC attention to risk management process can be seen in other meetings such as the Assurance Committees and the monthly Care Group Performance Committee.

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 This report is presented to the Audit & Risk Committee to provide assurance that the Trust continues to develop and strengthen its Risk Management function.

Alan Wolfe
Deputy Director of Corporate Affairs
April 2025

Board of Directors - RMC Approved 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')
6284	16/09/2020	Broadhurst, Miss Lucy	Care Group 4 (Community, Therapies, Dietetics & Medical Imaging)	Cardiac Physiology Staffing Levels	Cardiac Physiology Staffing Levels consistently unable to meet all the needs of the service. This includes performance against waiting list targets, staff wellbeing, training of students and governance responsibilities. The staffing challenges affect all sections of Cardiac Physiology (Echo, Devices, Non-Invasive Cardiology, Reception). The current establishment of the department is 36.17 WTE (June 2023).	High 15	High 15	Moderate 9	25/03/2025	28/04/2025	[Barsby, Melvina 25/03/25 12:01:33] Update 25/03/25- MB- Risk and action plan reviewed. Unable to reduce risk due to staffing levels remaining inadequate. Issues- Ongoing staff absences/ turn over across the department Disparity in workforce establishment/ workload- business case in progress	Approved Risk	Business case to increase staffing	01/07/2022	30/05/2025		Broadhurst, Miss Lucy
													Source Locum Support for Non-Invasive Team	28/11/2024	30/05/2025		Barsby, Melvina
													Support Admin/ Reception Team	02/12/2024	30/06/2025		Barsby, Melvina
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	03/04/2025	02/05/2025	[Wolfe, Alan 03/04/25 15:54:06] Risk reviewed at April 2025 RMC, informed by the Director of Estate and Facilities that the risk is to be discussed at the H&S Committee April 25 with view to reduce Likelihood to 3, this is due to the lack of related incidents in the five years since the risk was opened. To come back to RMC once approved and removed from high risk register.	Approved Risk	Theatres require UPS/IPS systems installing - possible locations	06/09/2023	31/01/2025	04/02/2025	Ramsden, Daniel
													Theatres require UPS/IPS systems installing - planning of works to start install in April	06/09/2023	12/08/2025		Ramsden, Daniel
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	01/04/2025	01/05/2025	[Rimmer, Claire 07/04/25 12:48:40] Discussed at RMC 01.04.25 - Risk remains the same. Nationally, the trust is working outside of recommendations of minimum standards that should be given to patients, however, there is no funding from the ICB to support this and no appetite for business case. There are a number of different services not able to provide psychological support because of the lack of infrastructure.	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	31/03/2025	26/03/2025	Hazeldine, Victoria
													Identify gaps in the provision (following the review) and escalate to ICB level	14/08/2024	14/05/2025	26/03/2025	Hazeldine, Victoria
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	03/04/2025	02/05/2025	[Wolfe, Alan 03/04/25 15:54:48] Risk reviewed at April 2025 RMC, informed by the Director of Estate and Facilities that the risk is to be discussed at the H&S Committee April 25 with view to reduce Likelihood to 3, this is due to the lack of related incidents in the two years since the risk was opened. To come back to RMC once approved and removed from high risk register.	Approved Risk	Refurbishment of Theatre 5&6 Ventilation (large capital funding required)	12/09/2023	31/03/2025		Dickinson, Scott
6912	11/05/2023	Cross, Gemma	Corporate Services	Long waits within UECC for mental health patients being admitted for detention under the Mental health act	Patients with mental health conditions presenting to UECC are experiencing long waits following assessment under the Mental health act which identifies them as requiring admission to RDASH (Mental health bed)	High 15	High 15	Moderate 9	03/04/2025	02/05/2025	[Wolfe, Alan 03/04/25 15:56:14] Risk reviewed at April 2025 RMC, informed by the Deputy Chief Nurse that the risk is to be discussed at Mental Health Committee April 25 with view to reduce Likelihood to 3, this is due to the lack of local incidents in the two years since the risk was opened. To come back to RMC once approved and removed from high risk register.	Approved Risk	meet with stakeholders to discuss problems	01/11/2023	02/11/2023	20/11/2023	Hammond, Lesley
													Arrange task and finish group with stakeholders, including RDASH, to discuss and work through pathways and escalations for patients	02/11/2023	28/03/2025		Cross, Gemma
													Working with RDASH around escalations (now linked to 855)	02/07/2024	20/12/2024	03/01/2025	Hammond, Lesley
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	01/04/2025	01/05/2025	[Wolfe, Alan 03/04/25 16:03:15] Risk reviewed at the April 25 RMC, agreed that the rating should remain in place until end of year complete. As with previous years this risk will; be closed once the end of year has been reported and a new 2025/26 financial risks opened. Risk linked directly to BAF risk D8.	Approved Risk	Theatre improvement programme.	03/03/2023	30/05/2025		Kilgariff, Mrs. Sally
													Outpatient utilisation programme.	23/03/2023	30/05/2025		Kilgariff, Mrs. Sally

Board of Directors - RMC Approved 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	Care Group 1 (UECC and Medicine)	Effect of un-embedded 4 hour and Acute Care Standards on Emergency Department	There is a risk of: - Not achieving the 4 hour target - Patient harm relating to long waits (according to the Royal College of Emergency Medicine and referenced in Lord Darzi's Report, long waits are likely to be causing an additional 14,000 more deaths a year) - strain on frontline staff This is caused by: - Specialties managing patients in the UECC, rather than SDEC area as per the non-elective plan of the Trust - Issues with patient flow and bed availability in the Trust - Increased attendances (2024 walk-in attendances remain consistently higher than 2023 and 2022, with January 2025 figures 5% above 2023 and 10% above 2022) - Delay in imaging (Risk 7001) - Lack of electronic referrals to specialities (Risk 6969) Resulting in: - overcrowding in the main waiting Room and delay in ambulance handovers - delays to time critical treatment and patient care - poor patient experience - patient harm, serious incident or death - staff burnout - none achievement of national targets (reputational damage)	High 20	High 20	Moderate 12	25/03/2025	29/04/2025	[Rimmer, Claire 12/03/25 16:33:00] Met with JR and HM 07.04.25 - Discussed ways to move forward with the risk following feedback from RMC and level of corporate input required. Action plan updated with elements within the CG control, including the bed configuration work and Medical SDEC Discussed ongoing work with CG4 to utilise virtual ward for early discharge, moving ward round functions to SHOP principles and working with the site team to improve flow towards the 4h target. Key barriers to mitigating the risk (from UECC perspective) are pressures from surgery, urology, orthopaedics. It was reported at Feb RMC that UECC is still being used to accept OMFS patients as transfers, so there is need in the surgery capacity to take those patients. These patients also require a lot of input from UECC. Headline narrative updated for clarity on the risk, cause and impact for reporting.	Approved Risk	Work with Executive team on embedding the standards and engagement with the Trust	01/11/2023	30/05/2025		Reynard, Jeremy
													ACT Programme	07/03/2025	30/09/2025		Beahan, Dr Jo
													Cross-Care Group and cross-specialty working to develop pathways to move to a hospital-wide 4h approach - monitored through weekly 4h meeting and performance meetings	13/09/2024	30/04/2025		Kilgariff, Mrs. Sally
													Bed Reconfiguration	07/03/2025	30/05/2025		Stewart, Paul
													Medical SDEC	07/03/2025	30/05/2025		Hammond, Lesley
7166	18/07/2024	Stewart, Paul	Care Group 1 (UECC and Medicine)	Care Group 1, General Medicine, risk to meeting financial control total	There is a risk of Care Group 1, General Medicine being unable to meet the financial control total in place at the start of the 2024/25 financial year.	High 20	High 20	Moderate 12	01/04/2025	02/05/2025	[Wolfe, Alan 03/04/25 16:04:23] Risk reviewed at the April 25 RMC, agreed that the rating should remain in place until Trust end of year complete. As with previous years this risk will be closed once the end of year has been reported by the Trust and a new 2025/26 financial risks opened for the Care Group. Risk linked directly to BAF risk D8.	Approved Risk	Financial Recovery Plan - Care Group Level	01/07/2024	31/03/2025	02/04/2025	Stewart, Paul
6969	18/08/2023	Staunton, Eamon	Care Group 1 (UECC and Medicine)	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	25/03/2025	29/04/2025	[Rimmer, Claire 18/03/25 12:48:38] Risk reviewed with JR and HM 07.03.25 - Discussed splitting the risk back out into two separate risks and seeking corporate ownership/input to move forward, as actions are largely beyond the control of the services/care group. Emailed Deputy MD regarding key issue 1 as links to the work in train around results acknowledgement. Emailed Director of HI regarding key issue 2 for further input/advice to support the Care Group - Electronic referrals are set up and live on Meditech. The issue is around clinical governance and processes to ensure services are using electronic referrals.	Approved Risk	progression of electronic referrals across care groups and specialities.	01/07/2024	30/04/2025		Staunton, Eamon
7001	12/10/2023	Reynard, Jeremy	Care Group 1 (UECC and Medicine)	In ability to get patients to CT in a timely manner	There is a risk from the delay to CT for patients in the UECC which significantly and frequently impacts the ability to achieve the 4 hour target, causing overcrowding in the department, as well as the risk with delays to getting CT results. This is caused by limited nursing, escort and portering capacity, alongside the high volume of CTs that are done in UECC that should be done in specialties. This results in delays to decisions based on CT results including delays to discharge, treatment and admission, which impact on the 4 hour target, patient safety and experience. It disrupts patient flow and can result in overcrowding 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 20	Moderate 8	25/03/2025	29/04/2025	[Rimmer, Claire 07/03/25 16:42:23] Risk reviewed with JR and HM: There is guidance for CT sonographers on scanning that will help and a CT vetting document is live. To mitigate the risk and alleviate the challenges, UECC would need to stop doing non-urgent CTs and these be completed in ward/specialty areas. Discussed number of CT scan requests as had been noted that this was high, however, it would be difficult to action lowering this due to the change in approach/accountability required. Action plan reviewed and updated. Requires further input from other departments to move forward.	Approved Risk	Review Transfer & Escort Policy - Ongoing work with the portering service, policy author and nursing, to ensure all parties are happy with the policy to safely move patients to and from scan.	07/03/2025	30/06/2025		Maton, Lynsey
													Review of Porter shift patterns for the core Porter-ing team	07/03/2025	30/06/2025		Bennett, Anthony
													Review CT Trauma guidelines with Radiology	07/03/2025	30/06/2025		McAuley, Heather
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	13/03/2025	14/04/2025	[Stewart, Paul 13/03/25 13:47:18] Risk reviewed 13/03/2025, at the point of review B6 is continuing to be utilised as escalation inpatient bed capacity and therefore in line with the previous review the risk remains unchanged.	Approved Risk	SHOP Ward round principles	13/03/2024	30/04/2025		Reynard, Jeremy
													Bed Reconfiguration Work	12/07/2024	30/05/2025		Stewart, Paul
5967	27/10/2019	Hammond, Lesley	Care Group 1 (UECC and Medicine)	Insufficient provision of medical cover within the UECC	The risk of the inability to fill the middle grade rota, particularly ST4s and especially at night (within UECC). There is a risk of not meeting the 4 hour target and delays to be seen by a clinician. Caused by insufficient clinical staff (UECC) to meet demands. Increased number of attendances, and gaps in the rotas. Resulting in excessive pressures and demands on staff filling shifts. This in turn results in less uptake of shifts. Poor patient experience and risk of harm. Financial overspend to fill gaps in the rota.	High 15	High 15	Moderate 9	25/03/2025	29/04/2025	[Rimmer, Claire 19/03/25 09:43:08] Risk reviewed with JR and HM 07.03.25: Risk details updated for clarity on lack of ST4s. Key effects of the risk are financial implications - consultants are having to act down and additional spend to fill gaps in the rotas. Barnsley had an uplift in rates so TRFT shifts have become less attractive, however, additional rates had been put in for nights at TRFT. There would be a number of deanery trainees which would make a difference and a new consultant was starting in April. OOH risk aspect removed from the risk - separate risk to be entered if remains prevalent. Additional actions added and advice sought from MD Office regarding continuation of uplifted pay rates inline with Barnsley, and M.Stafford regarding workforce plan.	Approved Risk	ACT programme	04/04/2022	16/06/2025		Hammond, Lesley
													Workforce Programme	07/03/2025	30/09/2025		Stafford, Dr Matthew
													Deanery Trainees	07/03/2025	30/04/2025		Reynard, Jeremy
													Consultant Recruitment	07/03/2025	30/04/2025		Reynard, Jeremy

Board of Directors - RMC Approved 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')
7204	18/09/2024	White, Mr. Lee	Care Group 2 (Surgery)	Risk of Theatre Cancellations (incurring 65 week breaches)	65 week breach patients	High 15	High 15	Low 6	18/03/2025	15/04/2025	[Howlett, Darren 03/03/25 11:26:20] Theatre cancellations continue to be impacting elective recovery. This is for all specialities. Much more intense focus to improve the cancellation rate and this has been improving over recent weeks as twice daily meetings happen, over staffing of lists and Anaesthetic workforce numbers improve. February showed a decrease in numbers and more lists were completed despite maintenance carried out. Service asked to provide a Capacity and demand and recruitment took place in Theatres and Anaesthetic out for speciality dr roles. Theatre manager commenced in role in Feb.	Approved Risk	Twice Daily Theatre Staffing Meetings	02/09/2024	31/12/2024	27/01/2025	Howlett, Darren
													MEOC activity increase	02/09/2024	31/03/2025	24/03/2025	Howlett, Darren
													Theatre weekend activity - to run initiatives for 3 months (Oct-Dec) as a trial to increase activity	01/10/2024	31/03/2025	24/03/2025	Howlett, Darren
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	14/04/2025	15/05/2025	Windsor, Claire 14/04/2025 12:40:55 Discussed at CG2 Performance meeting - review business case to attempt to scale down ask for the initial request (currently sat with matron / ward manager)	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	30/05/2025		Howlett, Darren

Board of Directors - RMC Approved 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	06/02/2025	30/04/2025	[Short, Sally Mrs. 10/04/25 16:27:13] No change to lack of trolleys. Trolley Area is being used for In patient beds. Part of 33 bedded ward Current meetings regarding SSDEC and facilities in progress, SLT and Corporate	Approved Risk	Review bed modelling to understand bed capacity needs - Care Group 2	19/07/2024	31/10/2025		Howlett, Darren
7140	10/06/2024	Howlett, Darren	Care Group 2 (Surgery)	Ability to Achieve Financial Control Total	There is a risk of the Care Group not achieving it's agreed financial control total for the financial year 24/25.	High 20	High 20	Moderate 12	01/04/2025	02/05/2025	[Wolfe, Alan 03/04/25 16:05:42] Risk reviewed at the April 25 RMC, an improving position for the Care Group was reported but due to the risk rating involved it was agreed that the rating should remain in place until Trust end of year complete. As with previous years this risk will be closed once the end of year has been reported by the Trust and a new 2025/26 financial risks opened for the Care Group. Risk linked directly to BAF risk D8.	Approved Risk	Cost improvement plans (full list in synopsis)	10/06/2024	31/03/2025	24/03/2025	Howlett, Darren
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	11/04/2025	31/05/2025	[Whitfield, Vicky 11/04/25 09:56:48] 11.4.25: All ECFs have now been approved (excepting one admin post which is in process). Posts have been advertised and the first interviews take place on 28th April. The new pathway is now in operation and staff who have been upgraded are almost at the end of the additional training and shadowing needed to take on diagnostic assessments. Overall, the backlog project is on track. However, the backlog wait times will only start to reduce from July onwards. ICB commissioners are aware of the continuing high level of referrals into the service which means that there is double the number of referrals being received as can be dealt with using core recurrent funding. TRFT have asked that the service spec - which is currently being updated - ensures that capacity, demand and KPIs are all in line.	Approved Risk	To keep parents and partners informed about the changes	01/02/2025	31/07/2025		Cowie, Alison
													To reduce the overall number of children waiting for neurodevelomental assessment through a 2 yr backlog project funded by commissioners	01/04/2025	31/03/2027		Cowie, Alison

The Rotherham NHS Foundation Trust

ISSUES REGISTER
April 2025

Issue: A relevant event that has happened, was not planned, and requires management action. It can be any concern, query, request for change, suggestion or off-specification raised during a project.

ID	Title	Status	Date Identified	Last Updated	Issue Author	Issue Description	Latest Update	Issue Owner	Priority Rating	Proposed Issue Resolution Date	Risk ID
3	Inpatient beds in the trolley area ASU	Open	23/07/2022	10/04/2025	Deborah Timms	ASU trolley area is not operating as surgical SDEC due to unfunded inpatient beds in both bays. This prevents flow from UECC for non ambulatory surgical patients to be managed in ASU. This prevents SDEC operating due to inpatients in non funded beds and there are increased admissions to hospital due to all patients managed in waiting area sometimes for long periods. This results in 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.	Short, Mrs. Sally 10/04/2025 16:27:13 No change to lack of trolleys. Trolley Area is being used for In patient beds. Part of 33 bedded ward Current meetings regarding SSDEC and facilities in progress, SLT and Corporate	Deborah Timms	3 - High	Plans in place for SDEC to remain on B6 during winter - March 25	6762

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.

Board of Directors' Meeting
2nd May 2025

The Rotherham NHS Foundation Trust

Agenda item	P/65/25
Report	**Risk Management Policy**
Executive Lead	Angela Wendzicha
Link with the BAF	Links to all BAF risks
How does this paper support Trust Values	Together – teams work collectively to ensure that risk management processes at the Trust are appropriate and well managed.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Trust has in place a Risk Management Policy that sets out the process and procedure in which all risks are assessed and monitored within the Trust. The Trust Ward to Board Risk Management process was audited by 360 Assurance with the report published in October 2024 containing an Audit Opinion of Significant assurance. There were two medium and one low findings raised with four actions including one to refresh guidance documents which support the Risk Management Policy. These documents have been refreshed and will be relaunched via the Trust intranet and the established Risk Management Training offered to staff by the Corporate Affairs Team. The Policy also now contains specific guidance on when and how risks and risk actions should be reviewed and recorded, another action related to the Policy. The Board of Directors reviewed and updated the Trust Risk Appetite Statement during Quarter 3 and as a result the Risk Management Policy has been updated.
Due Diligence (include the process the paper has gone through prior to presentation at the meeting)	The policy had previously been presented to the January 2025 Audit and Risk Committee where it was approved pending minor amendments which have been incorporated into this version of the document.
Board powers to make this decision	For approval

Who, What and When (what action is required, who is the lead and when should it be completed?)	No additional action is required. The Director of Corporate Affairs will be charged with compliance with the policy and will be supported by the Deputy Director of Corporate Affairs during this process.
Recommendations	It is recommended that the Board of Directors approve the policy.
Appendices	1. Risk Management Policy

Ref No: 609

RISK MANAGEMENT POLICY

SECTION 1
PROCEDURAL INFORMATION

Version:	4
Title of originator / author:	Director of Corporate Affairs
Title of Responsible committee	Board of Directors
Title of Ratifying Committee:	Document Ratification Group
Date ratified:	
Date issued:	
Review date:	
Target audience:	Trust wide

Document History Summary

Version	Date	Author	Status	Comment
1a	Apr 2017	Quality Governance, Compliance and Risk Manager	Draft	Risk Management Guidelines To be discussed at the April 2017 Risk Management Committee
1b	June 2017	Quality Governance, Compliance and Risk Manager	Draft	Risk Management Guidelines Approved – subject to amendments at DRG in May 2017 and so rediscussed in June 2017 Risk Management Committee
1	July 2017	Quality Governance, Compliance and Risk Manager	Final	Risk Management Guidelines Ratified by Trust Document Ratification Group
2a	June 2019	Quality Governance, Compliance and Risk Manager	Draft	Risk Management Guidelines To be reviewed by the Risk Management Committee & The Risk Analysis Group
2	June 2019	Quality Governance, Compliance and Risk Manager	Final	Risk Management Guidelines Ratified by Trust Document Ratification Group
3a	September 2020	Quality Governance, Compliance and Risk Manager	Draft	Converted to Risk Management Policy
3	December 2020	Quality Governance, Compliance and Risk Manager	Final	Ratified by Trust Document Ratification Group
4a	September 2022	Quality Governance, Compliance and Risk Manager	Draft	Circulated for comments
4b	September 2022	Quality Governance, Compliance and Risk Manager	Final	Document sent for approval
4	April 23	Quality Governance, Compliance and Risk Manager	Final	Ratified by Trust Document Ratification Group
5	January 2025	Deputy Director of Corporate Affairs		

Section 1 Contents

Section 1 Appendices

Section 2 Contents

1. INTRODUCTION

1.1 The Rotherham NHS Foundation Trust (the Trust) acknowledges that risk is inherent in the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances.

1.2 The identification of these risks, together with proactive management and mitigation, is essential and the Trust recognises the importance of effective risk management as a fundamental element of the Trust's governance framework and system of internal control.

1.3 The Trust is committed to embedding a risk management culture and making risk management a core organisational process that underpins delivery of the Trust's strategic aims and upholds our corporate responsibility to provide the highest standards of patient care and staff safety.

1.4 To support an integrated approach to risk management the Trust has documented the structures and the processes that are in place to identify, manage and eliminate or reduce risks to a tolerable level.

1.5 This policy provides a structured approach to the management of risk and supports the implementation of the Risk Management and Health and Safety Strategies in the Trust. It outlines how risks should be identified/ recorded and managed. Instructions on using DatixWeb are on the Hub. It must be read in conjunction with the Risk Management and Health and Safety Strategies, including the Trust's Risk Appetite.

2. PURPOSE & SCOPE

2.1 Purpose

2.1.1 The purpose of the Policy is to provide the overarching principles and detail the structures and standards required for the management of risk (clinical and non-clinical) across the Trust.

2.1.2 The key objective is to support managers and staff in the management of risk to ensure that the Trust is able to effectively deliver its objectives, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected.

2.1.3 It clarifies accountability arrangements for the management of risk within the Trust from 'Board to Ward' and 'Ward to Board', setting out the responsibility of directors and senior managers in respect of leadership in risk management, confirms the role that all staff within the organisation have in relation to responsibility for the identification and reporting of risks.

2.1.4 The Policy outlines clear reporting arrangements and describes how risks are escalated through the Trust's governance structure and how the effectiveness of risk management is scrutinised and monitored.

2.1.5 Detailed instructions setting out the operation of risk management are provided in separate associated procedural documents, as follows;

- How to Attach Documents to Risk Assessments in Datix Guide
- How to Export a Risk Register to Excel Guide
- How to Review a Risk Guide
- Action Planning in Datix Risk Module
- Datix - Linking Records (Incidents, Risks, Complaints, Claims, Safety Alerts)
- Datix - Ad-hoc Searches and Saving Queries
- Datix - Guide to Attaching Documents
- All Datix Guidance Documents can be found at:
- https://intranet.xrothgen.nhs.uk/TeamCentre/CorporateServices/ChiefNursingTeam/SitePages/Datix%20Guides.aspx

2.2 Scope

Risk Management is the responsibility of all colleagues within the Trust, and so therefore the policy applies to all areas and activities of the Trust and to all staff, contractors, volunteers, students, locum and agency staff and staff employed on honorary contracts.

3. DEFINITIONS AND ABBREVIATIONS

3.1 Definitions

Risk:
Risk can be defined as the probability that a specific adverse event will occur in a specific time period or as a result of a specific situation. The probability or threat of a change, injury liability, loss or other negative occurrence, caused by internal and external vulnerabilities, and which may be neutralised through premeditated actions. Risk is the combination of likelihood and consequence of a hazard being realised.

Emerging Risk:
Emerging risk: A new or unforeseen risk that we haven't yet contemplated. This is a risks that should be on our radar, but is not, and its potential for harm or loss is not fully known

External Risks
Those risks that the organisation does not have control over, and cannot easily predict their likelihood of occurrence or the actual impact to the organisation, examples include Covid-19. Natural factors, economic factors,

and political factors are among the sub-categories of external risk. (Beers, 2020)

System Risk Management
System risks are not a separate risks but a reflection of organisationally owned risks, focusing on the impact they have across all system partners.

Issue:
An “issue” already has occurred and a “risk” is a potential issue that may or may not happen and can impact the project positively or negatively. Risk is an event that has not happened yet but may; an issue is something that already has happened.

Hazard Identification:
A Hazard is a source of potential harm or a situation with a potential to cause loss such as low staffing levels, incorrectly completed documents, chemical, finance or reputation etc. They are the underlying cause of risk, and as such the term has particular relevance in the identification of risk.

Likelihood:
Likelihood is the probability of each outcome occurring, quantifying the risks of a particular incident happening, including the frequency in which it may arise.

Risk Assessment:
Risk Assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk.

Risk management:
is defined as “The process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure” (The Institute of Risk Management)

Control Measures:
Sometimes referred to as Controls, are the precautions that are put into place to reduce/mitigate the risk.

Risk Tolerance Levels:
The Trust will establish risk tolerance levels consistent with the general risk appetite statement available in the Risk Management Strategy 2025 – 2027.

Risk Register:
A risk register can be described as ‘a log of risks of all kinds that threaten an organisation’s success in achieving declared aims and objectives. It is a dynamic living document, which is populated through the organisation’s risk assessment and evaluation process. This enables risk to be quantified and ranked. It provides a structure for collating information about risks that helps

both in the analysis of risks and in decisions about whether or how those risks should be treated. (***Definition - CASU, Keele University***)

3.2 Abbreviations

CASU	*Controls Assurance Support Unit*
CSU	Clinical Support Unit
ETM	Executive Team Meeting
HSE	Health and Safety Executive
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
RMC	Risk Management Committee
SIRO	Senior Information Risk Owner
SMART	Specific, Measurable, Achievable, Realistic, Timely
TRFT	The Rotherham NHS Foundation Trust

4. ROLES & RESPONSIBILITIES

Roles	Responsibilities
Chief Executive (CE)	The Chief Executive as 'accountable officer' has overall accountability and responsibility for risk management within the Trust, ensuring the implementation of an effective risk management system. The Chief Executive must seek assurance from the systems and processes for risk management and ensure that these meet regulatory, statutory and legal requirements. Operationally, the Chief Executive delegates responsibility for implementation of risk management to the Chief Nurse.
Director of Corporate Affairs	The Director of Corporate Affairs has delegated responsibility for risk management from the Chief Executive. As such they are responsible for ensuring that all risk and assurance processes are devised, implemented and embedded throughout the Trust and for reporting to Executive Team Meeting (ETM) any significant issues arising from the implementation of the Policy, including non-compliance or lack of effectiveness arising from the monitoring processes. The Director of Corporate Affairs is also responsible

	for the management of the Board Assurance Framework (BAF), ensuring it is robust and effective.
Deputy Director of Corporate Affairs	The Deputy Director of Corporate Affairs supports the Director of Corporate Affairs in the day to day management of the Trust's Risk Register. The Deputy Director of Corporate Affairs supports the review, development and embedding of the Risk Management Strategy and Policy across the Trust to ensure that there is an effective Risk Management System in place. The Deputy Director of Corporate Affairs supports the Trust and the Board of Directors by providing a risk management function that facilitates and monitors the implementation of effective risk management practices and assists risk owners in identifying, assessing and managing and reviewing risk. Specifically, the Department supports all areas of the Trust in the use of Datix to record risk and produce risk reports in an agreed format to facilitate 'ward to board' governance and, where necessary, the escalation of risk.
Corporate Governance & Risk Manager	The Corporate Governance & Risk Manager supports the Deputy Director of Corporate Affairs in the day to day management of the Trust's Risk Register.
Care Group Management Teams	Colleagues are responsible for the implementation of this Policy at corporate and service level including the establishment and continual management of Care Group Risk Registers and project risks registers. They are responsible for managing risk within their Services and Care Group through their Care Group monthly governance groups. The Care Group management team should also ensure

	that the Trust Risk and Governance Terms of Reference, standardized agenda template and Risk report template should be used for all Care Group Risk & Governance Committees. The teams are required to ensure that through Care Group governance meetings and other relevant forums that risks are shared, focusing on the risk action plans and escalating areas of concern where required. They are responsible for ensuring that all risk assessments are reviewed and approved and all risks reviewed in a timely manner and action plans recorded and updated on the Datix database.
Governance Leads	Governance Leads are responsible for the management of identified risks within the scope of their responsibility, ensuring that risks are reviewed and maintained in a timely manner. The Governance Leads are responsible for co-ordinating risk management processes in their Care Group/Department by: • consulting with teams to identify and assess risks and determine mitigating actions; • maintaining arrangement for oversight of all Care Group risks and ensuring that these are recorded on Datix and undergo regular review and quality assurance; • promoting the risk management policy, procedures / best practice and communicating changes as necessary; and • sharing information and knowledge on risks within their

	area through membership of relevant groups and committees.
Risk Management Specialist Officers	Certain roles within the Trust have Trust-wide risk related roles and responsibilities to supporting and contributing to the development of Trust-wide and Care Group risk management and governance arrangements and for providing specialist advice, education and training to ensure compliance with statutory requirements and best practice. This includes a Senior Information Risk Owner (SIRO) who is the nominated lead to ensure the Trust's information risk is properly identified and managed and that appropriate assurance mechanisms are in place.
Risk Owners	Risk Owners are responsible for; • Identifying the risks • Reporting the risks on Datix • Recording, maintaining and monitoring risk action plans through the Datix database • Sharing the content of the risks in their area • Managing the risks on a day to day basis • Keeping the risk data on Datix up to date; this should include inclusion of all minutes and dates related to the risk from any Care Group and Trust Governance/Risk Management meeting in the risk record for audit purposes.
Colleagues	Management of risk is a fundamental duty of all staff. All staff must ensure that identified risks and incidents are reported in order to ensure appropriate actions are taken. These requirements also extend to locum and agency staff.
Partner Organisations and Contractors	Specific risks identified in the Trust will be shared with any other relevant organisation working in partnership with the Trust.
Board Of Directors	The Trust Board of Directors has overall responsibility for ensuring that

	effective internal controls (clinical, organisational and financial) are in place and for reviewing the effectiveness of these controls. The Chief Executive is required to produce an Annual Governance Statement that confirms to the Board of Directors the adequacy of controls in place to manage risk. The Board approves the implementation of the Risk Management Policy (this document) and oversees its effectiveness through the described monitoring and review processes. The Board of Directors sets the Risk Appetite Statement each year. Through the Quarterly Risk Register reports, the Board assures itself that the Trust identifies and effectively manages any risks that could impact on the achievement of its Strategic Aims. Board Committees provide additional oversight of strategic and high level risk within their remit.
Assurance Committees of the Board	Each Assurance Committee of the Board has a role for risks pertaining to their area of focus. They have roles in reviewing the management of the risks held on the Risk Register and Board Assurance Framework. They review the Board Assurance Framework and ensure that the Board of Directors receive assurance that effective controls are in place to manage Corporate risk and report on any significant risk management and assurance issues. Each of these Committees has oversight responsibility for a section of the Risk Register within the remit of their own Terms of Reference and performs detailed scrutiny of controls and assurances. Via their Non-Executive Chair, each reports formally

	to the Board of Directors, to confirm delivery of assurance or to escalate matters as necessary.
Audit & Risk Committee	The Audit & Risk Committee is a sub-committee of the Board and with delegated authority from the Board of Directors, the Audit & Risk Committee has overall responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical). Specifically, this Committee is responsible for providing an independent and objective view of internal control. • Ensures that an annual review of the risk management process is undertaken by the internal audit function and provides assurance to the Board of Directors based on its outcome. • Reviews the adequacy of the underlying assurance processes that indicate the effectiveness of the management of principal risks to the achievement of corporate objectives as reported in the Quarterly Risk Register report.
Executive Team Meeting (ETM)	The ETM utilises the risk register to understand the risks to achieving the accountabilities of the Chief Executive, specifically all risks with a score of 15 (or above) on the risk register. ETM has responsibility for ensuring that those risks are regularly reviewed, that risks are being mitigated and resources are being effectively allocated in line with the level of risk appetite and tolerance established by the Board. The ETM is responsible for the implementation of risk management

	and its assurance mechanisms. Individual Executive Directors provide leadership on the management of key areas of risk with their roles and are responsible for overseeing a programme of risk management activities for their areas of responsibility.
Risk Management Committee	The primary purpose of the Trust's Risk Management Committee is to provide assurance to the Board on the function of systems of risk management via the Executive Team Meeting (ETM).
Specialist Risk Groups	In addition to the above, there are a number of specialist Trust-wide groups (e.g. Infection Prevention and Control Committee, Information Governance Committee etc.) that have specific risk management responsibilities. They are detailed in their terms of reference.

5. PROCEDURAL INFORMATION

Only colleagues of the Trust who have attended appropriate agreed risk assessment or risk management training should carry out a risk assessment supported by relevant individuals in the Trust such as the Care Group Governance Leads.

The Trust adopts a structured approach to risk management whereby risks are identified, assessed and controlled and, where necessary, escalated or de-escalated through the governance mechanisms of the Trust. Staff should work to identify not only current risks but also complete horizon scanning to be aware of risks that are likely to emerge in the future.

5.1 Systematic Risk Assessment Process

Effective risk assessment is a core element in good risk management. There are five steps in the risk assessment process.

5.1.1 Stage 1 - Identify the Hazard

Risk identification is fundamental to effective risk management and all staff have a role to play in identifying clinical and non-clinical risks to the delivery of safe, effective and high quality care.

There is no unique method for identifying risks. Risks may be identified in a number of ways and from a variety of sources, for example:

- Risk assessment of everyday operational activities, especially when there is a change in working practice or environment
- Clinical risk assessments
- Environmental / workplace risk assessments
- Any risk identified through Care Group Business Continuity planning process/ single point of failure
- Risk assessment as part of Trust business – at all levels of the organisation
- Annual planning cycle
- Performance management of key performance indicators
- Internal risk assessment processes e.g. requirements to assess risks as part of development and approval of policies, procedures, strategies and plans
- Claims, Incidents and Complaints
- Organisational learning
- External reviews, visits, inspections and accreditation
- Information Governance Toolkit
- Staff and patient surveys
- National recommendations including safety alerts, NICE guidance etc.
- Internal and External Audit
- Clinical audits
- Information from partner organisations
- Environment scanning of future risks (both opportunities and threats)

This list is not exhaustive. In general, the more methods that are used the more likely that all relevant risks will be identified.

There are two distinct phases to risk identification:

a) Initial Risk identification - relevant to new services, new techniques, projects

b) Continuous Risk Identification – relevant to existing services and should include new risks or changes in existing risks e.g. external changes such as new guidance, imminence, legislation etc.

All risks that are identified must be recorded and logged as appropriate on the either the Trust's locally held Environmental Assessment form, Ligature Assessment form, COSHH form (on Alcumus Sypol), Security Assessment record or the Trust's register of risks (Datix) if the risk is rating at 8 or above. This provides a formal record of the risks that the Trust has identified as having a potential impact on the achievement of objectives.

Failure to properly describe risk is a recognised problem in risk management. Common pitfalls include describing the impact of the risk and not the risk itself, defining the risk as a statement which is simply the converse of the objective, defining the risk as an absence of controls etc. A simple tip is to consider describing the risk in terms of cause and effect.

5.1.2 **Stage 2 - Evaluate the Risk**

Having identified and described the risk, the next step is to assess the risk. This allows for the risk to be assigned a standard rating which determines what actions (if any) need to be taken.

A standardised approach to describing and scoring risks must be followed.
All risks are scored and graded according to likelihood (chance) and consequence using the Trust's Risk Assessment Matrix (See Appendix 1). Adopting a single standard assessment tool ensures a consistent approach is taken to the description, evaluation and monitoring of risk across the Trust.
In evaluating the risk, it is important to rate the likelihood (chance) of the hazard causing reasonable foreseeable harm (Impact/Consequence/ Severity) and then rate the severity.

Ideally, risk assessment is an objective process and wherever possible should draw on independent evidence and valid quantitative data. However, such evidence and data may not be available and assessor(s) will be required to make a subjective judgement. When facing uncertainty, the assessor(s) should take a precautionary approach.

The risk assessment should be undertaken by someone competent in the risk assessment process and should involve staff familiar with the activity being assessed. Depending on the severity of the risk, the Care Group Risk/Governance Lead should be notified. Trade union representatives, external assessors or experts should be involved or consulted, as appropriate.

Risks are assigned a score based on a combination of the **likelihood** of a risk being realised and the **consequences** if the risk is realised.

The Trust uses three risk scores:

- Inherent/Initial Risk Score: This is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risks and is used as a benchmark against which the effect of risk management will be measured.

- Current Risk Score: This is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans to mitigate the risks are developed and implemented.

- Target Risk Score: This is the score that is expected after the action plan has been fully implemented, and should take guidance from the TRFT Risk Appetite Statement.

-

Scoring the consequences

Use Appendix 1 Qualitative Measures of Consequences (Actual / Potential), to score the consequence, with existing controls in place:

Choose the most appropriate domain(s) from the left hand column of the table. Then work along the columns in the same row and, using the descriptors as a guide, assess the severity of the consequence on the scale 1 = Negligible, 2 = Minor, 3 = Moderate, 4 = Major and 5 = Catastrophic.

The Consequence score will remain the same in the majority of risks and the risk rating is lowered by decreasing the likelihood score as mitigations as contained in the risk action plan are introduced.

Scoring the likelihood

Use Appendix 1 Likelihood Assessment, to score the likelihood of the consequence(s) occurring with existing controls in place, use the frequency scale of Rare = 1, Unlikely = 2, Possible = 3, Likely = 4 and Almost Certain = 5.

Likelihood can be scored by considering:

1. Frequency i.e. how many times the consequence(s) being assessed will actually be realised

or

2. Probability i.e. what is the chance the consequence(s) being assessed will occur in a given period.

   Scoring the risk

   Calculate the risk score by multiplying the consequence score by the likelihood score. See table below.

   IMPORTANT: It may be appropriate to assess more than one domain of consequence. This may result in generating different scores. Use your judgement to decide on the **overall** score, however as a rule-of-thumb take the highest domain score.

	Likelihood ('L')				
Impact ('I')	***Rare (1)***	***Unlikely (2)***	***Possible (3)***	***Likely (4)***	***Almost certain (5)***
Catastrophic (5)	**5**	**10**	**15**	**20**	**25**
Major (4)	**4**	**8**	**12**	**16**	**20**
Moderate (3)	**3**	**6**	**9**	**12**	**15**
Minor (2)	**2**	**4**	**6**	**8**	**10**
Negligible (1)	**1**	**2**	**3**	**4**	**5**

IMPORTANT: If a risk is rated at **20** or **25** the risk assessor should contact the Deputy Director of Corporate Affairs or the Corporate Governance & Risk Manager to discuss the rating; all risks rated at 25 must be escalated to a Trust Executive as Risk Owner and for immediate Trust action planning.

5.1.3 Stage 3 - Control Measures

The next step is to identify the control measures:

- What are they?
- Do they work?
- Do they control the hazard and the risk?

Always assess things as they are now including any foreseeable changes, then evaluate the risk with any additional control measures (actions) required, review the risk rating again as this should decrease the risk score. If it does not, then the additional control measures may not be worth implementing. Remember the risk might have to be accepted as it is.

When deciding what to do to reduce the risk, remember that the reduction should be "*so far as is reasonably practicable*". This phrase means that the cost of reduction should not be disproportionate to the risk. If the cost of reduction is high and the risk is low, it would be unreasonable.

Once a risk has been assessed, staff will need to decide how best to respond based on the Trust Risk Appetite (set out in appendix 3) and the resources available. A target risk score and, where risks are to be treated, an associated robust (SMART) action plan should be assigned to each risk to ensure that risks are controlled within a timely manner and to an acceptable level. The risk action plan must be recorded in the Datix risk record, risks will not be approved by the RMC without an appropriate action plan.

However, not all risks can be dealt with in the same way and risk management responses can be a mix of four main actions; Transfer, Tolerate, Treat or Terminate.

Tolerate the risk

The risk may be considered tolerable without the need for further mitigating action, for example if the risk is rated LOW or if the Trust's ability to mitigate the risk is constrained or if taking action is disproportionately costly.

If the decision is to tolerate the risk, consideration should be given to develop and agree contingency arrangements for managing the consequences if the risk is realised. The risk will be considered a Managed Risk and recorded as such in Datix.

Treating the Risk

This is the most common response to managing a risk. It allows the organisation to continue with the activity giving rise to the risk while taking mitigating action to reduce the risk to an acceptable level i.e. as low as reasonably practicable. In general, action plans will reduce the risk over time but not eliminate it.

It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance to the Trust that the risk will be reduced to an acceptable level.

Action plans must be documented on the risk assessment form, have a nominated owner and progress monitored by the appropriate risk forum.

Transfer the risk

Risks may be transferred for example by conventional insurance or by sub-contracting a third party to take the risk. This option is particularly suited to mitigating financial risks or risks to assets.

It is important to note that reputational risk cannot be fully transferred.

Terminate the risk

The only response to some risks is to terminate the activity giving rise to the risk or by doing things differently.

However, this option is limited in the NHS (compared to the private sector) where many activities with significant associated risks are deemed necessary for the public benefit.

Oversight of these action plans takes place at a Care Group and corporate management level in accordance with the Trust's governance arrangements described in section 4.2 of this Policy.

5.1.4 Stage 4 - Recording and Approval of the Assessment

DatixWeb, the Trust's risk management system, is used to support the recording, management and review of risks and production of risk registers across the Trust to ensure consistency of recording. All risks must be recorded on Datix. Risks will not be recognised until they are recorded and approved on Datix. Datix allows control measures to be recorded and actions to be scheduled, with a full audit trail of changes to the risk assessment.

The risk action plan must be recorded in the Datix risk record, risks will not be approved by the RMC without an appropriate action plan.

Information feeds through levels of risk registers, through to the organisation-wide risk register. The system is able to report at different levels, look at trends across fields and record and manage actions.

Risks must be approved in line with the management responsibility table below.

Risk Score	Primary Descriptor	Management level
15 and above	High Risk	These must be reviewed and approved by the Risk Management Committee and oversight of the risks provided at the Executive Team Meeting. They will also be reviewed by the Board committees monthly and the Board quarterly.
8-12	Moderate Risk	These must be reported and approved at the Care Group CSU Governance meeting. There should be oversight by the Care Group Leadership team (through Care Group reporting mechanisms)..
1-6	Low/Managed Risk	Approved and managed at Care Group ward/team level, these are automatically considered to be Managed Risks and should be recorded in the appropriate Datix module.

5.1.5 Stage 5 - Reviewing the assessment

There is a legal requirement that a review must be carried out if:

- There is reason to suspect that it is no longer valid, e.g. incidents are still happening; or
- There has been a significant change.

It is best practice to carry out a review on a regular basis, which will allow for anything that has been missed or to enable you to consider improvements. It is suggested that risks are reviewed in line with the following (as a minimum);

- Risk score 0-6 on an annual basis
- Risk score 8-12 on a quarterly basis
- Risk score 15 or above on a monthly basis.

(The review should be undertaken by the end of the relevant month.)

All risks must be reviewed by the Care Groups in accordance with their agreed review date which should be informed by its current risk score and action plan. Care Group arrangements for monitoring Risk Profile (risk age / score / type) should identify risks where the review date has expired, risks that have not reached target risk score within an agreed timeline, as well as risks recommended for closure, or where risk status can be changed, (e.g. from 'treated' to 'tolerated').

Care Group Risk & Governance Committees should always review out of date action plans and use the Trust Risk and Governance Terms of Reference, standardized agenda template and Risk report template. Where possible Care Group Risk & Governance Committees should use Datix as a live tool for the review of risks during these committees.

When the Risk Owner believes the action plan is completed and the risk has been mitigated to the target rating the risk should be an agenda item on the next Care Group Governance Meeting for discussion and approval to forward for formal closure at the Risk Management Committee. The risk owner should include details of why the risk should be closed in Datix, dates of the Care Group Governance Meeting. The 'Approval status' field should remain as 'Approved Risk'. This fields will be amended following the RMC by the Governance Lead.

The review must be recorded on Datix by the Risk Owner, supported by the Care Group / Departmental Governance Lead, and must ensure that the Risk Assessment represents the current situation taking into account any changes to the context, deterioration of controls, implementation of actions or changes in Risk Appetite (target risk score).

When a risk is an agenda item at a Trust meeting such as the Risk Management Committee (RMC) or any of the Trust Board Committees it is the responsibility of the Care Group Lead present at these meetings to relay the recorded decision of the Committee via the relevant recorded minute to the Risk Owner. It is then the responsibility of the Risk Owner to ensure that the risk record within Datixweb is updated to include the recorded minuted decision and appropriate changes to dates, such as but not limited to Risk Review Date, Action Plan Review Date, Trust Management Committee (Date Approved) etc.

5.2 Risk Reporting / Escalation and Assurance

An integral part of effective risk management is ensuring that risks are reported and escalated within the Trust to ensure that appropriate action and prioritisation of resources can take place.

Risk profile (risk age / score / type) is monitored through the Trust's care group and corporate governance structure with new Care Group approved risks reported in line with the table below. Risks can also be raised at Board Committee or Board of Directors level, these will be initially managed via the Corporate Affairs Team who will liaise with Care Groups and Corporate Services in order to allocate the appropriate Risk Owner, the risk will then follow the process as outlined in the table below.

Risks are also escalated according to the progress in reaching the target score. Where a risk cannot be managed to an acceptable level of risk within available resource or in an agreed timescale then the risk must be escalated to the Risk Management Committee for consideration and onward escalation to ETM.

The maximum time a moderate level risk (current risk score of 8 or above) will be 'Treated' before it is escalated is 24 months*****. At this time any risk that has not reached an acceptable risk level (its target risk score) must be escalated to the Risk Management Committee for consideration and onward escalation to ETM.

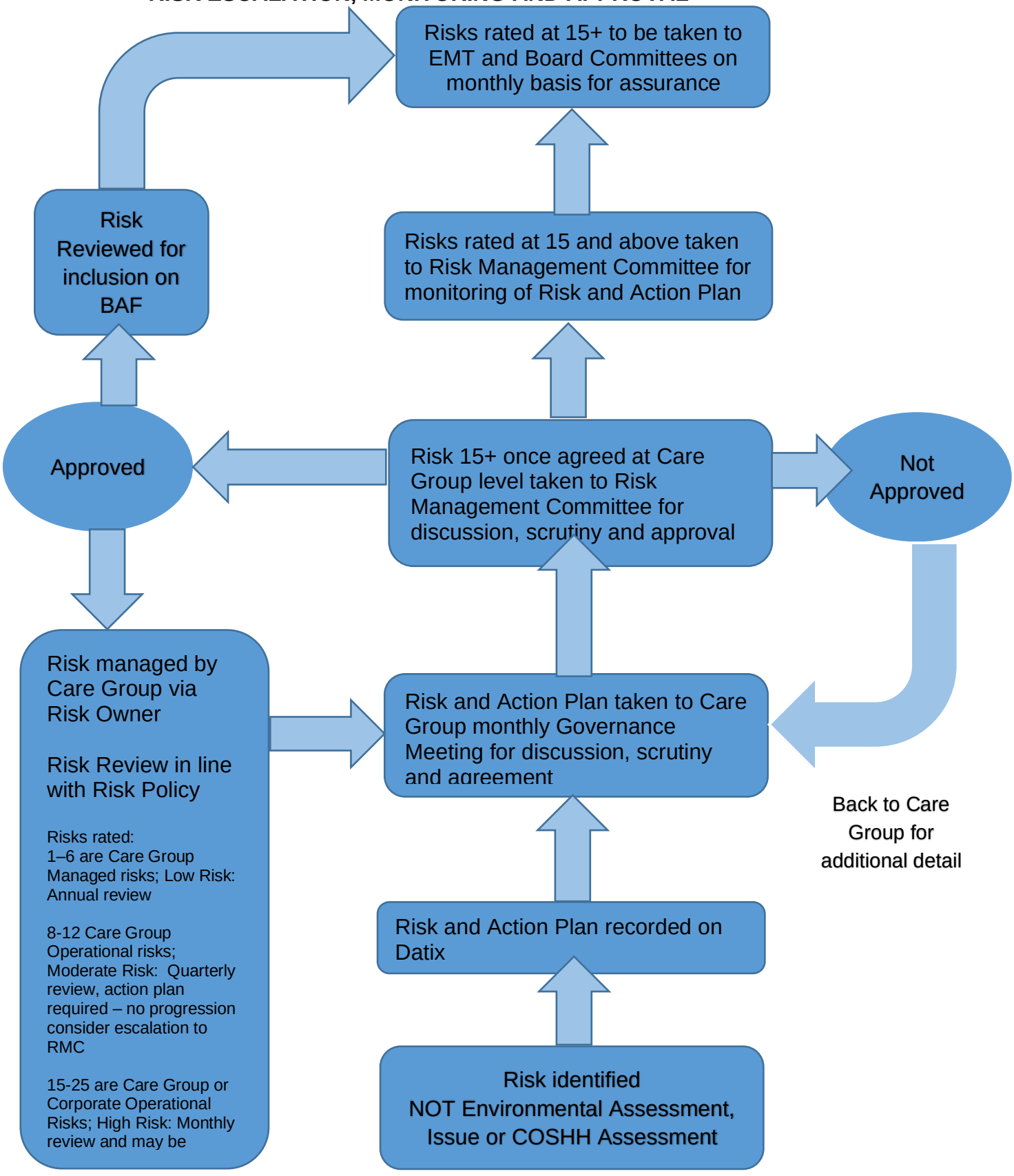
*****Consideration should always be paid to individual risks that are graded as Moderate due to only involving limited numbers of patients (low likelihood) that however might have potentially Major or Catastrophic consequences. These should be reviewed on a case by case basis for escalation within the 24 months' timeframe.

The data recorded on Datix will be used to produce reports to facilitate risk escalation and provide assurance regarding the effective implementation of this Policy. These reports may be adapted at any time to suit the requirements of a particular committee or group; however, some reports are scheduled as detailed in the table below.

The Risk Management Committee will review risks graded at 15+ and allocate them on contents and impact on Strategic Objectives to a specified Trust Board Committee, all Committees will be made aware of all 15+risks so that cross assurance and learning can be encouraged.

Risk Reporting, Escalation and Assurance arrangements can be represented in flowchart form as depicted below:

RISK ESCALATION, MONITORING AND APPROVAL



5.3 Risk Appetite

Risk Appetite identifies the amount of risk the Board is willing to accept in pursuit of its strategic objectives for the financial year in question.

The Board articulates this through a Risk Appetite Statement which defines tolerances for balancing different elements of risk, including patient safety, reputation, workforce and financial / value for money, based on how much, or little the Trust wishes to commit in terms of risk. These limits are then used to derive acceptable Target Scores for Risk.

The Risk Appetite Statement will be refreshed and updated every year. further information regarding the Board Risk Appetite Statement is found at Appendix 4 and covers the following categories/types of risk:

Clinical Innovation
Commercial
Compliance/Regulatory
Financial/Value for money (VFM)
Partnerships
Reputation
Quality – Clinical Effectiveness, Patient Experience & Safety
People / Culture & Workforce
Environmental
Estates
Information Governance
Information Technology (IT) & Cyber Security
Fire Safety / General Security
Inequality

The statement will detail the “amount of risk an organisation (TRFT) is willing to accept in pursuit of strategic objectives”.

5.4 Emerging risks

Emerging risks are newly identified or unforeseen risks that have the potential to cause significant impact but are not yet fully understood or recognised. These risks often arise from national enquiries, regulatory changes, societal shifts, or unexpected events.

As part of the Risk Management Policy, the organisation proactively scans the internal and external environment to identify potential emerging risks. This is promoted and collated through the Risk Management Committee and Board Committees with Senior Leaders playing a key role in information sharing and horizon scanning. Approved and newly identified emerging risks are reported to the Audit and Risk Committee on a quarterly basis.

Once identified, these risks will be evaluated for their likelihood, potential impact, and urgency, even in the absence of complete information and will be reported monthly to the Risk Management Committee. By maintaining a

forward-looking approach, it ensures emerging risks are appropriately monitored and addressed.

5.5 External risks

External risks are events or circumstances outside the organisation's control that can significantly affect its operations, objectives, or performance. While the organisation cannot influence these risks directly, the Trust is committed to identifying and monitoring external risks through environmental scanning, trend analysis, and engagement with industry and governmental bodies.

The Trust is also responsible for contingency planning, scenario analysis, and developing adaptive strategies which are monitored through the Trust's Emergency Planning & Business Resilience operation to mitigate the effects of external risks and maintain organisational resilience.

5.6 System risk management

System risks are a reflection of organisationally owned risks that are impacted by the broader system of partners and stakeholders.

Recognised interconnected risks are escalated to Risk Management Committee with action plans submitted. The action plans will most likely include actions beyond the Trust's control that require external input and this information should be disseminated through partnership groups and forums to ensure that system-wide resilience is strengthened.

5.7 Issues log

An issues log is a formal document used to record and track problems, challenges, or concerns that arise from the Trust Risk Register and Risk Management function. Issues are actual events or problems that have already occurred and require resolution.

The Issues Log is overseen by the Audit and Risk Committee and reported to all Board Committees. It is a dynamic document and regularly updated to reflect the current status of each issue and it is the role of the Risk Management Committee to monitor the actions put in place and track their resolution.

5.8 Internal audit

Internal audit evaluates the effectiveness of the organisation's risk management framework, ensuring risks are identified, assessed, and managed appropriately. Auditors assess the design and operation of internal controls, compliance and regulatory assurance, governance, efficiency and continuous improvement. This includes verifying that emerging risks, system-wide risks and issues are addressed and incorporated into the organisation's overall strategy.

Internal audit report quarterly to Audit and Risk Committee and compile an Annual Report, providing an opinion for the financial year in relation to the approved audit plan.

5.9 Scheduled Risk Reports

REPORT	FORUM	FOR	SCHEDULE	CONTENT
NEW RISKS	Care Group Management Team 15+ Risk Management Committee	Discussion, scrutiny and agreement of risk, risk rating and action plan Approval	Monthly New/draft risks logged on Datix should be approved within four weeks	All new/draft risks logged onto Datix within four weeks
RISK TO BE CLOSED / MANAGED / CHANGE TO RATING	Care Group Management Team Risk Management Committee	Approval Approval	Monthly	All risks recommended for closing or to be managed/tolerated.
APPROVED RISKS (SCORING 15 OR ABOVE	Risk Management Committee	Scrutiny	Monthly	All risks approved by Care Group CSU Governance meeting with a current risk score of 15 or above will be reported to RMC in line with its meeting schedule
RISK PAST REVIEW DATE	Care Group Management Team Risk Management Committee	Review for action Information	Monthly Bi monthly	Risks past review date per Care Group / Department will be published on the first working day of the month
NEW APPROVED RISKS >=15	ETM	Debate	Monthly	All newly approved risks with a score of 15 or more following approval at RMC
RISKS <=12 NOT AT TARGET RISK SCORE	Care Group Management Team Risk Management Committee	Review for escalation / action	Monthly Bi-Monthly	All risks that have not reached target score within agreed timeline.
RISKS >=15	Board of Directors Board Committee	Review for action / assurance	Quarterly	Risks reporting 15 or above.

6. REFERENCES

- Health and Safety at Work etc. Act 1974
- The Management of Health and Safety at Work Regulations 1999
- Audit Commission (2009). Use of Resources Framework – Overall approach and key lines of enquiry. London: Audit Commission. http://www.auditcommission.gov.uk
- Health and Safety Executive (HSE). (2010). Leading Health and Safety at Work: Leadership Actions for Directors and Board Members London: HSE http://www.hse.gov.uk
- NHS Improvement (National Patient Safety Agency. (2008)). A risk matrix for risk managers. London:
- NHS Improvement (National Patient Safety Agency. (2007)). Healthcare risk assessment made easy. London

7. ASSOCIATED DOCUMENTATION

Risk Management Strategy 2025 – 2027

Health and Safety Strategy 2023 – 2026

Further Datix related guidance can be accessed through the following link:

https://intranet.xrothgen.nhs.uk/TeamCentre/CorporateServices/ChiefNursingTeam/SitePages/Datix%20Guides.aspx

APPENDIX 1

The Rotherham NHS Foundation Trust

LIKELIHOOD AND CONSEQUENCE DETAILS

Qualitative Measures of Consequences (Actual / Potential)

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Injury (Physical / Psychological)	▶ Adverse event requiring no/minimal intervention or treatment	▶ Minor injury or illness – first aid treatment needed ▶ Health associated infection which may/did result in semi-permanent harm ▶ Affects 1-2 people	▶ Moderate injury or illness requiring professional intervention ▶ No staff attending mandatory / key training ▶ RIDDOR / Agency reportable incident (8-14 days lost) ▶ Adverse event which impacts on a small number of patients ▶ Affects 3-15 people	▶ Major injury / long term incapacity / disability (e.g. loss of limb) ▶ >14 days off work ▶ Affects 16 – 50 people	▶ Fatalities ▶ Multiple permanent injuries ▶ or irreversible health effects ▶ An event affecting >50 people
Patient Experience	▶ Reduced level of patient experience which is not due to delivery of clinical care	▶ Unsatisfactory patient experience directly due to clinical care – readily resolvable Increase in length of hospital stay by 1-3	▶ Unsatisfactory management of patient care – Care Groupl resolution (with potential to go to independent review) ▶ Increased length of hospital stay by 4 – 15 days	▶ Unsatisfactory management of patient care with long term effects ▶ Increased length of hospital stay >15 days ▶ Misdiagnosis	▶ Incident leading to death ▶ Totally unsatisfactory level or quality of treatment / service
Environmental Impact	▶ Onsite release of substance averted ▶ Minimal or no impact on the environment	▶ Onsite release of substance contained ▶ Minor damage to Trust property <£10K	▶ On site release no detrimental effect ▶ Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K - £50K	▶ Offsite release with no detrimental effect / on site release with potential for detrimental effect ▶ Major damage to Trust property – external organisations required to	▶ Onsite /off site release with realised detrimental / catastrophic effects ▶ Loss of building / major piece of equipment vital to the Trust business continuity ▶ Catastrophic impact on the environment

Qualitative Measures of Consequences (Actual / Potential)

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
		▶ Minor impact on the environment	▶ Moderate impact on the environment	remedy – associated costs >£50K ▶ Major impact on the environment	
Staffing & Competence	▶ Short term low staffing level (<1 ▶ day) – temporary disruption to patient care ▶ Minor competency related failure reduces service quality <1 day ▶ Low staff morale affecting one person	▶ On-going low staffing level - minor reduction in quality of patient care ▶ Unresolved trend relating to competency reducing service quality ▶ 75% - 95% staff attendance at mandatory / key training ▶ Low staff morale (1% - 25% of staff)	▶ Late delivery of key objective / service due to lack of staff ▶ 50% - 75% staff attendance at mandatory / key training ▶ Unsafe staffing level .> 5 days ▶ Serious error due to ineffective training and / or competency ▶ Low staff morale (25% - 50% of staff)	▶ Uncertain delivery of key objective / service due to lack of staff ▶ 25%-50% staff attendance at mandatory / key training ▶ Unsafe staffing level >5days ▶ Serious error due to ineffective training and / or competency ▶ Very low staff morale (50% – 75% of staff)	▶ Non-delivery of key objective / service due to lack of staff ▶ On-going unsafe staffing levels ▶ Loss of several key staff ▶ Critical error due to lack of staff or insufficient training and / or competency ▶ Less than 25% attendance at mandatory / key training on an on-going basis ▶ Very low staff morale (>75%)
Complaints / Claims	▶ Informal / Care Group resolved complaint ▶ Potential for settlement / litigation <£500	▶ Overall treatment / service substandard ▶ Formal justified complaint (Stage 1) ▶ Minor implications for patient safety if unresolved ▶ Claim <£10K	▶ Justified complaint (Stage 2) involving lack of appropriate care ▶ Claim(s) between £10K - £100K ▶ Major implications for patient safety if unresolved	▶ Multiple justified complaints ▶ Independent review ▶ Claim(s) between £100K - £1M Non-compliance with national standards with significant risk to patients if unresolved	▶ Multiple justified complaints ▶ Single major claim ▶ Inquest / ombudsman inquiry ▶ Claims >£1M
Financial	▶ Small loss ▶ Theft or damage of personal property<£50	▶ Loss <£100K ▶ <5% over project budget / schedule slippage ▶ Theft or loss of personal property £500	▶ Loss of £100K - £500K ▶ 5 – 10% over project budget / schedule slippage ▶ Theft or loss of personal property >£750	▶ Loss of >£500K - £1M ▶ 10 – 25% over project budget / schedule slippage ▶ Purchasers failing to pay on time	▶ Loss > £1M ▶ >25% over project budget / schedule slippage ▶ Loss of contract / payment by results

Qualitative Measures of Consequences (Actual / Potential)

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Business / Service Interruption	▶ Loss / interruption of > 1 hour; no impact on delivery of patient care / ability to provide services	▶ Short term disruption, of >8 hours with minor impact	▶ Loss / interruption > 1 day ▶ Disruption causes unacceptable impact on patient care ▶ Non-permanent loss of ability to provide service	▶ Loss / interruption of > 1 week ▶ Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked ▶ Temporary service closure	▶ Permanent loss of core service / facility ▶ Disruption to facility leading to significant 'knock-on' effect across Care Group health economy ▶ Extended service closure
Inspection / Statutory Duty	▶ Small number of recommendations which focus on minor quality improvement ▶ No or minimal impact or breach of guidance	▶ Minor recommendations which can be implemented by low level of management ▶ Breach of Statutory legislation ▶ No audit trial to demonstrate that objectives are being met (NICE, HSE, NSF etc.)	▶ Challenging recommendations which can be addressed with ▶ Single breach of statutory duty ▶ Non-compliance with core standards <50% of objectives within standards being met	▶ Enforcement action ▶ Multiple breaches of statutory duty ▶ Improvement Notice ▶ Critical Report ▶ Low performance rating ▶ Major noncompliance with core standards	▶ Multiple breaches of statutory duty ▶ Prosecution ▶ Complete systems change required ▶ Severely critical report ▶ Zero performance rating ▶ No objectives / standards being met
Publicity / Reputation	▶ Rumours ▶ Potential for public concern	▶ Care Groupl Media – short term – minor effect on public attitudes / staff morale ▶ Elements of public expectation not being met	▶ Care Groupl media – long term - moderate effect – impact on public perception of Trust & staff morale	▶ National media <3 days– public confidence in organisation undermined – use of services affected	▶ National / International adverse publicity >3 days ▶ MP concerned (questions in the House) ▶ Total loss of public confidence
Fire Safety / General Security	▶ Minor short term (<1day) shortfall in fire safety system ▶ Security incident with no adverse outcome	▶ Temporary ▶ (<1 month) shortfall in fire safety system / single detector etc. (nonpatient area)	▶ Fire Code noncompliance / lack of single detector – patient area etc. ▶ Security incident leading to compromised staff / patient safety	▶ Significant failure of critical component of fire safety system (patient area) ▶ Serious compromise of staff / patient safety	▶ Failure of multiple critical components of fire safety system (high risk patient area) ▶ Infant / young person abduction

Qualitative Measures of Consequences (Actual / Potential)

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
		▶ Security incident managed by Care Group ▶ Controlled drug discrepancy – accounted for	▶ Controlled drug discrepancy – not accounted for		
Information Governance / IT	▶ Breach of confidentiality – no adverse outcome ▶ Unplanned loss of IT facilities < half a day	▶ Minor breach of confidentiality ▶ readily resolvable ▶ Unplanned loss of IT facilities < 1 day ▶ Health records incident / documentation incident – readily resolvable	▶ Moderate breach of confidentiality complaint initiated ▶ Health records / documentation incident - patient care affected with short term consequence	▶ Serious ▶ breach ▶ of confidentiality – more than one person ▶ Unplanned loss of IT facilities >1 day but less than 1 week ▶ Health records / documentation incident - patient care affected with major consequence	▶ Serious breach of confidentiality – large numbers ▶ Unplanned loss of IT facilities > 1 week ▶ Health records / documentation incident - catastrophic consequence
Project time plan	▶ Insignificant schedule from baseline plan ▶ Insignificant impact on value and/or time to realise declared benefits against profile	▶ <5% variance in schedule from plan ▶ <5%	▶ 5 - 10% variance in schedule from base line plan ▶ 5 - 10% variance on value and/or time to realise declared benefits against profile	▶ 10 - 25% variance in schedule from base line plan ▶ 10 - 25% variance on value and/or time to realise declared benefits against profile	▶ 25% variance in schedule from base line plan ▶ > 25% variance on value and/or time to realise declared benefits against profile

Likelihood Assessment

(use in order of preference)

Likelihood scores (broad descriptors of frequency)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur, but it is not a persisting issue/circumstances	Will undoubtedly happen/recur possibly frequently

Likelihood scores (time-framed descriptors of frequency)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Likelihood scores (probability descriptors)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Probability Will it happen or not?	<0.1 per cent	0.1-1 per cent	1-10 per cent	10-50 per cent	>50 per cent

The Rotherham NHS Foundation Trust

TRFT Risk Appetite

Risk Appetite Statement

Risk appetite is usually defined as 'the amount and type of risk that an organisation is willing to take in order to meet its strategic objectives'. Depending on their sector, culture and objectives, organisations will have different risk appetites. A range of appetites exist for different risks and these may change over time. The Strategic Risk Appetite is then bound to the organisation's Risk Tolerance, which are the boundaries within which the executive are willing to allow the true day-to- day risk profile of the organisation to fluctuate, while they are executing strategic objectives in accordance with the Board's strategy and risk appetite. It is worth noting that the risk tolerance can be limited by legal or regulatory requirements.

The Rotherham NHS Foundation Trust (TRFT) recognises that its long term stability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, TRFT will not accept risks that materially provide a negative impact on quality, this includes Clinical Effectiveness, Patient Experience & Safety. However, TRFT has a greater appetite to take considered risks in terms of their impact on organisational issues in relation to other risk types.

The board of directors is responsible for the organisation's risk appetite, risk tolerance and attitude to risk taking, so at the June 2024 Strategic Board the members were asked to provide their respective acceptable levels of risk for each of the Risk Types via an anonymous audience interaction tool. The levels of risk were based on the Good Governance Institute (GGI) May 2020 publication Risk Appetite for NHS Organisations and the TRFT Risk Management Policy risk matrix 2023.

The GGI risk matrix included within this document (Appendix 1) differs from the TRFT Risk Management Policy 2023 in that it has 6 levels of risk rather than three in the TRFT document it was agreed that with respect to Risk Appetite the GGI matrix would be used, Table 2 includes the TRFT scoring as this will be used operationally to set risk target ratings.

The GGI have developed the following risk matrix for grading the Risk Appetite, as can be seen in table 1.

GGI and Risk Levels						
GGI RISK LEVEL	Avoid	Minimal	Cautious	Open	Seek	Mature
GGI DESCRIPTOR	Avoidance of risk and uncertainty is a Key Organisational objective	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of residual risk and only have limited reward potential.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward	Eager to innovate and to choose options offering higher business rewards (despite greater inherent risk)	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

Table 1

The full GGI risk matrix can be found at Appendix 3, however for reference the individual risk descriptors from the matrix have been inserted into table 2, below, in order to provide clarity on each of the Risk Types found in the TRFT Risk Appetite framework.

Table 2 below

Good Governance Institute

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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TRFT Operational Health, Safety & Welfare Risk Assessment			
Task			
Site		Department	
Risk Assessor		Assessment Type	
OSU/CSU			
Department Manager			
Date of Assessment		Review Date	
People/ Service affected by the risk			

TRFT Operational Health, Safety & Welfare Risk Assessment

Likelihood:	**Severity:**
1. Rare 2. Unlikely 3. Possible 4. Likely 5. Certain	1. Negligible 2. Minor 3. Moderate 4. Major 5. Catastrophic

Risk = Likelihood x Severity

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
Frequency How often might it / does it happen	Will probably never happen / recur	Unlikely to happen / recur, but it is possible it may do so	Will possibly happen or recur occasionally	Is likely to happen / recur persistently	Will undoubtedly happen/ recur, possibly frequently
Risk Rating	Low Risk (1-6)	Moderate (8-12)	High Risk (1-25)		

Risk Rating = Likelihood x Severity e.g. 3 (Possible) x 4 (Major) = 12					
Likelihood (L)					
Certain - 5	*5*	*10*	*15*	20	25
Likely – 4	*4*	*8*	*12*	16	20
Possible – 3	*3*	*6*	*9*	12	15
Unlikely – 2	*2*	*4*	*6*	8	10
Rare – 1	*1*	*2*	*3*	*4*	*5*
	Negligible – 1	**Minor – 2**	**Moderate – 3**	**Major – 4**	**Catastrophic – 5**
	Severity (S)				

1 - 6	1 - Low Risk/ Managed Risk	Local action, beware of aggregated/multiple green issues.
8 – 12	2 - Moderate Risk	Local action, contact the Risk Dept. for advice if concerned.
15 – 25	4 – High Risk	Take action and notify the Risk Dept. (? Datix Investigation or Serious Incident (SI)).

Hazards	**Risk from the Hazard/How the Hazard can cause harm**	**Current Controls in place**	**Likelihood of Harm (L)**	**Severity of Harm (S)**	**Risk Rating L x S**	**Additional Controls**	**Residual Risk (after additional controls completed) L x S**

Action Plan	**Date Completed**
1.	
2.	
3.	
4.	
5.	
Signature of Manager	
Name of Manager	
Date	Review Date:

Additional Control Measure for <insert department/ward>	*<Insert any additional control measure as a document into this box>*

References	**Versions**

RISK MANAGEMENT POLICY

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING

8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

Risk Management Committee

9. APPROVAL OF THE DOCUMENT

This document was approved by: the Trust Board.

10. RATIFICATION OF THE DOCUMENT

This document was ratified by the Trust Document Ratification Group.

11. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed every three years by the Quality Governance, Compliance and Risk Manager unless such changes occur as to require an earlier review.

12. DISSEMINATION AND COMMUNICATION PLAN

To be disseminated to	Disseminated by	How	When	Comments
DRG Admin Support via "DRG Admin Support" email. Library & Knowledge Services via "policies" email.	Author	Email	Within 1 week of ratification	Remove watermark from ratified document and inform DRG Admin Support if a revision and which document it replaces and where it should be located on the Hub. Ensure all documents templates are uploaded as word documents.
Communication Team	DRG Admin Support	Email	Within 1 week of ratification	Communication team to inform all email users of the location of the document.
All email users	Communication Team	Email	Within 1 week of ratification	Communication team will inform all email users of the policy and provide a link to the policy.
Key individuals Staff with a role/responsibility within the document Heads of Departments / Matrons	Author	Meeting / Email as appropriate	When final version completed	The author must inform staff of their duties in relation to the document.

To be disseminated to	Disseminated by	How	When	Comments
All staff within area of management	Heads of Departments / Matrons	Meeting / Email as appropriate	As soon as received from the author	Ensure evidence of dissemination to staff is maintained. Request removal of paper copies Instruct them to inform all staff of the policy including those without access to emails

13. IMPLEMENTATION AND TRAINING PLAN

What	How	Associated action	Lead	Timeframe
Risk Management Training	It is essential for all Risk Owners, band 8a's (or equivalent) and above. Ward/Team Managers and their deputies, along with any other interested individuals are encouraged to attend.	None	Deputy Director of Corporate Affairs and Corporate Governance and Risk Manager	On-going
Risk Assessor Training	All Risk Assessors are required to undertake Risk Assessor Training	None	Health & Safety Advisor	On-going

14. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF THE TRUST DOCUMENT

14.1 Process for Monitoring Compliance and Effectiveness

Audit / Monitoring Criteria	Process for monitoring e.g. audit, survey	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Action plans approved and monitored by
Roles & Responsibilities	Review of meetings	Deputy Director of Corporate Affairs	Annual	Risk Management Committee	Risk Management Committee
Training attendance	Review of attendance	Deputy Director of Corporate Affairs	Monthly	Risk Management Committee	Risk Management Committee
Identification of Risks	Review of risks	Care Group Governance and Performance Meetings	Monthly	Risk Management Committee	Risk Management Committee
Management of Risks	Review of risks	Care GroupGovernance and Performance Meetings	Monthly	Risk Management Committee	Risk Management Committee

14.2 Standards/Key Performance Indicators (KPIs)

To Be Agreed at Risk Management Committee.

15. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been conducted on this policy. A copy is available on request from rgh-tr.edi@nhs.net

Ref No: 609

RISK MANAGEMENT POLICY

SECTION 1
PROCEDURAL INFORMATION

Version:	4
Title of originator / author:	~~Quality Governance, Compliance and Risk Manager~~Director of Corporate Affairs
Title of Responsible committee	Board of Directors
Title of Ratifying Committee:	Document Ratification Group
Date ratified:	~~28 April 2023~~
Date issued:	~~28 April 2023~~
Review date:	~~28 April 2026~~
Target audience:	Trust wide

Document History Summary

Version	Date	Author	Status	Comment
1a	Apr 2017	Quality Governance, Compliance and Risk Manager	Draft	Risk Management Guidelines To be discussed at the April 2017 Risk Management Committee
1b	June 2017	Quality Governance, Compliance and Risk Manager	Draft	Risk Management Guidelines Approved – subject to amendments at DRG in May 2017 and so rediscussed in June 2017 Risk Management Committee
1	July 2017	Quality Governance, Compliance and Risk Manager	Final	Risk Management Guidelines Ratified by Trust Document Ratification Group
2a	June 2019	Quality Governance, Compliance and Risk Manager	Draft	Risk Management Guidelines To be reviewed by the Risk Management Committee & The Risk Analysis Group
2	June 2019	Quality Governance, Compliance and Risk Manager	Final	Risk Management Guidelines Ratified by Trust Document Ratification Group
3a	September 2020	Quality Governance, Compliance and Risk Manager	Draft	Converted to Risk Management Policy
3	December 2020	Quality Governance, Compliance and Risk Manager	Final	Ratified by Trust Document Ratification Group
4a	September 2022	Quality Governance, Compliance and Risk Manager	Draft	Circulated for comments
4b	September 2022	Quality Governance, Compliance and Risk Manager	Final	Document sent for approval
4	April 23	Quality Governance, Compliance and Risk Manager	Final	Ratified by Trust Document Ratification Group
5	January 2025	Deputy Director of Corporate Affairs		

Section 1 Contents

Section 1 Appendices

Section 2 Contents

1. INTRODUCTION

1.1 The Rotherham NHS Foundation Trust (the Trust) acknowledges that risk is inherent in the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances.

1.2 The identification of these risks, together with proactive management and mitigation, is essential and the Trust recognises the importance of effective risk management as a fundamental element of the Trust's governance framework and system of internal control.

1.3 The Trust is committed to embedding a risk management culture and making risk management a core organisational process that underpins delivery of the Trust's strategic aims and upholds our corporate responsibility to provide the highest standards of patient care and staff safety.

1.4 To support an integrated approach to risk management the Trust has documented the structures and the processes that are in place to identify, manage and eliminate or reduce risks to a tolerable level.

1.5 This policy provides a structured approach to the management of risk and supports the implementation of the Risk Management and Health and Safety Strategies in the Trust. It outlines how risks should be identified/ recorded and managed. Instructions on using DatixWeb are on the Hub. It must be read in conjunction with the Risk Management and Health and Safety Strategies, including the Trust's Risk Appetite.

2. PURPOSE & SCOPE

2.1 Purpose

2.1.1 The purpose of the Policy is to provide the overarching principles and detail the structures and standards required for the management of risk (clinical and non-clinical) across the Trust.

2.1.2 The key objective is to support managers and staff in the management of risk to ensure that the Trust is able to effectively deliver its objectives, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected.

2.1.3 It clarifies accountability arrangements for the management of risk within the Trust from 'Board to Ward' and 'Ward to Board', setting out the responsibility of directors and senior managers in respect of leadership in risk management, confirms the role that all staff within the organisation have in relation to responsibility for the identification and reporting of risks.

2.1.4 The Policy outlines clear reporting arrangements and describes how risks are escalated through the Trust's governance structure and how the effectiveness of risk management is scrutinised and monitored.

2.1.5 Detailed instructions setting out the operation of risk management are provided in separate associated procedural documents, as follows;

- ~~Datix Guide - Risk Reports for Governance Meetings~~
- How to Attach Documents to Risk Assessments in Datix Guide
- How to Export a Risk Register to Excel Guide
- ~~•~~
- How to Review a Risk Guide
- Action Planning in Datix Risk Module
- Datix - Linking Records (Incidents, Risks, Complaints, Claims, Safety Alerts)
- Datix - Ad-hoc Searches and Saving Queries
- Datix - Guide to Attaching Documents
- All Datix Guidance Documents can be found at:
- https://intranet.xrothgen.nhs.uk/TeamCentre/CorporateServices/ChiefNursingTeam/SitePages/Datix%20Guides.aspx

2.2 Scope

Risk Management is the responsibility of all colleagues within the Trust, and so therefore the policy applies to all areas and activities of the Trust and to all staff, contractors, volunteers, students, locum and agency staff and staff employed on honorary contracts.

3. DEFINITIONS AND ABBREVIATIONS

3.1 Definitions

Risk:
Risk can be defined as the probability that a specific adverse event will occur in a specific time period or as a result of a specific situation.

The probability or threat of a change, injury liability, loss or other negative occurrence, caused by internal and external vulnerabilities, and which may be neutralised through premeditated actions.

Risk is the combination of likelihood and consequence of a hazard being realised.

Emerging Risk:

Emerging risk: A new or unforeseen risk that we haven't yet contemplated. This is a risks that should be on our radar, but is not, and its potential for harm or loss is not fully known

External Risks
Those risks that the organisation does not have control over, and cannot easily predict their likelihood of occurrence or the actual impact to the organisation, examples include Covid-19. Natural factors, economic factors, and political factors are among the sub-categories of external risk. (Beers, 2020)

System Risk Management
System risks are not a separate risks but a reflection of organisationally owned risks, focusing on the impact they have across all system partners.

Issue:
An “issue” already has occurred and a “risk” is a potential issue that may or may not happen and can impact the project positively or negatively. Risk is an event that has not happened yet but may; an issue is something that already has happened.

Hazard Identification:
A Hazard is a source of potential harm or a situation with a potential to cause loss such as low staffing levels, incorrectly completed documents, chemical, finance or reputation etc. They are the underlying cause of risk, and as such the term has particular relevance in the identification of risk.

Likelihood:
Likelihood is the probability of each outcome occurring, quantifying the risks of a particular incident happening, including the frequency in which it may arise.

Risk Assessment:
Risk Assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk.

Risk management:
is defined as “The process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure” (The Institute of Risk Management)

Control Measures:

Sometimes referred to as Controls, are the precautions that are put into place to reduce/mitigate the risk.

Risk Tolerance Levels:
The Trust will establish risk tolerance levels consistent with the general risk appetite statement available in the Risk Management Strategy 2025~~0~~ – 2027~~5~~.

Risk Register:
A risk register can be described as 'a log of risks of all kinds that threaten an organisation's success in achieving declared aims and objectives. It is a dynamic living document, which is populated through the organisation's risk assessment and evaluation process. This enables risk to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated. (***Definition - CASU, Keele University***)

3.2 Abbreviations

CASU	*Controls Assurance Support Unit*
CSU	Clinical Support Unit
ETM	Executive Team Meeting
HSE	Health and Safety Executive
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
RMC	Risk Management Committee
SIRO	Senior Information Risk Owner
SMART	Specific, Measurable, Achievable, Realistic, Timely
TRFT	The Rotherham NHS Foundation Trust

4. ROLES & RESPONSIBILITIES

Roles	Responsibilities
Chief Executive (CE)	The Chief Executive as 'accountable officer' has overall accountability and responsibility for risk management within the Trust, ensuring the implementation of an effective risk management system. The Chief Executive must seek assurance from the systems and processes for risk management and ensure that these meet regulatory, statutory and legal requirements. Operationally, the Chief Executive delegates responsibility for implementation of risk management to the Chief Nurse.
Director of Corporate Affairs	The Director of Corporate Affairs has

	delegated responsibility for risk management from the Chief Executive. As such they are responsible for ensuring that all risk and assurance processes are devised, implemented and embedded throughout the Trust and for reporting to Executive Team Meeting (ETM) any significant issues arising from the implementation of the Policy, including non-compliance or lack of effectiveness arising from the monitoring processes. The Director of Corporate Affairs is also responsible for the management of the Board Assurance Framework (BAF), ensuring it is robust and effective.
Deputy Director of Corporate Affairs ~~Quality Governance, Compliance and Risk Manager~~	The Deputy Director of Corporate Affairs~~Quality Governance, Compliance and Risk Manager~~ supports the Director of Corporate Affairs in the day to day management of the Trust's Risk Register. The Deputy Director of Corporate Affairs ~~Quality Governance, Compliance and Risk Manager~~ supports the review, development and embedding of the Risk Management Strategy and Policy across the Trust to ensure that there is an effective Risk Management System in place. The Deputy Director of Corporate Affairs ~~Quality Governance, Compliance and Risk Manager~~ supports the Trust and the Board of Directors by providing a risk management function that facilitates and monitors the implementation of effective risk management practices and assists risk owners in identifying, assessing and managing and reviewing risk. Specifically, the Department supports all areas of the Trust in the use of Datix to record risk and produce risk reports in an agreed format to facilitate 'ward to board' governance and, where necessary, the escalation of risk.

Corporate Governance & Risk Manager	The Corporate Governance & Risk Manager supports the Deputy Director of Corporate Affairs in the day to day management of the Trust's Risk Register.
~~Divisional~~ Care Group Management Teams	Colleagues are responsible for the implementation of this Policy at corporate and service level including the establishment and continual management of ~~Divisional~~ Care Group Risk Registers and project risks registers. They are responsible for managing risk within their Services and Care Group through their ~~divisional~~ Care Group monthly governance groups. The Care Group management team should also ensure that the Trust Risk and Governance Terms of Reference, standardized agenda template and Risk report template should be used for all Care Group Risk & Governance Committees. The teams are required to ensure that through ~~Divisional~~ Care Group governance meetings and other relevant forums that risks are shared, focusing on the risk action plans and escalating areas of concern where required. They are responsible for ensuring that all risk assessments are reviewed and approved and all risks reviewed in a timely manner and action plans recorded and updated on the Datix database.
Governance Leads	Governance Leads are responsible for the management of identified risks within the scope of their responsibility, ensuring that risks are reviewed and maintained in a timely manner. The Governance Leads are responsible for co-ordinating risk management processes in their ~~Division~~Care Group/Department by:

	• consulting with teams to identify and assess risks and determine mitigating actions; • maintaining arrangement for oversight of all ~~divisional~~ Care Group risks and ensuring that these are recorded on Datix and undergo regular review and quality assurance; • promoting the risk management policy, procedures / best practice and communicating changes as necessary; and • sharing information and knowledge on risks within their area through membership of relevant groups and committees.
Risk Management Specialist Officers	Certain roles within the Trust have Trust-wide risk related roles and responsibilities to supporting and contributing to the development of Trust-wide and ~~divisional~~ Care Group risk management and governance arrangements and for providing specialist advice, education and training to ensure compliance with statutory requirements and best practice. This includes a Senior Information Risk Owner (SIRO) who is the nominated lead to ensure the Trust's information risk is properly identified and managed and that appropriate assurance mechanisms are in place.
Risk Owners	Risk Owners are responsible for; • Identifying the risks • Reporting the risks on Datix • Recording, maintaining and monitoring risk action plans through the Datix database • Sharing the content of the risks in their area • Managing the risks on a day to day basis • Keeping the risk data on Datix up to date; this should include inclusion of all minutes and

	dates related to the risk from any ~~Divisional~~ Care Group and Trust Governance/Risk Management meeting in the risk record for audit purposes.
Colleagues	Management of risk is a fundamental duty of all staff. All staff must ensure that identified risks and incidents are reported in order to ensure appropriate actions are taken. These requirements also extend to locum and agency staff.
Partner Organisations and Contractors	Specific risks identified in the Trust will be shared with any other relevant organisation working in partnership with the Trust.
Board Of Directors	The Trust Board of Directors has overall responsibility for ensuring that effective internal controls (clinical, organisational and financial) are in place and for reviewing the effectiveness of these controls. The Chief Executive is required to produce an Annual Governance Statement that confirms to the Board of Directors the adequacy of controls in place to manage risk. The Board approves the implementation of the Risk Management Policy (this document) and oversees its effectiveness through the described monitoring and review processes. The Board of Directors sets the Risk Appetite Statement each year. Through the Quarterly Risk Register reports, the Board assures itself that the Trust identifies and effectively manages any risks that could impact on the achievement of its Strategic Aims. Board Committees provide additional oversight of strategic and high level risk within their remit.
Assurance Committees of the Board	Each Assurance Committee of the Board has a role for risks pertaining to their area of focus. They have roles in reviewing the management of the

	risks held on the Risk Register and Board Assurance Framework. They review the Board Assurance Framework and ensure that the Board of Directors receive assurance that effective controls are in place to manage Corporate risk and report on any significant risk management and assurance issues. Each of these Committees has oversight responsibility for a section of the Risk Register within the remit of their own Terms of Reference and performs detailed scrutiny of controls and assurances. Via their Non-Executive Chair, each reports formally to the Board of Directors, to confirm delivery of assurance or to escalate matters as necessary.
Audit & Risk Committee	The ~~Risk &~~ Audit & Risk Committee is a sub-committee of the Board and with delegated authority from the Board of Directors, the ~~Risk &~~ Audit & Risk Committee has overall responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical). Specifically, this Committee is responsible for providing an independent and objective view of internal control. • Ensures that an annual review of the risk management process is undertaken by the internal audit function and provides assurance to the Board of Directors based on its outcome. • Reviews the adequacy of the underlying assurance processes that indicate the effectiveness of the management of principal risks to the achievement of corporate objectives as reported in the Quarterly Risk Register report.

Executive Team Meeting (ETM)	The ETM utilises the risk register to understand the risks to achieving the accountabilities of the Chief Executive, specifically all risks with a score of 15 (or above) on the risk register. ETM has responsibility for ensuring that those risks are regularly reviewed, that risks are being mitigated and resources are being effectively allocated in line with the level of risk appetite and tolerance established by the Board. The ETM is responsible for the implementation of risk management and its assurance mechanisms. Individual Executive Directors provide leadership on the management of key areas of risk with their roles and are responsible for overseeing a programme of risk management activities for their areas of responsibility.
Risk Management Committee	The primary purpose of the Trust's Risk Management Committee is to provide assurance to the Board on the function of systems of risk management via the Executive Team Meeting (ETM).
Specialist Risk Groups	In addition to the above, there are a number of specialist Trust-wide groups (e.g. Infection Prevention and Control Committee, Information Governance Committee etc.) that have specific risk management responsibilities. They are detailed in their terms of reference.

5. PROCEDURAL INFORMATION

Only colleagues of the Trust who have attended appropriate agreed risk assessment or risk management training should carry out a risk assessment supported by relevant individuals in the Trust such as the ~~Divisional~~ Care Group Governance Leads.

The Trust adopts a structured approach to risk management whereby risks are identified, assessed and controlled and, where necessary, escalated or de-escalated through the governance mechanisms of the Trust. Staff should

work to identify not only current risks but also complete horizon scanning to be aware of risks that are likely to emerge in the future.

5.1 Systematic Risk Assessment Process

Effective risk assessment is a core element in good risk management. There are five steps in the risk assessment process.

5.1.1 Stage 1 - Identify the Hazard

Risk identification is fundamental to effective risk management and all staff have a role to play in identifying clinical and non-clinical risks to the delivery of safe, effective and high quality care.

There is no unique method for identifying risks. Risks may be identified in a number of ways and from a variety of sources, for example:

- Risk assessment of everyday operational activities, especially when there is a change in working practice or environment
- Clinical risk assessments
- Environmental / workplace risk assessments
- Any risk identified through ~~Division~~ Care Group Business Continuity planning process/ single point of failure
- Risk assessment as part of Trust business – at all levels of the organisation
- Annual planning cycle
- Performance management of key performance indicators
- Internal risk assessment processes e.g. requirements to assess risks as part of development and approval of policies, procedures, strategies and plans
- Claims, Incidents and Complaints
- Organisational learning
- External reviews, visits, inspections and accreditation
- Information Governance Toolkit
- Staff and patient surveys
- National recommendations including safety alerts, NICE guidance etc.
- Internal and External Audit
- Clinical audits
- Information from partner organisations
- Environment scanning of future risks (both opportunities and threats)

This list is not exhaustive. In general, the more methods that are used the more likely that all relevant risks will be identified.

There are two distinct phases to risk identification:

a) Initial Risk identification - relevant to new services, new techniques, projects

b) Continuous Risk Identification – relevant to existing services and should include new risks or changes in existing risks e.g. external changes such as new guidance, imminence, legislation etc.

All risks that are identified must be recorded and logged as appropriate on the either the Trust's locally held Environmental Assessment form, Ligature Assessment form, COSHH form (on Alcumus Sypol), Security Assessment record or the Trust's register of risks (Datix) if the risk is rating at 8 or above. This provides a formal record of the risks that the Trust has identified as having a potential impact on the achievement of objectives.

Failure to properly describe risk is a recognised problem in risk management. Common pitfalls include describing the impact of the risk and not the risk itself, defining the risk as a statement which is simply the converse of the objective, defining the risk as an absence of controls etc. A simple tip is to consider describing the risk in terms of cause and effect.

5.1.2 **Stage 2 - Evaluate the Risk**

Having identified and described the risk, the next step is to assess the risk. This allows for the risk to be assigned a standard rating which determines what actions (if any) need to be taken.

A standardised approach to describing and scoring risks must be followed.
All risks are scored and graded according to likelihood (chance) and consequence using the Trust's Risk Assessment Matrix (See Appendix 1). Adopting a single standard assessment tool ensures a consistent approach is taken to the description, evaluation and monitoring of risk across the Trust.
In evaluating the risk, it is important to rate the likelihood (chance) of the hazard causing reasonable foreseeable harm (Impact/Consequence/ Severity) and then rate the severity.

Ideally, risk assessment is an objective process and wherever possible should draw on independent evidence and valid quantitative data. However, such evidence and data may not be available and assessor(s) will be required to make a subjective judgement. When facing uncertainty, the assessor(s) should take a precautionary approach.

The risk assessment should be undertaken by someone competent in the risk assessment process and should involve staff familiar with the activity being assessed. Depending on the severity of the risk, the ~~Division~~ Care Group Risk/Governance Lead should be notified. Trade union representatives, external assessors or experts should be involved or consulted, as appropriate.

Risks are assigned a score based on a combination of the **likelihood** of a risk being realised and the **consequences** if the risk is realised.

The Trust uses three risk scores:

- Inherent/Initial Risk Score: This is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risks and is used as a benchmark against which the effect of risk management will be measured.

- Current Risk Score: This is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans to mitigate the risks are developed and implemented.

- Target Risk Score: This is the score that is expected after the action plan has been fully implemented, ~~in line~~and should take guidance from the ~~with~~TRFT Risk Appetite Statement.

-

Scoring the consequences

Use Appendix 1 Qualitative Measures of Consequences (Actual / Potential), to score the consequence, with existing controls in place:

Choose the most appropriate domain(s) from the left hand column of the table. Then work along the columns in the same row and, using the descriptors as a guide, assess the severity of the consequence on the scale 1 = Negligible, 2 = Minor, 3 = Moderate, 4 = Major and 5 = Catastrophic.

The Consequence score will remain the same in the majority of risks and the risk rating is lowered by decreasing the likelihood score as mitigations as contained in the risk action plan are introduced.

Scoring the likelihood

Use Appendix 1 Likelihood Assessment, to score the likelihood of the consequence(s) occurring with existing controls in place, use the frequency scale of Rare = 1, Unlikely = 2, Possible = 3, Likely = 4 and Almost Certain = 5.

Likelihood can be scored by considering:

1. Frequency i.e. how many times the consequence(s) being assessed will actually be realised

or

2. Probability i.e. what is the chance the consequence(s) being assessed will occur in a given period.

Scoring the risk

Calculate the risk score by multiplying the consequence score by the likelihood score. See table below.

IMPORTANT: It may be appropriate to assess more than one domain of consequence. This may result in generating different scores. Use your judgement to decide on the **overall** score, however as a rule-of-thumb take the highest domain score.

	Likelihood ('L')				
Impact ('I')	***Rare (1)***	***Unlikely (2)***	***Possible (3)***	***Likely (4)***	***Almost certain (5)***
Catastrophic (5)	**5**	**10**	**15**	**20**	**25**
Major (4)	**4**	**8**	**12**	**16**	**20**
Moderate (3)	**3**	**6**	**9**	**12**	**15**
Minor (2)	**2**	**4**	**6**	**8**	**10**
Negligible (1)	**1**	**2**	**3**	**4**	**5**

IMPORTANT: If a risk is rated at **20** or **25** the risk assessor should contact the ~~Quality, Governance, Compliance & Risk Manager~~Deputy Director of Corporate Affairs or the Corporate Governance & Risk Manager to discuss the rating; all risks rated at 25 must be escalated to a Trust Executive as Risk Owner and for immediate Trust action planning.

5.1.3 Stage 3 - Control Measures

The next step is to identify the control measures:

- What are they?
- Do they work?
- Do they control the hazard and the risk?

Always assess things as they are now including any foreseeable changes, then evaluate the risk with any additional control measures (actions) required, review the risk rating again as this should decrease the risk score. If it does not, then the additional control measures may not be worth implementing. Remember the risk might have to be accepted as it is.

When deciding what to do to reduce the risk, remember that the reduction should be "*so far as is reasonably practicable*". This phrase means that the cost of reduction should not be disproportionate to the risk. If the cost of reduction is high and the risk is low, it would be unreasonable.

Once a risk has been assessed, staff will need to decide how best to respond based on the Trust Risk Appetite (set out in appendix 3) and the resources

available. A target risk score and, where risks are to be treated, an associated robust (SMART) action plan should be assigned to each risk to ensure that risks are controlled within a timely manner and to an acceptable level. The risk action plan must be recorded in the Datix risk record, risks will not be approved by the RMC without an appropriate action plan.

However, not all risks can be dealt with in the same way and risk management responses can be a mix of four main actions; Transfer, Tolerate, Treat or Terminate.

Tolerate the risk

The risk may be considered tolerable without the need for further mitigating action, for example if the risk is rated LOW or if the Trust's ability to mitigate the risk is constrained or if taking action is disproportionately costly.

If the decision is to tolerate the risk, consideration should be given to develop and agree contingency arrangements for managing the consequences if the risk is realised. The risk will be considered a Managed Risk and recorded as such in Datix.

Treating the Risk

This is the most common response to managing a risk. It allows the organisation to continue with the activity giving rise to the risk while taking mitigating action to reduce the risk to an acceptable level i.e. as low as reasonably practicable. In general, action plans will reduce the risk over time but not eliminate it.

It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance to the Trust that the risk will be reduced to an acceptable level.

Action plans must be documented on the risk assessment form, have a nominated owner and progress monitored by the appropriate risk forum.

Transfer the risk

Risks may be transferred for example by conventional insurance or by sub-contracting a third party to take the risk. This option is particularly suited to mitigating financial risks or risks to assets.

It is important to note that reputational risk cannot be fully transferred.

Terminate the risk

The only response to some risks is to terminate the activity giving rise to the risk or by doing things differently.

However, this option is limited in the NHS (compared to the private sector) where many activities with significant associated risks are deemed necessary for the public benefit.

Oversight of these action plans takes place at a ~~divisional~~ Care Group and corporate management level in accordance with the Trust's governance arrangements described in section 4.2 of this Policy.

5.1.4 Stage 4 - Recording and Approval of the Assessment

DatixWeb, the Trust's risk management system, is used to support the recording, management and review of risks and production of risk registers across the Trust to ensure consistency of recording. All risks must be recorded on Datix. Risks will not be recognised until they are recorded and approved on Datix. Datix allows control measures to be recorded and actions to be scheduled, with a full audit trail of changes to the risk assessment.

The risk action plan must be recorded in the Datix risk record, risks will not be approved by the RMC without an appropriate action plan.

Information feeds through levels of risk registers, through to the organisation-wide risk register. The system is able to report at different levels, look at trends across fields and record and manage actions.

Risks must be approved in line with the management responsibility table below.

Risk Score	Primary Descriptor	Management level
15 and above	High Risk	These must be reviewed and approved by the Risk Management Committee and oversight of the risks provided at the Executive Team Meeting. They will also be reviewed by the Board ~~assurance~~ committees monthly and the Board quarterly.
8-12	Moderate Risk	These must be reported and approved at the ~~divisional~~ Care Group CSU Governance meeting. There should be oversight by the ~~Divisional~~ Care Group Leadership team (through ~~Divisional~~ Care Group reporting mechanisms)..
1-6	Low/Managed Risk	Approved and managed at ~~divisional~~ Care Group ward/team level, these are automatically considered to be Managed Risks and should be recorded in the appropriate Datix module.

5.1.5 Stage 5 - Reviewing the assessment

There is a legal requirement that a review must be carried out if:

- There is reason to suspect that it is no longer valid, e.g. incidents are still happening; or
- There has been a significant change.

It is best practice to carry out a review on a regular basis, which will allow for anything that has been missed or to enable you to consider improvements. It is suggested that risks are reviewed in line with the following (as a minimum);

- Risk score 0-6 on an annual basis
- Risk score 8-12 on a quarterly basis
- Risk score 15 or above on a monthly basis.

(The review should be undertaken by the end of the relevant month.)

All risks must be reviewed ~~divisionally~~ by the Care Groups in accordance with their agreed review date which should be informed by its current risk score and action plan. ~~Divisional~~ Care Group arrangements for monitoring Risk Profile (risk age / score / type) should identify risks where the review date has expired, risks that have not reached target risk score within an agreed timeline, as well as risks recommended for closure, or where risk status can be changed, (e.g. from 'treated' to 'tolerated').

Care Group Risk & Governance Committees should always review out of date action plans and use the Trust Risk and Governance Terms of Reference, standardized agenda template and Risk report template. Where possible Care Group Risk & Governance Committees should use Datix as a live tool for the review of risks during these committees.

When the Risk Owner believes the action plan is completed and the risk has been mitigated to the target rating the risk should be an agenda item on the next ~~Divisional~~ Care Group Governance Meeting for discussion and approval to forward for formal closure at the Risk Management Committee. The risk owner should include details of why the risk should be closed in Datix, dates of the ~~Divisional~~ Care Group Governance Meeting. The 'Approval status' field should remain as 'Approved Risk'. This fields will be amended following the RMC by the Governance Lead.

The review must be recorded on Datix by the Risk Owner, supported by the ~~Division~~ Care Group / Departmental Governance Lead, and must ensure that the Risk Assessment represents the current situation taking into account any changes to the context, deterioration of controls, implementation of actions or changes in Risk Appetite (target risk score).

When a risk is an agenda item at a Trust meeting such as the Risk Management Committee (RMC) or any of the Trust Board ~~Assurance~~ Committees it is the responsibility of the ~~Divisional~~ Care Group Lead present at these meetings to relay the recorded decision of the Committee via the relevant recorded minute to the Risk Owner. It is then the responsibility of the

Risk Owner to ensure that the risk record within Datixweb is updated to include the recorded minuted decision and appropriate changes to dates, such as but not limited to Risk Review Date, Action Plan Review Date, Trust Management Committee (Date Approved) etc.

5.2 Risk Reporting / Escalation and Assurance

An integral part of effective risk management is ensuring that risks are reported and escalated within the Trust to ensure that appropriate action and prioritisation of resources can take place.

Risk profile (risk age / score / type) is monitored through the Trust's ~~divisional~~ care group and corporate governance structure with new ~~divisionally~~ Care Group approved risks reported in line with the table ~~above~~below. Risks can also be raised at Board Committee or Board of Directors level, these will be initially managed via the Corporate Affairs Team who will liaise with Care Groups and Corporate Services in order to allocate the appropriate Risk Owner, the risk will then follow the process as outlined in the table below.

Risks are also escalated according to the progress in reaching the target score. Where a risk cannot be managed to an acceptable level of risk within available resource or in an agreed timescale then the risk must be escalated to the Risk Management Committee for consideration and onward escalation to ETM.

The maximum time a moderate level risk (current risk score of 8 or above) will be 'Treated' before it is escalated is 24 months*****. At this time any risk that has not reached an acceptable risk level (its target risk score) must be escalated to the Risk Management Committee for consideration and onward escalation to ETM.

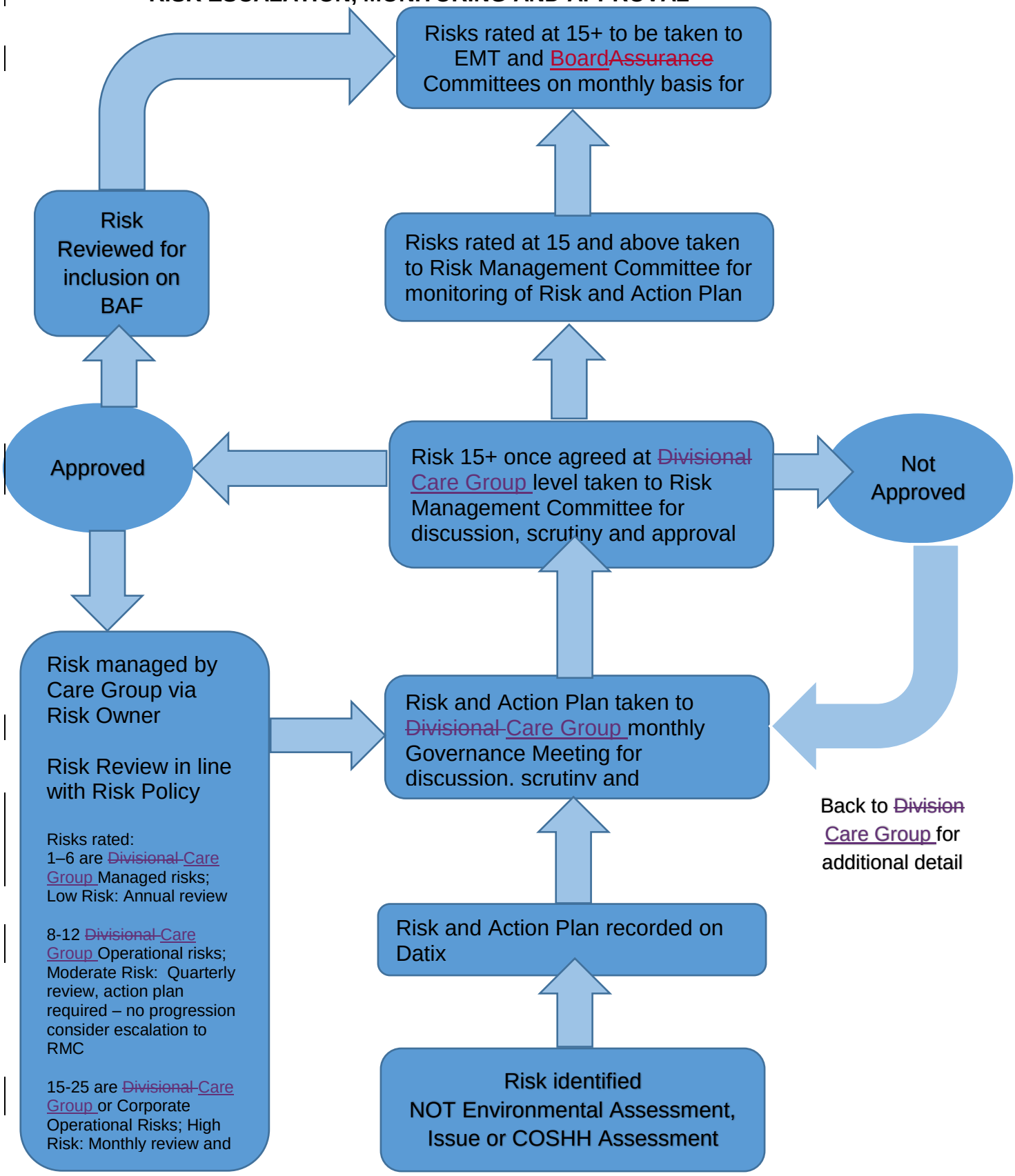
*****Consideration should always be paid to individual risks that are graded as Moderate due to only involving limited numbers of patients (low likelihood) that however might have potentially Major or Catastrophic consequences. These should be reviewed on a case by case basis for escalation within the 24 months' timeframe.

The data recorded on Datix will be used to produce reports to facilitate risk escalation and provide assurance regarding the effective implementation of this Policy. These reports may be adapted at any time to suit the requirements of a particular committee or group; however, some reports are scheduled as detailed in the table below.

The Risk Management Committee will review risks graded at 15+ and allocate them on contents and impact on Strategic Objectives to a specified Trust Board~~Assurance~~ Committee, all Committees will be made aware of all 15+risks so that cross assurance and learning can be encouraged.

Risk Reporting, Escalation and Assurance arrangements can be represented in flowchart form as depicted below:

RISK ESCALATION, MONITORING AND APPROVAL



5.3 Risk Appetite

Risk Appetite identifies the amount of risk the Board is willing to accept in pursuit of its strategic objectives for the financial year in question.

The Board articulates this through a Risk Appetite Statement which defines tolerances for balancing different elements of risk, including patient safety, reputation, workforce and financial / value for money, based on how much, or little the Trust wishes to commit in terms of risk. These limits are then used to derive acceptable Target Scores for Risk.

The Risk Appetite Statement will be refreshed and updated every year. ~~The current~~ further information regarding the Board Risk Appetite Statement is found at Appendix 4 and covers the following categories/types of risk:

Clinical Innovation
Commercial
Compliance/Regulatory
Financial/Value for money (VFM)
Partnerships
Reputation
Quality – Clinical Effectiveness, Patient Experience & Safety
~~Quality – Clinical Effectiveness~~
~~Quality – Patient Experience (Including Complaints & Claims)~~
~~Quality – Patient Safety (Including Complaints & Claims)~~
People / Culture & Workforce
Environmental
Estates
Information Governance
Information Technology (IT) & Cyber Security
Fire Safety / General Security
Inequality

The statement will detail the "amount of risk an organisation (TRFT) is willing to accept in pursuit of strategic~~statement will detail the "the amount of risk an organization (TRFT) is willing to accept in pursuit of strategic~~ objectives". ~~TRFT is willing to accept a target rating of 6-10 for a Financial/Value for money (VFM) related risk, however it is only willing to accept a target rating of 1-5 for Patient Safety risks, the target risk rating should always fall within the parameters of this statement~~

5.4 Eemerging risks

Emerging risks are newly identified or unforeseen risks that have the potential to cause significant impact but are not yet fully understood or recognised. These risks often arise from national enquiries, regulatory changes, societal shifts, or unexpected events.

As part of the Rrisk Mmanagement ppolicy, the organisation proactively scans the internal and external environment to identify potential emerging

risks. This is promoted and collated through the Risk Management Committee and Board ~~Assurance~~ Committees with Senior Leaders playing a key role in information sharing and horizon scanning. Approved and newly identified emerging risks are reported to the Audit and Risk Committee on a quarterly basis.

Once identified, these risks will be evaluated for their likelihood, potential impact, and urgency, even in the absence of complete information and will be reported monthly to the Risk Management Committee. By maintaining a forward-looking approach, it ensures emerging risks are appropriately monitored and addressed.

5.5 Eexternal risks

External risks are events or circumstances outside the organisation's control that can significantly affect its operations, objectives, or performance.

While the organisation cannot influence these risks directly, the Trust is committed to identifying and monitoring external risks through environmental scanning, trend analysis, and engagement with industry and governmental bodies.

The Trust is also responsible for c~~C~~ontingency planning, scenario analysis, and developing adaptive strategies ~~are developed and~~which are monitored through the Trust's Emergency Planning & Business Resilience????~~(emergency planning??)~~ operation to mitigate the effects of external risks and maintain organisational resilience.

5.6 S~~s~~ystem risk management

System risks are a reflection of organisationally owned risks that are impacted by the broader system of partners and stakeholders.

Recognised interconnected risks are escalated to Risk Management Committee with action plans submitted. The action plans will most likely include actions beyond the Trust's control that require external input and this information should be disseminated through partnership groups and forums to ensure that system-wide resilience is strengthened.

5.7 I~~i~~ssues log

An issues log is a formal document used to record and track problems, challenges, or concerns that arise from the Trust Risk Register and Risk Management function. Issues are actual events or problems that have already occurred and require resolution.

The Issues Log is overseen by the Audit and Risk Committee and reported to all Board ~~Assurance~~ Committees. It is a dynamic document and regularly updated to reflect the current status of each issue and it is the role of the Risk

Management Committee to monitor the actions put in place and track their resolution.

5.8 ~~I~~internal audit

Internal audit evaluates the effectiveness of the organisation's risk management framework, ensuring risks are identified, assessed, and managed appropriately. Auditors assess the design and operation of internal controls, compliance and regulatory assurance, governance, efficiency and continuous improvement. This includes verifying that emerging risks, system-wide risks and issues are addressed and incorporated into the organisation's overall strategy.

Internal audit report quarterly to Audit and Risk Committee and compile an Annual Report, providing an opinion for the financial year in relation to the approved audit plan.

5.9 Scheduled Risk Reports ~~TITLE REQUIRED FOR TABLE BELOW~~

REPORT	FORUM	FOR	SCHEDULE	CONTENT
NEW RISKS	~~Divisional~~ Care Group Management Team 15+ Risk Management Committee	Discussion, scrutiny and agreement of risk, risk rating and action plan Approval	Monthly New/draft risks logged on Datix should be approved within four weeks	All new/draft risks logged onto Datix within four weeks
RISK TO BE CLOSED / MANAGED / CHANGE TO RATING	~~Divisional~~ Care Group Management Team Risk Management Committee	Approval Approval	Monthly	All risks recommended for closing or to be managed/tolerated.
APPROVED RISKS (SCORING 15 OR ABOVE	Risk Management Committee	Scrutiny	Monthly	All risks approved by ~~Divisional~~ Care Group CSU Governance meeting with a current risk score of 15 or above will be reported to RMC in line with its meeting schedule
	~~Divisional Performance Review~~	~~Debate~~	~~Bi monthly~~	
RISK PAST REVIEW DATE	~~Divisional~~ Care Group Management Team Risk Management Committee	Review for action Information	Monthly Bi monthly	Risks past review date per ~~Division~~ Care Group / Department will be published on the first working day of the month

REPORT	FORUM	FOR	SCHEDULE	CONTENT
NEW APPROVED RISKS >=15	ETM	Debate	Monthly	All newly approved risks with a score of 15 or more following approval at RMC
RISKS <=12 NOT AT TARGET RISK SCORE	~~Divisional~~ Care Group Management Team	Review for escalation / action	Monthly	All risks that have not reached target score within agreed timeline.
	Risk Management Committee		Bi-Monthly	
RISKS >=15	Board of Directors Board Committee	Review for action / assurance	Quarterly	Risks reporting 15 or above.

Table 1: Scheduled Risk Reports

5.4 EMERGING RISKS

Emerging risks are newly identified or unforeseen risks that have the potential to cause significant impact but are not yet fully understood or recognised. These risks often arise from national enquiries, regulatory changes, societal shifts, or unexpected events.
As part of the risk management policy, the organisation proactively scans the internal and external environment to identify potential emerging risks. This is promoted and collated through Risk Management Committee and Board Assurance Committee with Senior Leaders playing a key role in information sharing and horizon scanning. Approved and newly identified emerging risks are reported to the Audit and Risk Committee on a quarterly basis.

Once identified, these risks will be evaluated for their likelihood, potential impact, and urgency, even in the absence of complete information and will be reported monthly to the Risk Management Committee. By maintaining a forward-looking approach, it ensures emerging risks are appropriately monitored and addressed.

5.5 EXTERNAL RISKS

External risks are events or circumstances outside the organisation's control that can significantly affect its operations, objectives, or performance.

While the organisation cannot influence these risks directly, the Trust is committed to identifying and monitoring external risks through environmental scanning, trend analysis, and engagement with industry and governmental bodies.

Contingency planning, scenario analysis, and adaptive strategies are developed and monitored through ????(emergency planning??) to mitigate the effects of external risks and maintain organisational resilience.

5.6 SYSTEM RISK MANAGEMENT

System risks are a reflection of organisationally owned risks that are impacted by the broader system of partners and stakeholders.

Recognised interconnected risks are escalated to Risk Management Committee with action plans submitted. The action plans will most likely include actions beyond the Trust's control that require external input and this information should be disseminated through partnership groups and forums to ensure that system-wide resilience is strengthened.

~~5.7 ISSUES LOG~~

~~An issues log is a formal document used to record and track problems, challenges, or concerns that arise from the Trust Risk Register and Risk Management function. Issues are actual events or problems that have already occurred and require resolution.~~
~~The Issues Log is overseen by the Audit and Risk Committee and reported to all Board Assurance Committees. It is a dynamic document and regularly updated to reflect the current status of each issue and it is the role of the Risk Management Committee to monitor the actions put in place and track their resolution.~~

~~5.8 INTERNAL AUDIT~~

~~Internal audit evaluates the effectiveness of the organisation's risk management framework, ensuring risks are identified, assessed, and managed appropriately. Auditors assess the design and operation of internal controls, compliance and regulatory assurance, governance, efficiency and continuous improvement. This includes verifying that emerging risks, system-wide risks and issues are addressed and incorporated into the organisation's overall strategy.~~

~~Internal audit report quarterly to Audit and Risk Committee and compile an Annual Report, providing an opinion for the financial year in relation to the approved audit plan.~~

6. REFERENCES

- Health and Safety at Work etc. Act 1974
- The Management of Health and Safety at Work Regulations 1999
- Audit Commission (2009). Use of Resources Framework – Overall approach and key lines of enquiry. London: Audit Commission. http://www.auditcommission.gov.uk
- Health and Safety Executive (HSE). (2010). Leading Health and Safety at Work: Leadership Actions for Directors and Board Members London: HSE http://www.hse.gov.uk
- NHS Improvement (National Patient Safety Agency. (2008)). A risk matrix for risk managers. London:
- NHS Improvement (National Patient Safety Agency. (2007)). Healthcare risk assessment made easy. London

7. ASSOCIATED DOCUMENTATION

Risk Management Strategy 202~~0~~5 – 202~~7~~5

Further Datix related guidance can be accessed through the following link:

~~How to Input a Risk Guide~~

https://intranet.xrothgen.nhs.uk/TeamCentre/CorporateServices/ChiefNursingTeam/SitePages/Datix%20Guides.aspx

~~How to Attach Documents to Risk Assessments in Datix Guide~~

~~How to Export a Risk Register to Excel Guide~~

~~How to Reject or Close a Risk Guide~~

~~How to Review a Risk Guide~~

APPENDIX 1

The Rotherham NHS Foundation Trust

LIKELIHOOD AND CONSEQUENCE DETAILS

Qualitative Measures of Consequences (Actual / Potential)

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Injury (Physical / Psychological)	▶ Adverse event requiring no/minimal intervention or treatment	▶ Minor injury or illness – first aid treatment needed ▶ Health associated infection which may/did result in semi-permanent harm ▶ Affects 1-2 people	▶ Moderate injury or illness requiring professional intervention ▶ No staff attending mandatory / key training ▶ RIDDOR / Agency reportable incident (8-14 days lost) ▶ Adverse event which impacts on a small number of patients ▶ Affects 3-15 people	▶ Major injury / long term incapacity / disability (e.g. loss of limb) ▶ >14 days off work ▶ Affects 16 – 50 people	▶ Fatalities ▶ Multiple permanent injuries ▶ or irreversible health effects ▶ An event affecting >50 people
Patient Experience	▶ Reduced level of patient experience which is not due to delivery of clinical care	▶ Unsatisfactory patient experience directly due to clinical care – readily resolvable Increase in length of hospital stay by 1-3	▶ Unsatisfactory management of patient care – ~~divisional~~ Care Groupl resolution (with potential to go to independent review) ▶ Increased length of hospital stay by 4 – 15 days	▶ Unsatisfactory management of patient care with long term effects ▶ Increased length of hospital stay >15 days ▶ Misdiagnosis	▶ Incident leading to death ▶ Totally unsatisfactory level or quality of treatment / service
Environmental Impact	▶ Onsite release of substance averted ▶ Minimal or no impact on the environment	▶ Onsite release of substance contained ▶ Minor damage to Trust property <£10K	▶ On site release no detrimental effect ▶ Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K - £50K	▶ Offsite release with no detrimental effect / on site release with potential for detrimental effect ▶ Major damage to Trust property – external organisations required to	▶ Onsite /off site release with realised detrimental / catastrophic effects ▶ Loss of building / major piece of equipment vital to the Trust business continuity

Qualitative Measures of Consequences (Actual / Potential)

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
		▶ Minor impact on the environment	▶ Moderate impact on the environment	remedy – associated costs >£50K ▶ Major impact on the environment	▶ Catastrophic impact on the environment
Staffing & Competence	▶ Short term low staffing level (<1 ▶ day) – temporary disruption to patient care ▶ Minor competency related failure reduces service quality <1 day ▶ Low staff morale affecting one person	▶ On-going low staffing level - minor reduction in quality of patient care ▶ Unresolved trend relating to competency reducing service quality ▶ 75% - 95% staff attendance at mandatory / key training ▶ Low staff morale (1% - 25% of staff)	▶ Late delivery of key objective / service due to lack of staff ▶ 50% - 75% staff attendance at mandatory / key training ▶ Unsafe staffing level .> 5 days ▶ Serious error due to ineffective training and / or competency ▶ Low staff morale (25% - 50% of staff)	▶ Uncertain delivery of key objective / service due to lack of staff ▶ 25%-50% staff attendance at mandatory / key training ▶ Unsafe staffing level >5days ▶ Serious error due to ineffective training and / or competency ▶ Very low staff morale (50% – 75% of staff)	▶ Non-delivery of key objective / service due to lack of staff ▶ On-going unsafe staffing levels ▶ Loss of several key staff ▶ Critical error due to lack of staff or insufficient training and / or competency ▶ Less than 25% attendance at mandatory / key training on an on-going basis ▶ Very low staff morale (>75%)
Complaints / Claims	▶ Informal / ~~divisionally~~ Care Group resolved complaint ▶ Potential for settlement / litigation <£500	▶ Overall treatment / service substandard ▶ Formal justified complaint (Stage 1) ▶ Minor implications for patient safety if unresolved ▶ Claim <£10K	▶ Justified complaint (Stage 2) involving lack of appropriate care ▶ Claim(s) between £10K - £100K ▶ Major implications for patient safety if unresolved	▶ Multiple justified complaints ▶ Independent review ▶ Claim(s) between £100K - £1M Non-compliance with national standards with significant risk to patients if unresolved	▶ Multiple justified complaints ▶ Single major claim ▶ Inquest / ombudsman inquiry ▶ Claims >£1M
Financial	▶ Small loss ▶ Theft or damage of personal property<£50	▶ Loss <£100K ▶ <5% over project budget / schedule slippage ▶ Theft or loss of personal property £500	▶ Loss of £100K - £500K ▶ 5 – 10% over project budget / schedule slippage ▶ Theft or loss of personal property >£750	▶ Loss of >£500K - £1M ▶ 10 – 25% over project budget / schedule slippage ▶ Purchasers failing to pay on time	▶ Loss > £1M ▶ >25% over project budget / schedule slippage ▶ Loss of contract / payment by results

Qualitative Measures of Consequences (Actual / Potential)

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Business / Service Interruption	▶ Loss / interruption of > 1 hour; no impact on delivery of patient care / ability to provide services	▶ Short term disruption, of >8 hours with minor impact	▶ Loss / interruption > 1 day ▶ Disruption causes unacceptable impact on patient care ▶ Non-permanent loss of ability to provide service	▶ Loss / interruption of > 1 week ▶ Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked ▶ Temporary service closure	▶ Permanent loss of core service / facility ▶ Disruption to facility leading to significant 'knock-on' effect across ~~divisional~~ Care Group health economy ▶ Extended service closure
Inspection / Statutory Duty	▶ Small number of recommendations which focus on minor quality improvement ▶ No or minimal impact or breach of guidance	▶ Minor recommendations which can be implemented by low level of management ▶ Breach of Statutory legislation ▶ No audit trial to demonstrate that objectives are being met (NICE, HSE, NSF etc.)	▶ Challenging recommendations which can be addressed with ▶ Single breach of statutory duty ▶ Non-compliance with core standards <50% of objectives within standards being met	▶ Enforcement action ▶ Multiple breaches of statutory duty ▶ Improvement Notice ▶ Critical Report ▶ Low performance rating ▶ Major noncompliance with core standards	▶ Multiple breaches of statutory duty ▶ Prosecution ▶ Complete systems change required ▶ Severely critical report ▶ Zero performance rating ▶ No objectives / standards being met
Publicity / Reputation	▶ Rumours ▶ Potential for public concern	▶ ~~Divisiona~~Care Groupl Media – short term – minor effect on public attitudes / staff morale ▶ Elements of public expectation not being met	▶ ~~Divisional~~ Care Groupl media – long term - moderate effect – impact on public perception of Trust & staff morale	▶ National media <3 days– public confidence in organisation undermined – use of services affected	▶ National / International adverse publicity >3 days ▶ MP concerned (questions in the House) ▶ Total loss of public confidence
Fire Safety / General Security	▶ Minor short term (<1day) shortfall in fire safety system ▶ Security incident with no adverse outcome	▶ Temporary ▶ (<1 month) shortfall in fire safety system / single detector etc. (nonpatient area)	▶ Fire Code noncompliance / lack of single detector – patient area etc. ▶ Security incident leading to compromised staff / patient safety	▶ Significant failure of critical component of fire safety system (patient area) ▶ Serious compromise of staff / patient safety	▶ Failure of multiple critical components of fire safety system (high risk patient area) ▶ Infant / young person abduction

Qualitative Measures of Consequences (Actual / Potential)

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
		▶ Security incident managed ~~divisionally~~by Care Group ▶ Controlled drug discrepancy – accounted for	▶ Controlled drug discrepancy – not accounted for		
Information Governance / IT	▶ Breach of confidentiality – no adverse outcome ▶ Unplanned loss of IT facilities < half a day	▶ Minor breach of confidentiality ▶ readily resolvable ▶ Unplanned loss of IT facilities < 1 day ▶ Health records incident / documentation incident – readily resolvable	▶ Moderate breach of confidentiality complaint initiated ▶ Health records / documentation incident - patient care affected with short term consequence	▶ Serious ▶ breach ▶ of confidentiality – more than one person ▶ Unplanned loss of IT facilities >1 day but less than 1 week ▶ Health records / documentation incident - patient care affected with major consequence	▶ Serious breach of confidentiality – large numbers ▶ Unplanned loss of IT facilities > 1 week ▶ Health records / documentation incident - catastrophic consequence
Project time plan	▶ Insignificant schedule from baseline plan ▶ Insignificant impact on value and/or time to realise declared benefits against profile	▶ <5% variance in schedule from plan ▶ <5%	▶ 5 - 10% variance in schedule from base line plan ▶ 5 - 10% variance on value and/or time to realise declared benefits against profile	▶ 10 - 25% variance in schedule from base line plan ▶ 10 - 25% variance on value and/or time to realise declared benefits against profile	▶ 25% variance in schedule from base line plan ▶ > 25% variance on value and/or time to realise declared benefits against profile

Likelihood Assessment

(use in order of preference)

Likelihood scores (broad descriptors of frequency)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur, but it is not a persisting issue/circumstances	Will undoubtedly happen/recur possibly frequently

Likelihood scores (time-framed descriptors of frequency)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Likelihood scores (probability descriptors)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Probability Will it happen or not?	<0.1 per cent	0.1-1 per cent	1-10 per cent	10-50 per cent	>50 per cent

The Rotherham NHS Foundation Trust

TRFT Risk Appetite

Risk Appetite Statement

Risk appetite is usually defined as 'the amount and type of risk that an organisation is willing to take in order to meet its strategic objectives'. Depending on their sector, culture and objectives, organisations will have different risk appetites. A range of appetites exist for different risks and these may change over time. The Strategic Risk Appetite is then bound to the organisation's Risk Tolerance, which are the boundaries within which the executive are willing to allow the true day-to- day risk profile of the organisation to fluctuate, while they are executing strategic objectives in accordance with the Board's strategy and risk appetite. It is worth noting that the risk tolerance can be limited by legal or regulatory requirements.

The Rotherham NHS Foundation Trust (TRFT) recognises that its long term stability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, TRFT will not accept risks that materially provide a negative impact on quality, this includes Clinical Effectiveness, Patient Experience & Safety. However, TRFT has a greater appetite to take considered risks in terms of their impact on organisational issues in relation to other risk types. ~~as listed below in Appendix 2.~~

~~The Rotherham NHS Foundation Trust (TRFT) recognises that its long term sustainability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, TRFT will not accept risks that materially provide a negative impact on quality.~~

~~However, TRFT has a greater appetite to take considered risks in terms of their impact on organisational issues. TRFT has a greatest appetite to peruse Commercial gain, partnerships, clinical innovation, financial and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within constraints of regulatory environment.~~

The board of directors is responsible for the organisation's risk appetite, risk tolerance and attitude to risk taking, so at the June 2024 Strategic Board the members were asked to provide their respective acceptable levels of risk for each of the Risk Types via an anonymous audience interaction tool. The levels of risk were based on the Good Governance Institute (GGI) May 2020 publication Risk Appetite for NHS Organisations and the TRFT Risk Management Policy risk matrix 2023.

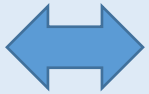
The GGI risk matrix included within this document (Appendix 1) differs from the TRFT Risk Management Policy 2023 in that it has 6 levels of risk rather than three in the TRFT document it was agreed that with respect to Risk Appetite the GGI matrix would be used, Table 2 includes the TRFT scoring as this will be used operationally to set risk target ratings.

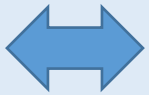
The GGI have developed the following risk matrix for grading the Risk Appetite, as can be seen in table 1.

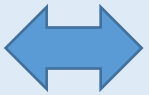
GGI and Risk Levels						
GGI RISK LEVEL	Avoid	Minimal	Cautious	Open	Seek	Mature
GGI DESCRIPTOR	Avoidance of risk and uncertainty is a Key Organisational objective	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of residual risk and only have limited reward potential.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward	Eager to innovate and to choose options offering higher business rewards (despite greater inherent risk)	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

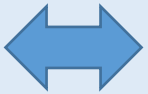
Table 1

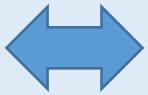
The full GGI risk matrix can be found at Appendix 3, however for reference the individual risk descriptors from the matrix have been inserted into table 2, below, in order to provide clarity on each of the Risk Types found in the TRFT Risk Appetite framework.

Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Strategic GGI Risk Appetite 2024/25	Strategic TRFT Risk Appetite Score 2024/25	Trend	GGI Risk Descriptor
Clinical Innovation	TRFT has a **LOW** risk appetite for Clinical Innovation risks.	6-10	Open	8 - 12		We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.
Commercial	TRFT has a **MODERATE** risk appetite for Commercial gain whilst ensuring quality and sustainability for our services.	12-15	Open	8 - 12		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

Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Strategic GGI Risk Appetite 2024/25	Strategic TRFT Risk Appetite Score 2024/25	Trend	GGI Risk Descriptor
Compliance/Regulatory	TRFT has a **LOW** risk appetite for Compliance/Regulatory risk, which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	6-10	Minimal	1 - 6		We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.
Financial/Value for money (VFM)	TRFT has a **LOW** risk appetite for financial risks which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.	6-10	Cautious	8 - 12		We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.
Partnerships	TRFT has a **MODERATE** risk appetite for partnerships which may support and benefit the people we serve.	12-15	Seek	15 - 25		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.

Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Strategic GGI Risk Appetite 2024/25	Strategic TRFT Risk Appetite Score 2024/25	Trend	GGI Risk Descriptor
Reputation	TRFT has a **VERY LOW** risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the	1-5	Minimal	1 - 6		Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.
Quality – Clinical Effectiveness, Patient Experience & Safety	TRFT has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users.	6-10	Minimal	1 - 6		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.
Quality – Patient Experience (including complaints and claims)	TRFT has a **VERY LOW** risk appetite for risks that may affect the experience of our service users.	1-5				
Quality – Patient Safety (including complaints and claims)	TRFT has a **VERY LOW** risk appetite for risks that may compromise safety.	1-5				

Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Strategic GGI Risk Appetite 2024/25	Strategic TRFT Risk Appetite Score 2024/25	Trend	GGI Risk Descriptor
People / Culture & Workforce	TRFT has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce risks.	12-15	Cautious (38%)/Seek (38%)	8 - 12		CAUTIOUS: 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. SEEK: 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.
Environment	TRFT has a **LOW** risk appetite for Environmental risks.	6-10	Cautious	8 - 12		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.

Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Strategic GGI Risk Appetite 2024/25	Strategic TRFT Risk Appetite Score 2024/25	Trend	GGI Risk Descriptor
Estates	TRFT has a VERY LOW risk appetite for Plant and Equipment risks.	1-5	Open (38%)/Seek (38%)	8 - 12		OPEN: 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. SEEK: 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.
Information Governance	TRFT has a LOW risk appetite for actions and decisions taken in relation to Information Governance risks.	6-10	Minimal	1 - 6		We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential..
IT & Cyber Security	TRFT has a LOW risk appetite for actions and decisions taken in relation to IT risks.	6-10	Minimal	1 - 6		We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.

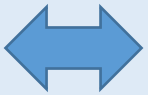
Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Strategic GGI Risk Appetite 2024/25	Strategic TRFT Risk Appetite Score 2024/25	Trend	GGI Risk Descriptor
Fire Safety / General Security	TRFT has a **VERY LOW** risk appetite for Fire Safety/General Security risks.	1-5	Minimal	1 - 6		We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.
Business / Service Interruption	TRFT has a **LOW** risk appetite for Business/Service Interruption risks.	6-10	Minimal	1 - 6		We are only willing to accept the possibility of very limited financial risk.
Inequality	TRFT has a LOW risk appetite for actions and decisions that may result in Inequality.	6-10	Avoid	1 - 6		We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.

Table 2 below

Risk Type	Risk Appetite	Risk Appetite Score 2020/21
Clinical Innovation	TRFT has a **LOW** risk appetite for Clinical Innovation risks.	6-10

Risk Type	Risk Appetite	Risk Appetite Score 2020/21
Commercial	TRFT has a **MODERATE** risk appetite for Commercial gain whilst ensuring quality and sustainability for our services.	**12-15**
Compliance/Regulatory	TRFT has a **LOW** risk appetite for Compliance/Regulatory risk, which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	**6-10**
Financial/Value for money (VFM)	TRFT has a **LOW** risk appetite for financial risks which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.	**6-10**
Partnerships	TRFT has a **MODERATE** risk appetite for partnerships which may support and benefit the people we serve.	**12-15**
Reputation	TRFT has a **VERY LOW** risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	**1-5**
Quality – Clinical Effectiveness	TRFT has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users.	**6-10**
Quality – Patient Experience (including complaints and claims)	TRFT has a **VERY LOW** risk appetite for risks that may affect the experience of our service users.	**1-5**
Quality – Patient Safety (including complaints and claims)	TRFT has a **VERY LOW** risk appetite for risks that may compromise safety.	**1-5**

Risk Type	Risk Appetite	Risk Appetite Score 2020/21
Workforce	TRFT has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce risks.	**12-15**
Environment	TRFT has a **LOW** risk appetite for Environmental risks.	**6-10**
Estates	TRFT has a **VERY LOW** risk appetite for Plant and Equipment risks.	**1-5**
Information Governance	TRFT has a **LOW** risk appetite for actions and decisions taken in relation to Information Governance risks.	**6-10**
IT	TRFT has a **LOW** risk appetite for actions and decisions taken in relation to IT risks.	**6-10**
Fire Safety / General Security	TRFT has a **VERY LOW** risk appetite for Fire Safety/General Security risks.	**1-5**
Business / Service Interruption	TRFT has a **LOW** risk appetite for Business/Service Interruption risks.	**6-10**
Inequality	TRFT has a LOW risk appetite for actions and decisions that may result in Inequality.	**6-10**

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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Section1

TRFT Operational Health, Safety & Welfare Risk Assessment			
Task			
Site		Department	
Risk Assessor		Assessment Type	
OSU/CSU			
Department Manager			
Date of Assessment		Review Date	
People/ Service affected by the risk			

Appendix 43

TRFT Operational Health, Safety & Welfare Risk Assessment

Likelihood:	**Severity:**
1. Rare 2. Unlikely 3. Possible 4. Likely 5. Certain	1. Negligible 2. Minor 3. Moderate 4. Major 5. Catastrophic

Risk = Likelihood x Severity					
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
Frequency How often might it / does it happen	Will probably never happen / recur	Unlikely to happen / recur, but it is possible it may do so	Will possibly happen or recur occasionally	Is likely to happen / recur persistently	Will undoubtedly happen/ recur,

					possibly frequently
Risk Rating	Low Risk (1-6)	Moderate (8-12)	High Risk (1-25)		
Risk Rating = Likelihood x Severity e.g. 3 (Possible) x 4 (Major) = 12					
Likelihood (L)					
Certain - 5	*5*	*10*	*15*	20	25
Likely – 4	*4*	*8*	*12*	16	20
Possible – 3	*3*	*6*	*9*	12	15
Unlikely – 2	*2*	*4*	*6*	8	10
Rare – 1	*1*	*2*	*3*	*4*	*5*
	Negligible – 1	**Minor – 2**	**Moderate – 3**	**Major – 4**	**Catastrophic – 5**
	Severity (S)				

1 - 6	1 - Low Risk/ Managed Risk	Local action, beware of aggregated/multiple green issues.
8 – 12	2 - Moderate Risk	Local action, contact the Risk Dept. for advice if concerned.
15 – 25	4 – High Risk	Take action and notify the Risk Dept. (? Datix Investigation or Serious Incident (SI)).

Hazards	**Risk from the Hazard/How the Hazard can cause harm**	**Current Controls in place**	**Likelihood of Harm (L)**	**Severity of Harm (S)**	**Risk Rating L x S**	**Additional Controls**	**Residual Risk (after additional controls completed) L x S**

Action Plan	**Date Completed**
1.	
2.	
3.	
4.	
5.	
Signature of Manager	
Name of Manager	
Date	Review Date:

Additional Control Measure for <insert department/ward>	*<Insert any additional control measure as a document into this box>*

References	**Versions**

RISK MANAGEMENT POLICY

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING

8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

Risk Management Committee

9. APPROVAL OF THE DOCUMENT

This document was approved by: the Trust Board.

10. RATIFICATION OF THE DOCUMENT

This document was ratified by the Trust Document Ratification Group.

11. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed every three years by the Quality Governance, Compliance and Risk Manager unless such changes occur as to require an earlier review.

12. DISSEMINATION AND COMMUNICATION PLAN

To be disseminated to	Disseminated by	How	When	Comments
DRG Admin Support via "DRG Admin Support" email. Library & Knowledge Services via "policies" email.	Author	Email	Within 1 week of ratification	Remove watermark from ratified document and inform DRG Admin Support if a revision and which document it replaces and where it should be located on the Hub. Ensure all documents templates are uploaded as word documents.
Communication Team	DRG Admin Support	Email	Within 1 week of ratification	Communication team to inform all email users of the location of the document.
All email users	Communication Team	Email	Within 1 week of ratification	Communication team will inform all email users of the policy and provide a link to the policy.
Key individuals Staff with a role/responsibility within the document Heads of Departments / Matrons	Author	Meeting / Email as appropriate	When final version completed	The author must inform staff of their duties in relation to the document.

To be disseminated to	Disseminated by	How	When	Comments
All staff within area of management	Heads of Departments / Matrons	Meeting / Email as appropriate	As soon as received from the author	Ensure evidence of dissemination to staff is maintained. Request removal of paper copies Instruct them to inform all staff of the policy including those without access to emails

13. IMPLEMENTATION AND TRAINING PLAN

What	How	Associated action	Lead	Timeframe
Risk Management Training	It is essential for all Risk Owners, band 8a's (or equivalent) and above. Ward/Team Managers and their deputies, along with any other interested individuals are encouraged to attend.	None	Deputy Director of Corporate Affairs and Corporate ~~Quality~~ Governance~~,~~ ~~Compliance~~ and Risk Manager	On-going
Risk Assessor Training	All Risk Assessors are required to undertake Risk Assessor Training	None	Health & Safety Advisor	On-going

14. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF THE TRUST DOCUMENT

14.1 Process for Monitoring Compliance and Effectiveness

Audit / Monitoring Criteria	Process for monitoring e.g. audit, survey	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Action plans approved and monitored by
Roles & Responsibilities	Review of meetings	~~Quality Governance, Compliance and Risk Manager~~Deputy Director of Corporate Affairs	Annual	Risk Management Committee	Risk Management Committee
Training attendance	Review of attendance	~~Quality Governance, Compliance and Risk Manager~~Deputy Director of Corporate Affairs	Monthly	Risk Management Committee	Risk Management Committee
Identification of Risks	Review of risks	~~Divisional~~ Care Group Governance and Performance Meetings	Monthly	Risk Management Committee	Risk Management Committee
Management of Risks	Review of risks	~~Divisional~~ Care GroupGovernance and Performance Meetings	Monthly	Risk Management Committee	Risk Management Committee

14.2 Standards/Key Performance Indicators (KPIs)

To Be Agreed at Risk Management Committee.

15. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been conducted on this policy. A copy is available on request from rgh-tr.edi@nhs.net

Board of Directors' Meeting
2 May 2025

The Rotherham NHS Foundation Trust

Agenda item	
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 • UECC Activity • 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. Sir Jim Mackey Letter – Working Together in 2025/26 to lay the foundations for reform 2. Mark Cubbon Email – Reducing Waiting Times and Returning to the 18-week RTT standard by 2029

1.0 Operational Matters

1.1 The **recovery of elective waiting times** remains a key focus with the overall RTT position improving further in March. The Trust has seen a 4.9% improvement in the RTT Standard with the Trust achieving 64.7% in March 2025 compared to 59.8% in March 2024, which now places the organisation in the top national quartile. TRFT is currently ranked 30 out of 123 acute and community Trusts, reflecting significant trust-wide improvement and performance. Of the 14 monitored specialties, 9 now remain in the top quartile nationally, with 1 in the second, 3 in the third, and only 1 in the fourth, demonstrating the impact of collaborative efforts across clinical services to improve access for our patients. The RTT standard was achieved across several specialties, including General Medicine, Geriatric Medicine, Respiratory, Paediatrics, and Paediatric Cardiology, as well as sub-specialties such as Diabetes & Endocrine, Stroke, and Rheumatology. These improvements are the result of targeted recovery plans, effective use of capacity, and close clinical engagement.

1.2 The Trust had committed to reducing the elective waiting list to 29,500 by March 2025. Due to significant operational pressures over winter, which impacted on our ability to increase activity, the waiting list stood at 31,601 in March 2025. Despite these challenges, we have seen a 4.2% reduction from 32,920 in August 2024 when the waiting list peaked.

1.3 In line with the national expectation for 2024/25, the Trust set a target to have no patients waiting over 65 weeks for treatment and is proud to report that this has been successfully achieved by year end. Our commitment to reducing long waits for treatment continues, with us now focusing on reducing waits over 52 weeks. While the number of patients waiting over 52 weeks peaked at 902 in January 2025, this was reduced to 790 by year end, placing the Trust in the second quartile nationally for 52-week waits.

1.4 The 2024/25 national planning guidance also set an objective to increase the percentage of patients that receive a **diagnostic test** within 6 weeks to 95%. The Trust has maintained a strong performance and consistently exceeded this standard throughout the year, achieving our internal ambition to maintain performance at 99% for 2024/25. The Trust has maintained this achievement since March 2024 and remains in the top decile of Trusts in the country for delivery against this standard.

1.5 In Cancer services, the Trust has seen notable progress. It achieved the Faster Diagnosis Standard of 80% in February 2025 (84.5%) and is predicted to achieve 81.2% in March 2025 pending validation. The national Cancer 62-Day Standard of 70% was achieved in February 2025 (70.7%), with a forecasted position of 76.4% In March 2025. The Trust also achieved the 31-Day General Treatment Standard of 96% in February 2025 (96.3%) and is currently on track to achieve 100% in March 2025.

1.6 The Trust received a letter from Sir Jim Mackey, the new Chief Executive of NHS England setting out the plan for Working together in 2025/26 to lay the foundations for reform (see appendix 1) along with an email from Mark Cubbon, the new National Director at NHS England for Elective Care, Cancer and Diagnostics (see appendix 2) focusing on reducing waiting times and returning to the 18-week RTT standard by 2029.

2.0 Urgent and Emergency Care Activity

2.1 The Trust achieved 65.5% in March against the 4-hour emergency care standard, which was an improvement on the previous month despite an increase in attendances. The number of attendances in March peaked at 9429, which is the highest level of attendances the Trust has seen since the UECC opened. Whilst performance has improved during the year, the internal trajectory was not achieved nor was the March 2025 78% requirement. A debrief on this has taken place and a new set of actions agreed at the Executive Team meeting.

2.2 The Trust has seen overall growth in UECC attendances of 8% in 2024/25 compared to 2023/24, comprising a 4% increase in ambulance demand and 10% increase in walk-in patients.

2.3 The additional demand did impact on flow and bed availability, impacting on the 4 hour performance for admitted patients. However, the number of patients in the department over 12 hours reduced in both February and March from the high levels seen in January. Performance for non-admitted patients also improved, with 76.4% of non-admitted patients seen within 4 hours.

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. The ICB is considering how to deliver the significant reduction in running costs announced recently.

3.2 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 including a Joint Executive Team meeting and a Joint Senior Leaders Team meeting.

3.3 I continue to chair specific meetings relating to three key workstreams of the South Yorkshire and Bassetlaw (SYB) Acute Federation, these include:

- The SYB QUIT Oversight Group
- The Diagnostic Oversight Group
- The Imaging Network Meeting
- The UEC Alliance Board

In addition, I have just joined the new 'Work and Health Board' which is leading the South Yorkshire delivery of the Pathways to Work programme under the auspices of Oliver Coppard, SY Mayor.

4.0 People

4.1 The embargo on the results of the NHS National Staff Survey (NSS) for the Trust in 2024 has now been lifted. Rotherham was placed in the upper quartile of Trusts that use Picker as their provider with the Trust being place 13th (compared to 8th last year); amongst the 21 Trusts in the Northeast and Yorkshire region, TRFT

was 4th best in aggregate staff survey scores across the 9 headline themes. The overall response rate was 64% compared to the sector average of 49%. Work is underway to develop both the Trust wide and local actions required to deliver improvements in 2025/26 for both patients and staff. Further information is provided in the report provided by the Director of People.

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

February 2025

INDIVIDUAL AWARD:	Bob Lumby, Welcome Desk Receptionist
TEAM AWARD:	Becky-Jo Pannett, Laura Nowell and Stephanie Bullock – Paediatric UECC
PUBLIC AWARD:	Radiology

March 2025

INDIVIDUAL AWARD:	Angela Trezise, Overseas Visitors Lead
INDIVIDUAL AWARD:	Harvey Morton, AMU Reception Apprentice
TEAM AWARD:	Recruitment Team
TEAM AWARD:	Paediatric UECC
PUBLIC AWARD:	Ward A4
PUBLIC AWARD:	Ward A6
PUBLIC AWARD:	Surgery and UECC

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

- Dr A Watkin, Anaesthetics (August 2025)

4.4 Following on from my notification last time about the retirement of Steve Hackett, our Director of Finance, I can confirm that from 1st July 2025, Chris Thickett, who is currently the Director of Finance at Barnsley will take up the role of Joint Director of Finance, covering both The Rotherham NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust.

4.5 I would also like to welcome Peter Walsh, Interim Joint Director of Corporate Affairs, who commenced with us at the beginning of April and will be providing cover during the temporary absence of our substantive Joint Director of Corporate Affairs.

4.6 This year's annual PROUD awards event will take place on Friday 21st June 2025. Nominations for the eleven individual categories closed on Monday 21st April and I am pleased to report that we have received over 500 nominations, including over 100 from members of the public.

Dr Richard Jenkins
Chief Executive
May 2025

To:
- NHS Trust and Foundation Trust chief executives
- NHS Trust and Foundation Trust chairs
- Integrated Care Board chief executives
- Integrated Care Board chairs

cc.
- NHS England Regional Directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

1 April 2025

Dear Colleague

Working together in 2025/26 to lay the foundations for reform

When we met on 13 March, I committed to writing out on day one to help give more clarity on what we need to do in the coming weeks and months.

Before getting into the detail, I would like to thank you for your support over the last few tricky weeks. I've been really encouraged by both the recognition of the challenge we face and the collective response you've shown to it – most notably through the revised planning submissions. It is very much appreciated.

2025/26 planning

Your efforts over the past two weeks have put our plans for 2025/26 in a much stronger position, so please pass on my thanks to everyone who has worked so hard to make this improvement. As it stands, we have a headline deficit of £311 million (appendix 1) (after accounting for the £2.2 billion deficit support reflected in the allocations, so £2.5 billion versus the £6.6 billion referenced on 13 March). This is a significant shift, and there has also been positive progress on the key operational standards.

We are currently working through plans, and delivery confidence, and our regional teams will be working with you to finalise all of this over the next few weeks. Hopefully, this will build confidence and help establish a clear path to balancing the books in 2025/26 and delivering on our key operational imperatives.

Whilst the movement on the numbers is clearly very welcome, I'm even more encouraged by the broader leadership response from you all.

Moving to a different way of working together as leaders

The publication of the 10 Year Health Plan and the outcome of the Spending Review will give us the ingredients to shift towards a medium-term approach to planning. We will initiate a process with you to shape how we make this work between June and September this year, when the outcome of the Spending Review is known. Ideally, I would also like to use that process to both set out parameters for 2026/27 and, as far as possible, obviate the need for further Planning Guidance later this year, leading to a smoother planning process for next year. Again, we will be discussing this with you in more detail over the coming weeks as part of our new way of working.

This should help us get back to having honest and transparent conversations about how we're all going to lead the recovery across the service. When we met on 13 March, I committed to greater transparency and moving back to a fair shares allocation policy over time, while unravelling some of the complexities that now exist around the money. A schedule is attached to this letter to confirm what allocations would have been if we had distributed allocations on a fair share basis (appendix 2). We will need to develop an affordable pace of change policy, but I think it's important that you can see where we are heading.

Key to all of this is not just creating a fair playing field but also getting back to a place where the solutions to the challenges we face lie in our own hands as leaders. I think the shift to greater openness and transparency will help us become more accountable to our public and our staff and less so to the centre.

Ultimately, I'd like us to focus on more of a devolved, rules-based system that is built on strong Board accountability. We should target creating a net surplus going forward, so that we can shift away from focusing so much of our leadership energy on deficit reduction and create the bandwidth to do much more on quality (including wider population health), access and leading our organisations and local systems.

ICBs are central to future plans

ICBs have a critical role to play in the future as strategic commissioners and this is going to be central to realising the ambitions that will be set out in the 10 Year Health Plan.

The 10 Year Health Plan will also set out the key components of an operating model that is rules-based, provides earned autonomy and incentivises good financial and operational performance. Importantly, alongside Penny Dash's (NHS England's new Chair) great work on quality, I am confident it will help reset and restore the focus on quality that we all want to see.

Reducing costs of ICBs by 50% will be a challenge, but it's important we move on this as quickly as possible to retain talent and seize the opportunities of ICBs acting primarily as strategic commissioners.

Our collective challenge over the coming weeks and months will be to manage the transition as carefully as we can while recognising:

- the need to maintain some core staff, such as recently delegated commissioning staff and, in the short term until further options are considered, continuing healthcare staff
- the need to maintain or invest in core finance and contracting functions in the immediate term
- the need to invest in strategic commissioning functions, building skills and capabilities in analytics, strategy, market management and contracting
- the need to commission and develop neighbourhood health, with the delivery being a provider function over time (GPs, PCNs, community and mental health trusts, social care, acute trusts or others)

We will share soon what we think is a reasonable running cost per head of the population via Regional Directors and the functional output of the Model ICB work will be shared by the end of April. ICBs are expected to use this information to create bottom-up plans that are affordable within the reduced running cost envelope – for sign off by the end of May – and implement the plan during Quarter 3. ICBs are encouraged to expedite these changes as any in-year savings can be used on a non-recurrent basis to address in-year transition pressures or risks to delivery in wider system operational plans. We are in discussion with Government colleagues about the impact this may have in terms of staffing reductions, and we are discussing the mechanisms this may entail, together with the costs and approvals of any exit arrangements. We will update you as soon as there is a clearer picture.

To meet this expectation, you should look carefully at functions where there is duplication. This includes:

- a number of assurance and regulatory functions (for example, safeguarding and infection control) where this is already done in providers and, in some cases, regions, without compromising statutory responsibilities
- wider performance management (as opposed to contract management) of providers which again already takes place in providers and at regional level
- comms and engagement which similarly exists in local authorities, providers and regions

Regional Directors will hold the ring with ICB Chief Executives on identifying how we are going to make the reductions, recognising that successfully reducing these costs will, in part, rely on cross-system arrangements going forward.

Reversing corporate cost growth in NHS providers

Since 2018/19, corporate costs in NHS providers have risen by 40% (£1.85 billion), excluding pay and pensions (56% including pay and pensions). While some of this cost growth has likely been necessary to improve clinical efficiency, we are now requesting that

all NHS providers reduce their corporate cost growth by 50% during Quarter 3 2025/26. These savings should be reinvested locally to enhance frontline services.

Some of these savings will be most effectively realised at a geographical or system level. Regional Directors will share benchmarking data for each provider and lean into this work to ensure that systems are collaborating, where appropriate, to determine the best approach. Also, in future, we will collect corporate cost data monthly to track progress and ensure delivery against this requirement.

Since 2019, there has been a substantial increase in the number of non-patient facing corporate nursing roles across NHS providers and ICBs. These roles have supported significant improvements within the nursing workforce, such as sustained post pandemic low leaver rates and reductions in vacancy levels.

However, initial analysis indicates significant sector and regional variation with the deployment and proportion of these roles within NHS providers. To ensure optimal deployment of the corporate nursing workforce, Duncan Burton, Chief Nursing Officer for England, will lead a benchmarking analysis to identify potential unwarranted variation and utilise this knowledge to set an appropriate threshold which we will ask systems and providers to align to in 2025/26. We aim to complete this work by the end of April 2025.

With regard to Wholly Owned Subsidiaries, we have adjusted our approval approach to subsidiary transaction assurance to reduce the burden on providers while ensuring that certain conditions are met. We will provide guidance shortly, informed by discussions with Unions nationally.

Enabling recovery through the NHS Standard Contract

We will shortly be publishing the response to the NHS Standard Contract consultation and the payment rules consultation for 25/26, which will set out a much more flexible approach to planning elective activity, including removing the elective payment limit, and proposals to strengthen the current activity management provisions within the contract.

This will be a first step in developing and strengthening commissioning, where commissioners and providers, where possible, jointly agree on affordable activity levels to meet key standards at the start of the year. This activity plan will be the basis on which providers and commissioners will work together during the year.

We will run a series of webinars to provide further details of the changes to the contract and outline the escalation routes we are putting in place.

Moving at pace to streamline the centre

As announced previously, Penny and Alan Milburn are jointly sponsoring the programme to bring together NHS England and the Department of Health and Social Care to create a

single aligned centre. It is very clear that our staff want and need to see things progress with speed and fairness, and we are all committed to deliver on this.

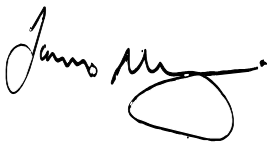
On Thursday, we had the last NHS England Board before the Interim NHSE Executive Team formally takes up their posts today. The Board was keen to publish the NHS Performance Assessment Framework for 2025/26, this being an important part of our oversight system and can be a useful instrument. This is very hard to get right given our current operational context. So, we agreed we would consult on the updated framework and allow some testing in Q1 before using the framework in earnest from then on.

We will also publish our Urgent and Emergency Care Delivery plan shortly, and it is essential that we are better prepared for winter this year. This will be a test of whether we are pivoting to the right approach, so I'd value your feedback. We'll use the UEC/winter planning activity to get some early conversations between the Interim NHSE Team and local leaders in the coming weeks and months.

Finally, I would like to reiterate how very grateful I am for Amanda's support through this transition and handover, and for all she did in her tenure. We all wish her well back at Guy's and St Thomas' when she starts there in the autumn.

I will do all I can in the time I am in this role to help lead us through this tricky phase, alongside all of you. It has been very clear to me in the few weeks I have been involved, before starting properly today, how committed you all are to helping get the NHS back on its feet and delivering all we want and need to for our patients and staff.

Thanks again, all the best and keep going.



Sir James Mackey
Chief Executive
NHS England

- Appendix 1 – 2025/26 financial plan summary as at 31 March 2025
- Appendix 2 – Distance to fair share allocation by system

Appendix 1 - 2025/26 financial plan summary as at 31 March 2025

Table: Regional 2025/26 Financial Plan submissions

Region Position	27th March submission	Deficit support	Gross Position	DfT % (inc Spec comm)	DfT £m (inc Spec comm)
EoE	0	169	(169)	(6.28)%	(237,458)
London	(63)	221	(284)	4.15%	10,960
Midlands	0	620	(620)	(2.36)%	(161,289)
NE&Y	0	233	(233)	(6.13)%	(190,238)
NW	(171)	542	(714)	6.25%	378,873
SE	(39)	329	(368)	5.28%	146,266
SW	(38)	91	(129)	(3.57)%	122,371
Total	**(311)**	**2,206**	**(2,518)**		

Please note over consumption of NHS resources is a postive distance from target (DfT)

Table: ICB 2025/26 Financial Plan submissions

Region	System	27th March submission	Deficit support	Gross Position	DfT % (inc Spec comm)	DfT £m (inc Spec comm)
EoE	NHS Bedfordshire, Luton and Milton Keynes ICB	0	0	0	(5.82)%	(157,595)
EoE	NHS Cambridgeshire and Peterborough ICB	0	0	0	0.51%	within range
EoE	NHS Hertfordshire and West Essex ICB	0	12	(12)	0.07%	within range
EoE	NHS Mid and South Essex ICB	0	106	(106)	1.92%	within range
EoE	NHS Norfolk and Waveney ICB	0	51	(51)	(0.09)%	within range
EoE	NHS Suffolk and North East Essex ICB	0	0	0	(2.87)%	(79,862)
London	NHS North Central London ICB	0	0	0	1.75%	within range
London	NHS North East London ICB	0	42	(42)	(2.18)%	(130,062)
London	NHS North West London ICB	0	0	0	(4.30)%	(290,668)
London	NHS South East London ICB	0	75	(75)	5.81%	307,036
London	NHS South West London ICB	(63)	104	(167)	3.06%	124,654
Midlands	NHS Birmingham and Solihull ICB	0	0	0	(3.44)%	(146,543)
Midlands	NHS Black Country ICB	0	95	(95)	(0.85)%	within range
Midlands	NHS Coventry and Warwickshire ICB	0	13	(13)	(3.16)%	(85,235)
Midlands	NHS Derby and Derbyshire ICB	0	45	(45)	(2.12)%	(63,712)
Midlands	NHS Herefordshire and Worcestershire ICB	0	73	(73)	3.88%	82,284
Midlands	NHS Leicester, Leicestershire and Rutland ICB	0	80	(80)	1.84%	within range
Midlands	NHS Lincolnshire ICB	0	0	0	(0.64)%	within range
Midlands	NHS Northamptonshire ICB	0	65	(65)	(1.77)%	within range
Midlands	NHS Nottingham and Nottinghamshire ICB	0	70	(70)	(1.23)%	within range
Midlands	NHS Shropshire, Telford and Wrekin ICB	0	84	(84)	3.70%	51,917
Midlands	NHS Staffordshire and Stoke-on-Trent ICB	0	95	(95)	1.44%	within range
NE&Y	NHS Humber and North Yorkshire ICB	0	79	(79)	(0.93)%	within range
NE&Y	NHS North East and North Cumbria ICB	0	33	(33)	(1.87)%	within range
NE&Y	NHS South Yorkshire ICB	0	71	(71)	(0.57)%	within range
NE&Y	NHS West Yorkshire ICB	0	49	(49)	(2.77)%	(190,238)
NW	NHS Cheshire and Merseyside ICB	(77)	178	(255)	3.10%	242,847
NW	NHS Greater Manchester ICB	(95)	200	(295)	0.55%	within range
NW	NHS Lancashire and South Cumbria ICB	0	164	(164)	2.60%	136,026
SE	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	0	54	(54)	(2.14)%	(96,856)
SE	NHS Frimley ICB	0	24	(24)	(2.64)%	(51,035)
SE	NHS Hampshire and Isle Of Wight ICB	0	63	(63)	0.66%	within range
SE	NHS Kent and Medway ICB	0	118	(118)	1.45%	within range
SE	NHS Surrey Heartlands ICB	0	26	(26)	4.02%	108,072
SE	NHS Sussex ICB	(39)	44	(84)	3.93%	186,085
SW	NHS Bath and North East Somerset, Swindon and Wiltshire IC	0	23	(23)	(0.66)%	within range
SW	NHS Bristol, North Somerset and South Gloucestershire ICB	0	0	0	(0.84)%	within range
SW	NHS Cornwall and The Isles Of Scilly ICB	0	0	0	(1.42)%	within range
SW	NHS Devon ICB	(38)	54	(92)	4.81%	163,317
SW	NHS Dorset ICB	0	14	(14)	(1.01)%	within range
SW	NHS Gloucestershire ICB	0	0	0	(1.91)%	within range
SW	NHS Somerset ICB	0	0	0	(2.54)%	(40,946)
	Total	**(311)**	**2,206**	**(2,518)**		

Please note over consumption of NHS resources is a postive distance from target (DfT)

Appendix 2 – Distance to fair shares allocation by system

Region	System Name	Including Specialist Commissioning		Excluding Specialist Commissioning	
		Distance to Target	Distance to Target £m value (to +/- 2.5% range)	Distance to Target	Distance to Target £m value (to +/- 2.5% range)
EoE	NHS Bedfordshire, Luton and Milton Keynes ICB	(5.8)%	(89.9)	(3.8)%	(29.3)
London	NHS North West London ICB	(4.3)%	(121.6)	(3.7)%	(71.8)
Midlands	NHS Birmingham and Solihull ICB	(3.4)%	(40.1)	(5.9)%	(127.8)
Midlands	NHS Coventry and Warwickshire ICB	(3.2)%	(17.9)	(2.9)%	(9.4)
EoE	NHS Suffolk and North East Essex ICB	(2.9)%	(10.2)	Within Range	Within Range
NE&Y	NHS West Yorkshire ICB	(2.8)%	(18.3)	Within Range	Within Range
SE	NHS Frimley ICB	(2.6)%	(2.7)	Within Range	Within Range
SW	NHS Somerset ICB	(2.5)%	(0.6)	Within Range	Within Range
London	NHS North East London ICB	Within Range	Within Range	(2.6)%	(6.6)
SE	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	Within Range	Within Range	(3.1)%	(23.5)
Midlands	NHS Derby and Derbyshire ICB	Within Range	Within Range	Within Range	Within Range
SW	NHS Gloucestershire ICB	Within Range	Within Range	Within Range	Within Range
NE&Y	NHS North East and North Cumbria ICB	Within Range	Within Range	Within Range	Within Range
Midlands	NHS Northamptonshire ICB	Within Range	Within Range	Within Range	Within Range
SW	NHS Cornwall and The Isles Of Scilly ICB	Within Range	Within Range	Within Range	Within Range
Midlands	NHS Nottingham and Nottinghamshire ICB	Within Range	Within Range	Within Range	Within Range
SW	NHS Dorset ICB	Within Range	Within Range	Within Range	Within Range
NE&Y	NHS Humber and North Yorkshire ICB	Within Range	Within Range	Within Range	Within Range
Midlands	NHS Black Country ICB	Within Range	Within Range	Within Range	Within Range
SW	NHS Bristol, North Somerset and South Gloucestershire ICB	Within Range	Within Range	(4.3)%	(41.9)
SW	NHS Bath and North East Somerset, Swindon and Wiltshire ICB	Within Range	Within Range	Within Range	Within Range
Midlands	NHS Lincolnshire ICB	Within Range	Within Range	Within Range	Within Range
NE&Y	NHS South Yorkshire ICB	Within Range	Within Range	Within Range	Within Range
EoE	NHS Norfolk and Waveney ICB	Within Range	Within Range	Within Range	Within Range
EoE	NHS Hertfordshire and West Essex ICB	Within Range	Within Range	Within Range	Within Range
EoE	NHS Cambridgeshire and Peterborough ICB	Within Range	Within Range	Within Range	Within Range
NW	NHS Greater Manchester ICB	Within Range	Within Range	Within Range	Within Range
SE	NHS Hampshire and Isle Of Wight ICB	Within Range	Within Range	Within Range	Within Range
Midlands	NHS Staffordshire and Stoke-on-Trent ICB	Within Range	Within Range	Within Range	Within Range
SE	NHS Kent and Medway ICB	Within Range	Within Range	Within Range	Within Range
London	NHS North Central London ICB	Within Range	Within Range	Within Range	Within Range
Midlands	NHS Leicester, Leicestershire and Rutland ICB	Within Range	Within Range	Within Range	Within Range
EoE	NHS Mid and South Essex ICB	Within Range	Within Range	3.0%	13.6
NW	NHS Lancashire and South Cumbria ICB	2.6%	5.2	4.0%	67.0
London	NHS South West London ICB	3.1%	23.0	2.9%	14.8
NW	NHS Cheshire and Merseyside ICB	3.1%	47.1	2.8%	22.6
Midlands	NHS Shropshire, Telford and Wrekin ICB	3.7%	16.8	5.5%	36.2
Midlands	NHS Herefordshire and Worcestershire ICB	3.9%	29.3	4.6%	39.4
SE	NHS Sussex ICB	3.9%	67.8	3.8%	53.7
SE	NHS Surrey Heartlands ICB	4.0%	40.8	4.7%	50.0
SW	NHS Devon ICB	4.8%	78.5	4.8%	67.8
London	NHS South East London ICB	5.8%	174.9	3.3%	35.4

From: ELECTIVEPMO (NHS ENGLAND - X24) <england.electivepmo@nhs.net>
Sent: 04 April 2025 15:11
Cc: EDWARDS, Fiona (NHS ENGLAND - X24) <fiona.edwards24@nhs.net>; BYWATER, Dale (NHS ENGLAND - X24) <dale.bywater1@nhs.net>; EDEN, Anne (NHS ENGLAND - X24) <anne.eden1@nhs.net>; PANNIKER, Clare (NHS ENGLAND - X24) <clare.panniker@nhs.net>; CLARKE, Caroline (NHS ENGLAND - X24) <caroline.clarke12@nhs.net>; DOHENY, Sue (NHS ENGLAND - X24) <sue.doheny@nhs.net>; SHEPHERD, Louise (NHS ENGLAND - X24) <louise.shepherd17@nhs.net>; Cubbon Mark (R0A) Manchester University NHS FT <mark.cubbon@mft.nhs.uk>; JONES, Elin (NHS ENGLAND - X24) <elin.jones8@nhs.net>; ELECTIVEPMO (NHS ENGLAND - X24) <england.electivepmo@nhs.net>
Subject: Message from Mark Cubbon

Dear Colleague

This is my first week at NHS England as National Director for Elective Care, Cancer and Diagnostics and I am looking forward to working with you as we focus on reducing waiting times and returning to the 18-week RTT standard by 2029. To deliver this for our patients, we will all need to work differently, with a renewed focus on productivity, delivery and the transformation of patient pathways – as set out in the elective reform plan which was published in January.

With that in mind, I thought it would be helpful to share a few key updates which will support the delivery of plans for this financial year and require your immediate focus. I am also sharing some thoughts about the work I am keen to progress with you over the coming weeks.

In his letter on 1 April, Jim mentioned the response to the NHS Standard Contract consultation – this has now been published on our website. The payment rules consultation for 2025/26 will follow shortly. We held webinars on 2 April to go through the implications for commissioners and providers – please let me know if you need any further detail from the contract team.

We will need you to go further on validation and will start working with you to do this right away. We remain some way off the levels of validation we need to see, with 14% unreported removals a month compared to 18 to 19% pre-Covid, and we know this is an essential discipline which provides an accurate view of our local waiting list position. The national elective team has already been working with your teams to support a validation 'sprint' to start on 6 April. We were planning to run sprints in Q1, Q3 and March 2026, with a payment cap of 5% (of your total waiting list). We are now removing this 5% limit, which will enable you to go further and validate your entire waiting list, with the incentive payment remaining the same per removal. We are discussing whether to increase the number of sprints, so early evidence of impact will help inform our next steps. This should not cause a delay to the full implementation of plans we have already agreed – please go ahead as planned with the added knowledge that there is no cap to constrain your validation. Your ongoing focus and oversight of this work is appreciated. If you require any additional information or support related to this work, please speak to a member of your regional team, or contact me directly.

As of 1 April, the new funding mechanism to fund pre-referral advice and guidance requests from GPs is available – with the aim of increasing requests from c2.4 million to 4 million during this financial year. Primary Care and ICB colleagues have been preparing for this change for some time so your local system should be ready to support the implementation of

plans right away. This has been well received in general practice and uptake will be maximised with a timely response, with direct conversion to referral and by communicating (where appropriate) the outcome directly to both the patient and the GP. The plans we have received from each provider assume a further uptake of A&G so it's important that we make best use of the new mechanism as quickly as possible.

We are continuing with the existing approach to tiering throughout 2025/26 and will work with regional teams to review provider plans throughout April against the elective delivery requirements set out in the planning guidance. We will then notify the relevant organisations and work closely with a small group of providers for enhanced oversight and to support the delivery of local improvements.

While driving these elective interventions to support the delivery of your local plans, we cannot afford to take our eye off the ball with our cancer and diagnostic commitments. We made good progress in both areas throughout 2024/25 and we will need to press on and deliver further improvements this year. While there was no specific target set for diagnostics in the planning guidance, we will need to drive further improvements to support the delivery of elective and cancer priorities.

Finally, I have already heard from a number of colleagues who are keen to understand more about the breadth of practical transformation support we can provide. I will aim to provide an update on this in the next couple of weeks. In the meantime, if you have any thoughts about ways we can help you and your teams, or if you have any questions about the points above, do give me a shout – mark.cubbon@mft.nhs.uk.

Thanks in advance for your support.

All the best,

Mark

Mark Cubbon
National Director of Elective Care, Cancer and Diagnostics
NHS England

Senior Executive Assistant: Julie Gwilliam julie.gwilliam@mft.nhs.uk
Tel: 0161 276 4755

Board of Directors' Meeting
2nd May 2025

The Rotherham NHS Foundation Trust

Agenda item	xxxx/25
Report	**Operational Objectives 2024/25 for review**
Executive Lead	Bob Kirton, 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 October 2024 to March 2025. 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 to board assurance committees as at the end of Q4 2024/25. By the end of the financial year there have been no significant escalations to the Executive Management Team that would warrant a formal request to assurance committees to make fundamental changes to the overall aim of any particular priority. However, it is evident that although the work streams developed to deliver the key change actions as outlined in the original mandates have made significant improvements in the main areas of focus, the perpetual increase in demand particularly for elective and non-elective services has hindered achievement of both local and national performance standards in some cases.

	A summary of the quarter four position for the four Organisational Priorities can be found below:- **Quality of Care – Focus on providing high quality care & improving the experience of patients** 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 show a positive result. **People and Culture - Focus on improving the experience of our people and developing our culture** This priority achieved top quartile engagement measure in the 2024-25 staff survey as planned. Staff turnover performance has remained stable and within the desired target range that is between 8% and 9.5%. Sickness absence has, unfortunately, not achieved the 4.8% target by year end. **Operational Delivery - Focus on our operational delivery and improving access to care** By the end of March 2025 two out of four metrics were showing statistically significant improvement. RTT has delivered a 4.9% improvement over the last 12 months from 59.8% in March 2024 to 64.7 March 2025. Progress has been made against achieving the constitutional standard with the following specialties achieving over 92% in March; General Medicine, Geriatric Medicine, Respiratory, Paediatrics, and Paediatric Cardiology, as well as sub-specialties of Diabetes & Endocrine, Stroke, and Rheumatology. T&O, Gynae and OMFS remain a concern with ongoing plans in place to support recovery. The 4 hour standard has not achieved trajectory at the end of 2024-25, however, performance has improved on previous years despite significant increases in attendances. The number of attendances in UEC have been increasing month on month over the past year, peaking at 9,429 in March 2025 against a baseline set at the end of March 2024 of 8219. Supporting metrics allied to patient flow have correspondingly deteriorated, particularly in terms of patients with no criteria to reside (19.5% in March 2025 against target of less than 10%) as well as time from decision to admit to admission (235.3 minutes in March 25 against a target reduction on last year's baseline of 144.2 minutes) Time to initial assessment has however improved significantly starting out at 22 minutes as at the end of March 2024, down to 7.3 minutes by the end of March 2025.

	Financial Sustainability - Focus on becoming a financially sustainable and productive organisation This priority has achieved the objective to deliver the financial plan overall, however, the trust remains behind plan on efficiency delivery.
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 – October 2024 to March 2025

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 second half of the financial year ending March 2025 and reports by exception any areas of concern.

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 April 2025 the Board Assurance Committees considered reports on progress made in all of their associated areas during the last three months of the yea. A high level summary of achievements made during the six month period is provided in the tables below.

Priority Title	Achievements Q4 - Summary
Quality of Care	**Quality Priorities**:- • **Pain Management** – Improvements in pain assessments on admission achieved. Pain Champions in place across the trust. Updates to Meditech achieved and EOLAS App launched. No further actions were planned during January to March due to awaiting results of the CQC inpatient survey.

Priority Title	Achievements Q4 - Summary
	• **Frailty Assessments** – Virtual ward and Clinical Frailty scores data is now being captured. New registrar has commenced which has increased the number of Comprehensive Geriatric Assessments (CGAs) completed, particularly through UECC. The first inpatients Frailty Audit commenced and the data dashboard is now live. • **Diabetes Management –** Sub groups started their programmes of work lead by a Consultant, Senior Nurse and Pharmacy representative. The Power BI dashboard has now been completed.. Improvements in patient outcomes have already been identified. Key policies and guidance have been prepared and the review and update of pathways has commenced. Quality Improvement workshop completed. **Patient Experience Improvement Plan –** End of life improvement work achieved. Launched Carers Promise, building and opening of PALS. **Exemplar Accreditation Programme** – Paediatrics, Neonates and Maternity Accredited.
People & Culture	• Health and Wellbeing programme in place with 5 supporting working groups set up to deliver 10 areas of focus • Completed the Health and Wellbeing diagnostic • Audit policy and assurance working group in place • Go live with new on line identity checks • Signed up to North West BAME Framework and assigned new BAME Staff Network lead (internal replacement) • New employee on line system (Loop) implemented • New Attendance Policy ready for launch in May 2025 • New 3 year integrated EDI plan published • 2024 National Staff Survey results distributed, maintained upper quartile performance • Procured new Occupational Health provision and launched #Look After Yourself department visits • Retention levels outturned at 8.4%

Priority Title	Achievements Q4 - Summary
Operational Delivery	**Deliver 4 hour performance of 80% before March 2025** • Transfer of Care Hub and Yorkshire Ambulance Service (YAS) single point of access (SPA) co-location pilot implemented • Mobile X-Ray initiative fully scoped ready for 6 month pilot to start in April 2025. • Virtual fracture clinic plans in place • Same Day Emergency Care (SDEC) exclusion criteria finalised • QI and engagement sessions held to support plans to reconfigure Medical bed base • UECC Capital Programme launched **Long-waiting patients (target 10 patients) and RTT performance (target 92.0% in 8 specialties)** • "Did not Attend" (DNA) Partial Booking process developed to support Access Policy. • Working with NHS England to pilot an AI DNA Prediction Tool in specialities with highest DNA rate . • Theatre Flow SOP and Cancellation SOP approved at Governance. • ENT integrated Clinical Triage into Job Plans and testing straight to test pathway • Outpatients Estate Working Group Established • Improved theatre utilisation meeting with list closed if not filled to 50% within 1 week • Weekly huddles with Service Managers, Support Managers and Booking teams to understand current booking status and any upcoming issues to feed into utilisation meeting. **Consistently deliver the Faster Diagnosis Standard (FDS) by Q4 (local target 80% (Standard is 77%)** • New UGI triage model in place with increased straight to test utilisation • Straight to test prostate MRI pathway evaluated and transferred to business as usual status • Good news clinic structures and improvement plans established in Upper and lower gastro intestinal, Urology, Skin, Lung and Gynaecology • Endoscopy data insights dashboard established with focus on utilisation and productivity • Monthly breach review meetings established with cancer improvement team and service managers • Endoscopy Amb Orders for Urgent Suspected Cancer (USC) cases now mandated to priority 3 • Standardised Good News Clinic processes and data capture established • Delivery in accordance with the Endoscopy Transformation Programme • Faster Diagnosis Standard performance by cancer v non-cancer now available at tumour group level • Baseline assessments of all Cancer MDTs undertaken to support MDT Optimisation

Priority Title	Achievements Q4 - Summary
Financial Sustainability	**Efficiency/CIP** - The final outturn position for the 24-25 CIP shows that £10,766k had been delivered/transacted year-to-date against a £12,766k target. A full-year-effect recurrent value of £5,766k had been transacted against the target. **Financial Plan** –. Monthly financial recovery meetings have continued to focus on additional unfunded bed capacity, premium rate pay and elective recovery income. The year to date position is favourable to plan by £483K. The Trust has therefore delivered against its duty to breakeven. **Elective Recovery** – Additional funding has been agreed for specific schemes to maximise elective activity and patient care across Care Groups and to increase income.

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

2.3.1 Quality of Care

Quality Priority - Frailty

Delays in reconfiguration of the medical bed base is impacting on flow and multi-disciplinary team capacity to complete comprehensive geriatric assessments for all patients that meet criteria. This is particularly affecting nursing staff availability. Discussions with clinical teams have continued, however, at the end of March final plans remain uncertain.

The first inpatient frailty audit was disrupted by periods of bed escalation and the introduction of new documentation within therapy services has impacted on data quality. The frailty inpatient audit subsequently requires further data refresh and analysis.

2.3.2 People & Culture

Sickness absence target remained at risk and was not delivered by end March 2025. The work streams contained in the health and wellbeing programme will continue to be rolled out with an expectation that the work will positively impact on attendance levels in the next 6 to 12 months. In some areas there is a lack of manager compliance with return to work and policy application which will be targeted as part on the new policy / toolkit launch, supported by bespoke training.

2.3.3 Operational Delivery

Staff shortages leading to last minute theatre cancellations have impacted on performance standards. 6-4-2 and utilisation meetings have been installed to help resolve issues sooner.

Lower Gastro-Intestinal and Urology pathways with Faster Diagnosis Standard below 80% is affecting standards. Improvement plans have been put into place with dedicated Cancer Improvement Team resource for these pathways.

There have been ongoing delays in the implementation of the Rotherham Breast Pain Pathway. The Care group is now progressing plans for an Advanced Clinical Practitioner delivery model to support the pathway work.

Capacity has hindered progress to complete IT developments in UEC that will progress efficient, paperless processes such as e-referrals, paperless ECGs and equipment tracking. Delays have been caused by unplanned absence of leading team members however work has resumed on their return to work albeit with a number of key milestones on plan having been deferred for delivery in 2025-26.

Medicine bed reconfiguration implementation has been delayed and is impacting on flow out of UEC and Same Day Emergency Care services. Consultation is continuing with clinicians to reach agreement. Delivery of the UEC capital plan on time will benefit patients needing same day emergency care in a bespoke setting that will provide “fit to sit” services and avoid inpatient admissions.

2.3.4 Financial Sustainability

During the 6 month reporting period there has been a significant risk to delivery of the CIP target and ultimately the financial plan. Additional bed capacity has remained open, which is over and above funded levels. Planned elective recovery schemes which are not delivered will impact on reducing long waiters and the trusts ability to deliver the deficit financial plan. The Improvement Group and Elective Recovery group are in place to harness improvement ideas and deliver key change actions at pace.

2.4 The Highlight reports attached at Appendix 2 confirm the status of the four Objectives for the three month period ending March 2025.

The reports are due to be submitted to the relevant Board Assurance Committees in April 2025 however due to timing of deadlines to trust board in May, the subsequent confirmation of assurance in terms of process and/or delivery and any agreed recommendations, actions and decisions is not yet confirmed.

Strategic plans are however being developed by Executives to confirm the priorities for 2025-26 delivery and within these there will be scope for transition of any objectives set out in the 2024-25 priorities that were not fully assured by the board’s committees in April 2025, subject to Executive approval.

For the purpose of this report therefore the assurance committee feedback from their previous meetings is provided below.

2.4.1 Quality Committee

The Quality Committee has noted that having reviewed the delivery of the operational objectives, there were a lot of systems, processes and evidence to support key aspects moving in the right direction.

It was further noted that the overall headlines of patient experience, patient safety and clinical effectiveness should remain the same in 2025-26 but with sub details refreshed. Consideration is to be given as to whether the staff survey and feedback from staff on patient safety could also be incorporated.

2.4.2 People and Culture Committee

The Committee has noted the decline in sickness absence and felt that the deterioration had been discussed in other items submitted on the Agenda at their meetings held bi-monthly.

This Committee therefore plans to review the reporting process in 2025-26 for the organisational priority aligned to People and Culture objectives as it aims to remove elements of duplication.

2.4.3 Finance and Performance Committee

The Finance and Performance Committee has noted that in relation to **Operational Delivery** areas of concern have been reported previously and in particular in relation to the achievement of the 4 hour standard, referral to treatment performance in some areas and theatre utilisation. The Committee acknowledged concerns around Gastroenterology and the partnership with Barnsley and that Dermatology and Cardiology are also under review.

The Committee have been updated on signs of improvement in theatre productivity in Orthopaedics and colorectal cancers have been reducing to single figures along with Ophthalmology which is also showing signs of turn around.

The benefit of making changes to the same day emergency care service as part of the Urgent and Emergency Care Capital Programme and the implementation of the medicine bed reconfiguration plans were further noted by the Committee, however, these changes were not in place at the end of March 2025.

Workforce challenges have been at the centre of the issues that operational leads have continually faced during 2024-25, however, key members of staff are returning and this has started to improve the outlook going into 2025-26.

The Finance and Performance Committee noted at the end of quarter three, in relation to **Financial Sustainability,** that the year to date position was adverse to plan by £1,744k. This was due to under-delivery of cost improvement plans, additional unfunded bed capacity, premium rate pay, and elective recovery income being below target. Monthly financial recovery meetings have continued 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 also in place to support progress and increase momentum.

As a result of the continued improvements up to the end of March, the trust has delivered against its duty to break even.

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

Bob Kirton
Managing Director
May 2025

APPENDIX 1
OPERATIONAL OBJECTIVES 2024-25 : HIGHLIGHT REPORTS OCTOBER 24 TO MARCH 25

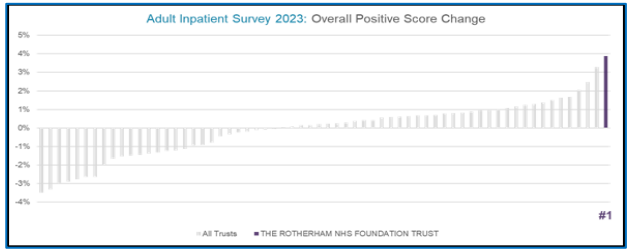
QUALITY OF CARE
FOCUS ON PROVIDING HIGH QUALITY CARE AND IMPROVING THE EXPERIENCE OF OUR PATIENTS

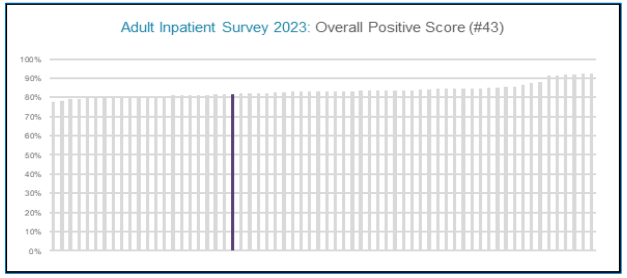
PEOPLE & CULTURE
FOCUS ON IMPROVING THE EXPERIENCES OF OUR PEOPLE AND DEVELOPING OUR CULTURE

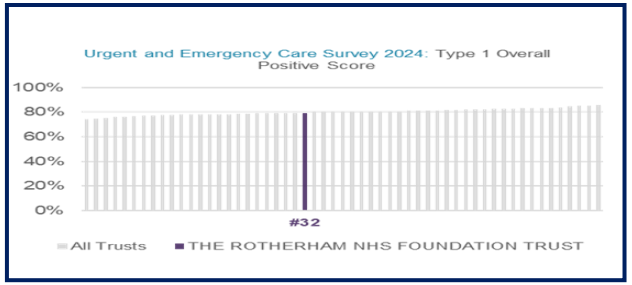
OPERATIONAL DELIVERY
FOCUS ON OUR OPERATIONAL DELIVERY AND IMPROVING ACCESS TO CARE

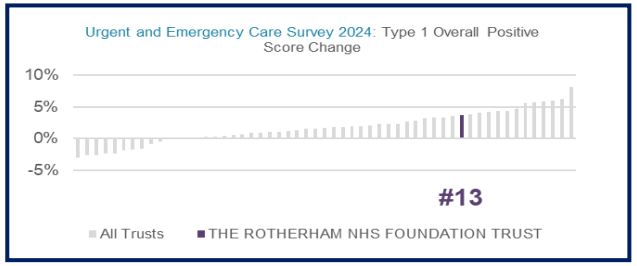
FINANCIAL SUSTAINABILITY
FOCUS ON BECOMING A FINANCIALLY SUSTAINABLE AND PRODUCTIVE ORGANISATION

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 show a positive result.		









Delivered this period – Q4 2024-25

Quality Priorities

- **Pain Management** – No further actions were planned in Q4 due to awaiting results of CQC inpatient survey.
- **Frailty Assessments -** First inpatients Frailty Audit commenced with 48 patients in scope. The Frailty dashboard is now developed in the live environment. Discussions relating to the reconfiguration of the medical bed base are continuing within Care Group 1 but final plans remain uncertain.
- **Diabetes Management -** Key policies and guidance have been prepared and progressing through governance processes. Review and update of pathways has commenced. Quality Improvement workshop completed looking at the last 12 months activity and exploring future opportunities for improvement across the patient pathway. The outcomes from the deep dive audit for patients arriving at UECC with existing diabetic problems and who are already under the community case load will be presented in Quarter 1 : 2025-26.

Patient Experience Improvement Plan – No further actions planned in Q4 due to completion of deadlines in November.

Exemplar Accreditation Programme – No further activity planned in Q4 due to the "year 2" programme commencing in April.

Quality Improvement Plan 2025-26 – Q1

The activities described below will continue into the new financial year with a view to transitioning into the trusts 2025-26 improvement priorities, subject to Quality Committee and Executive Leads approval.

- Commence Year 2 Exemplar Accreditation Programme
- Frailty QI – embed comprehensive geriatric assessment standards, build a sustainable workforce model, continue dashboard development and plan a second audit

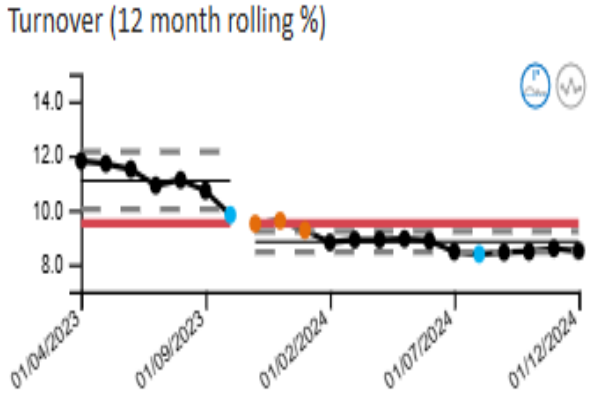
2025-26 Quality Priorities were agreed in principle at the Quality Committee and Executive team meetings held in March and will be subject to approval at Trust Board in May.

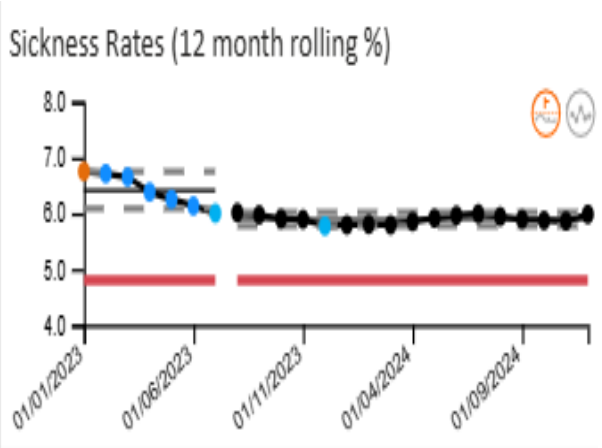
1. Reducing delays in cancer diagnosis and treatment
2. Antimicrobial stewardship
3. Diabetes

Risks/issues/escalations to delivery of the objectives

Quality Priority Frailty – Issues (1) – delay in reconfiguration of the medical bed base is impacting on flow and multi-disciplinary team capacity to complete comprehensive geriatric assessments for all patients that meet criteria. This is particularly affecting nursing staff availability. (2) The first inpatient frailty audit was disrupted by periods of bed escalation and the introduction of new documentation within therapy services has impacted on data quality. The frailty inpatient audit subsequently requires further data refresh and analysis

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		





Delivered this period

- New Attendance Policy drafted, going through governance route for launch in May 2025. Engagement meetings held with staff network groups and staff side, stakeholders.
- The new 3-year integrated EDI plan published.
- National Staff Survey Reports distributed, TRFT maintained upper quartile performance. **Objective Achieved**
- TRFT presented a webinar with NHSE on our approach to implementation of team rostering through case studies and good practice examples.
- Completed the procurement exercise for renewal of the Occupational Health contract. There will be more emphasis on provision of our general health and wellbeing offer in the new contract
- Continue to support staff health and wellbeing through #Look After Yourself" department visits
- Retention levels outturned at 8.4% . **Objective Achieved**

Planned next period

Reporting process to be reviewed at the People & Culture Committee as it aims to remove elements of duplication. The new People & Culture operational objectives to be finalised.

Risks/issues/escalations to delivery of the objectives

- Sickness absence target remains at risk and will not be delivered by end March 2025. The work streams contained in the health and wellbeing programme will continue to be rolled out with an expectation that the work will positively impact on attendance levels in the next 6 to 12 months. In some areas there is a lack of manager compliance with return to work and policy application which will be targeted as part on the new policy / toolkit launch, supported by bespoke training.

Operational Delivery

Objectives

Focus on our operational delivery and improving access to care

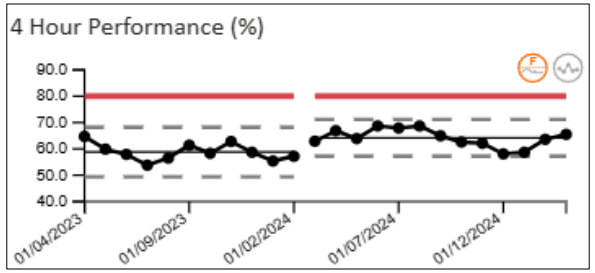
Deliver 4 hour performance of 80% before March 2025; go beyond the national ambition on long waiters and RTT performance; consistently deliver the Faster Diagnostic Standard by Q4

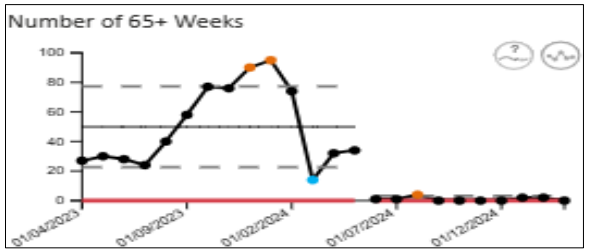
Executive Lead(s)

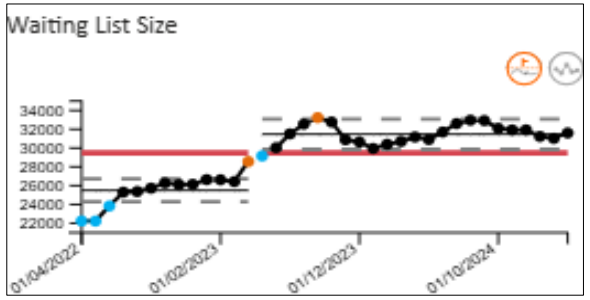
Chief Operating Officer
Director of Operations

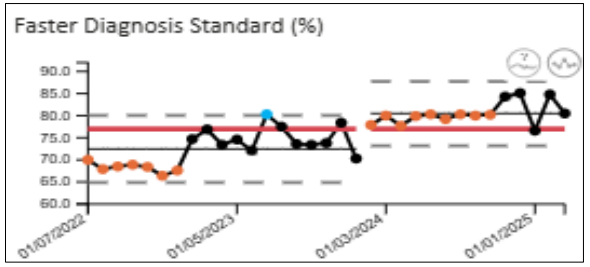
Summary Position

Two out of four metrics are now showing statistically significant improvement. 65 week waiters were eliminated from September and remains at zero at the end of March. Faster Diagnostic Standard has consistently delivered against the standard. RTT has achieved General Medicine, Geriatric Medicine, Respiratory, Paediatrics, and Paediatric Cardiology, as well as sub-specialties of Diabetes & Endocrine, Stroke, and Rheumatology, although T&O, Gynae and OMFS have remained a concern. 4 hour performance for March remains below target at 65.5% against the trust target of 80% (78% nationally).









Delivered this period

Deliver 4 hour performance of 80% before March 2025

- Yorkshire Ambulance Service (YAS) and Transfer of Care team co-location completed in order to facilitate single point of access strategy
- Virtual fracture clinic plans finalised and clinical lead appointed
- SDEC exclusion criteria finalised
- QI and engagement session held in January to support plans to reconfigure Medical bed base
- Mobile x-ray pilot developed (NEW)

Long-waiting patients (target 10 patients) and RTT performance (target 92.0% in 8 specialties)

- Developed PTL ToR, Validation SoP and Waiting List Management SoP.
- Introduced standardised templates in Orthopaedics
- RTT training in progress. Access Policy updated.
- Virtual Fracture Clinic developed with plan to launch in May.
- ENT integrated Clinical Triage into Job Plans and testing straight to test pathway
- Outpatients Estate Working Group Established
- DNA AI tool Testing
- Improved theatre utilisation meeting with list closed if they are not filled to 50% within 1 week
- Weekly huddles with Service Managers, Support Managers and Booking teams to understand current booking status and any upcoming issues to feed into utilisation meeting.

Consistently deliver the Faster Diagnosis Standard (FDS) by Q4 (Standard is 80%)

- Endoscopy Amb Orders for Urgent Suspected Cancer (USC) cases now mandated to priority 3
- Standardised Good News Clinic processes and data capture established
- Improvement plans in place for LGI, UGI, Urology, Lung, Skin and Gynae
- Delivery in accordance with the Endoscopy Transformation Programme
- FDS performance by cancer v non-cancer now available at tumour group level
- Baseline assessments of all Cancer MDTs undertaken to support MDT Optimisation

2025-26 - Q1 planned activity

The planned activities described below will continue into the new financial year with a view to transitioning (if agreed by Executive Leads) into the trusts 2025-26 improvement priorities.

Non-Elective Care

- UEC capital estate reconfiguration completed
- Streaming pathways confirmed
- Offer to turn around at the front door (to virtual wards) developed
- Hot clinics identified
- SDEC business case (operating model/workforce design) signed off
- Medical bed base reconfiguration implemented
- Single Point of Access business model in development (YAS/North & East Region)
- Identify co-dependencies against Place level plans for ambulatory care, frailty and other areas of focus

Elective Care – Theatres, Outpatients, Cancer and Endoscopy

- Establish Waiting List Network Meeting
- Plan Super Clinics in T&O, ENT, OMFS and Gynae
- Follow-up Back log task and finish group
- New Theatre Timings Live. Patient bookings adjusted to ensure data not impacted
- Increase High Flow Lists
- Review roles and responsibilities in Theatres
- Review Pre-assessment booking process with a view to standardise
- Pilot delivery of the Rotherham Breast Pain Pathway
- Establish a Trust wide Amb Order priority solution for urgent cancer cases
- Targeted improvement focus on FDS achievement in cancer cases
- Pathway analysis and subsequent improvement plan for Head and Neck
- Continued deliver in accordance with the Endoscopy Transformation Programme
- Progress MDT Optimisation work at a local and regional level across all tumour groups

Risks/issues/escalations to delivery of the objectives

- 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
- Issues - Challenged high volume LGI and Urology pathways with FDS <80% - Mitigation - LGI and Urology improvement plans in place. Dedicated Cancer Improvement Team resource for these pathways.
- Issues - Delays in the implementation of the Rotherham Breast Pain Pathway - Mitigation - Care Group progressing plans for ACP led delivery model.
- Issues – Capacity to complete IT developments in UEC that will progress paperless processes such as e-referrals, paperless ECGs, equipment tracking – Mitigation – delays were caused by unplanned absence of leading team members however work has resumed on their return to work
- Issues – Medicine bed reconfiguration implementation impacting on flow out of UEC/SDEC – Mitigation – ongoing consultation with clinicians and delivery of UEC capital plans

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 efficiency delivery. Financial plan delivered overall.		

Efficiency/CIP

	Jan-25	Feb-25	Mar-25
	£'000	£'000	£'000
Actual	5,957	6,342	10,766
Cumulative Target	9,843	11,292	12,741

Financial Plan

	Jan-25	Feb-25	Mar-25
	£'000	£'000	£'000
Actual	(1,544)	(701)	299
Expected target	(493)	(543)	(184)

Elective Recovery

	Jan-25	Feb-25	Mar-25
	£'000	£'000	£'000
Actual	50,633	56,127	61,149
Cumulative target	52,499	57,431	62,607

Delivered this period

Efficiency/CIP

The final outturn position for the 24-25 CIP shows that £10,766k had been delivered/transacted year-to-date against a £12,766k target. A full-year-effect recurrent value of £5,766k had been transacted against the target.

Financial Plan

The year to date position is favourable to plan by £483K. This is due to the continued improvements to deliver against CIP targets, elective recovery performance targets, financial recovery targets and surge funding received from NHSE. The Trust has therefore delivered against its duty to breakeven.

Elective Recovery

Additional elective recovery schemes continued to be funded in the last quarter of the year. It is expected that the actual position will increase prior to the final deadline for recording.

Planned next period

Efficiency/CIP

Care groups and corporate areas have developed plans for known savings for 2025/26, with those savings currently totalling c£1.9m. Care Groups/Corporate areas to review non-recurrent schemes in 24-25 for recurrent delivery in 25-26.

Financial Plan

The Trust submitted a breakeven (control total) financial plan to NHS England. Recurrent budgets have been rolled forward for Care Groups and Corporate Services. Risks and opportunities will be considered separately through a confirm and challenge process prior to any agreement to funding through reserves.

Elective Recovery

Schemes will continue to be funded from April 2025 to maximise activity for the benefit of patients. Proposed schemes were approved in principle at the Elective Delivery Group meeting in April 2025, subject to the sign off via the usual governance process.

Risks/issues/escalations to delivery of the objectives

The risks going into 2025/26 financial year remain similar to 2024/25. There remains a significant risk to delivery of the CIP target and ultimately the financial plan.

Additional capacity remains open, which is over and above funded bed capacity.
If planned elective recovery schemes are not delivered this will impact on reducing long waiters and delivery of the financial plan.

The Rotherham NHS Foundation Trust

Hashim Din
Senior People Professional Apprentice &
SY Apprenticeship Awards Nominee

Health T-Level Students
Scarlett Ayrton
Fazal Rahman
Alicia Hubery

Eve Bellis
Industry Skills Coach – T-Levels

T-Levels & Apprenticeships

- 5 T-Levels placements in the last 6 months
- Plans to increase numbers & placement locations

- 308 apprenticeship completions
- 170 apprentices on programme, 50% clinical & 50% non-clinical
- Introduction of the new Data Academy
- Numerous award nominee's

RNN Group - Health - T-Levels

- Clear academic uplift to students from TRFT placements
- Increased career progression opportunities
- Increased motivation & engagement

- *"I didn't realise there were so many roles within the NHS – it's opened my eyes to new career paths."*
- *"This experience has solidified my ambition to build a career in the NHS."*
- *"I've really enjoyed networking with staff and starting to build professional relationships in a healthcare setting."*

Daniel Andrew – Healthcare Assistant Practitioner Level 5

- Excellent support from the team & management
- Assignments aligned with the role in the Community Therapy Team
- Achieved a Merit in the apprenticeship & distinction in the Foundation Degree
- Grateful to be given the opportunity & looking forward to further education/development
- No idea to be nominated for the SY App Awards & proud to be shortlisted

Christine Hazlehurst – Senior Leader Level 7

- The apprenticeship has contributed significantly to both personal & academic growth
- Implemented new positive changes in the workplace
- Improved knowledge, skills, behaviours & time management
- Confidence has grown in particularly in the role of a Senior Leader
- Being nominated and shortlisted for the Health & Public Service Apprentice of the Year award was completely unexpected, but such a wonderful surprise.

Questions

Board of Directors' Meeting
2nd May 2025

The Rotherham NHS Foundation Trust

Agenda item	/25
Report	**NHS Staff Survey 2024/25 and next steps 2025/26**
Executive Lead	Daniel Hartley, Director of People
Link with the BAF	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	This work underpins the Trust's objectives across all areas and supports Ambitious, Caring and Together.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The NHS staff survey is both an improvement tool and an opportunity to benchmark the Trust against peers, and against previous year performance. It provides a rich level of data broken down to service level to enable actions to be taken to improve staff experience. In terms of benchmarking against peers, for the overall results the Trust places 4th out of the 21 Acute/Acute and Community Trusts in the North East and Yorkshire (top quartile) and 21st out of the 122 Acute/Acute and Community Trusts in England (top quartile) Trust scores have reduced slightly across each of the 7 People Promise themes, engagement and morale. Other than our overall engagement score which is marginally behind 2020 (Covid) these results represent the 2nd best performance the Trust has had in each area. As set out in our People and Culture Strategy 2024-27 the Trust's approach to making improvements in staff experience is through co-creating and delivering 'We said, we did' plans both Trust wide and for each service area. Trust wide 'We said, we did' priorities are currently being developed for launch later in May and are being discussed at People and Culture committee on 25th April and will be agreed at the Executive Team meeting on the 1st May. As such a verbal update will be provided to Board, along with the final 24/25 position. Using the staff survey insight to drive engagement and improvement is the task of every senior leader and manager for their teams. We have reinforced this by making this a key organisational priority for 2025/26 as is proposed to Board elsewhere on today's agenda.
Recommendations	The Board is asked to • note the Trust's position in this year's National Staff Survey and it's use as a key improvement tool; and

	• note the improvement work underway designed to improve the experience of our people led both Trust wide and in services
Appendices	Appendix 1 – NHS Staff Survey and next steps summary presentation

The Rotherham NHS Foundation Trust

NHS Staff Survey 2024/25 and next steps 2025/26

Board of Directors

2nd May 2025

Full NHS staff survey results benchmarked against peers and with a breakdown for services can be found at the following links

NHS Staff Survey 2024 Benchmark Report

NHS Staff Survey 2024 Breakdown Report

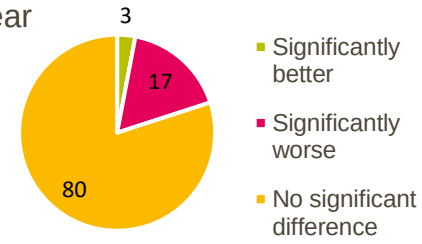
Recap and update

The Rotherham NHS Foundation Trust

Results

- The NHS staff survey is both an improvement tool and an opportunity to benchmark the Trust against peers, and against previous year performance. It provides a rich level of data broken down to service level to enable actions to be taken to improve staff experience.
- The Trust places 4th out of the 21 Acute/Acute and Community Trusts in the North East and Yorkshire. Top quartile.
- The Trust places 21st out of the 122 Acute/Acute and Community Trusts in England. Top quartile.

Comparison to 2023



Context

- Trust scores have reduced slightly across each of the 7 People Promise themes, engagement and morale. Other than our overall engagement score which is marginally behind 2020 (Covid) these results represent the 2nd best performance the Trust has ever had in each area. We are above average (first or second quartile) for each people promise area, engagement and morale.
- The mean reduction is 0.09 per People Promise area, engagement and morale. Of the 9 areas in total 4 of the reductions are not considered statistically significant, 5 are. In a challenging year, the NHS acute average has reduced in 5 of the 9 areas.

Comparison with average

Improvement

- As set out in our People and Culture Strategy 2024-27 the Trust's approach to making improvements in staff experience is through co-creating and delivering 'We said, we did' action plans both Trust wide and for each service area. Trust wide We said we did priorities are currently being developed for launch later in May, along with the 12 month update from the 24/25 priority areas.
- Using the staff survey insight to drive engagement and improvement is the task of every senior leader and manager for their teams. We have reinforced this by making this a key organisational priority for 2025/26 as is proposed to Board elsewhere on today's agenda.

Our strategic approach

Our Vision

We will always ACT the right way and be PROUD to provide healthcare to the people of Rotherham

Our Values

Ambitious
Caring
Together

Our Strategic Ambitions (PROUD)

- **P**atients
- **R**otherham
- **O**ur partners
- **U**s
- **D**elivery

Trust Strategy

People and Culture Strategy

Equality, Diversity and Inclusion plan

To implement this strategy care groups and services will involve team members in developing and delivering **'we said, we did'** plans based on staff survey feedback. These will be complemented by a Trust wide **'we said, we did'** plan covering the areas that need a whole organisation focus.

We said, We did

+

Workforce plans

Our People and Culture Strategy is rooted in our values and relates to the 'Us' in PROUD. It also influences all of our strategic ambitions as our culture sets the tone for how we make our vision a reality through our people. We want all our people to be proud to work in a compassionate and inclusive organisation that delivers excellent healthcare for patients.

This strategy aligns to our overall Trust strategy and complements other Trust wide strategies. Each year we will set out our specific objectives as part of annual priority setting.

We will develop workforce plans for service areas and the whole Trust and underpin all our work with an **equality, diversity and inclusion (EDI) plan**. Our EDI plan will be designed to make sure we take effective action so that all our people have a great experience of work and can fulfil their potential.

Trust wide

Service specific and Trust wide

NHS
The Rotherham
NHS Foundation Trust

Extract from Trust People and Culture strategy p4

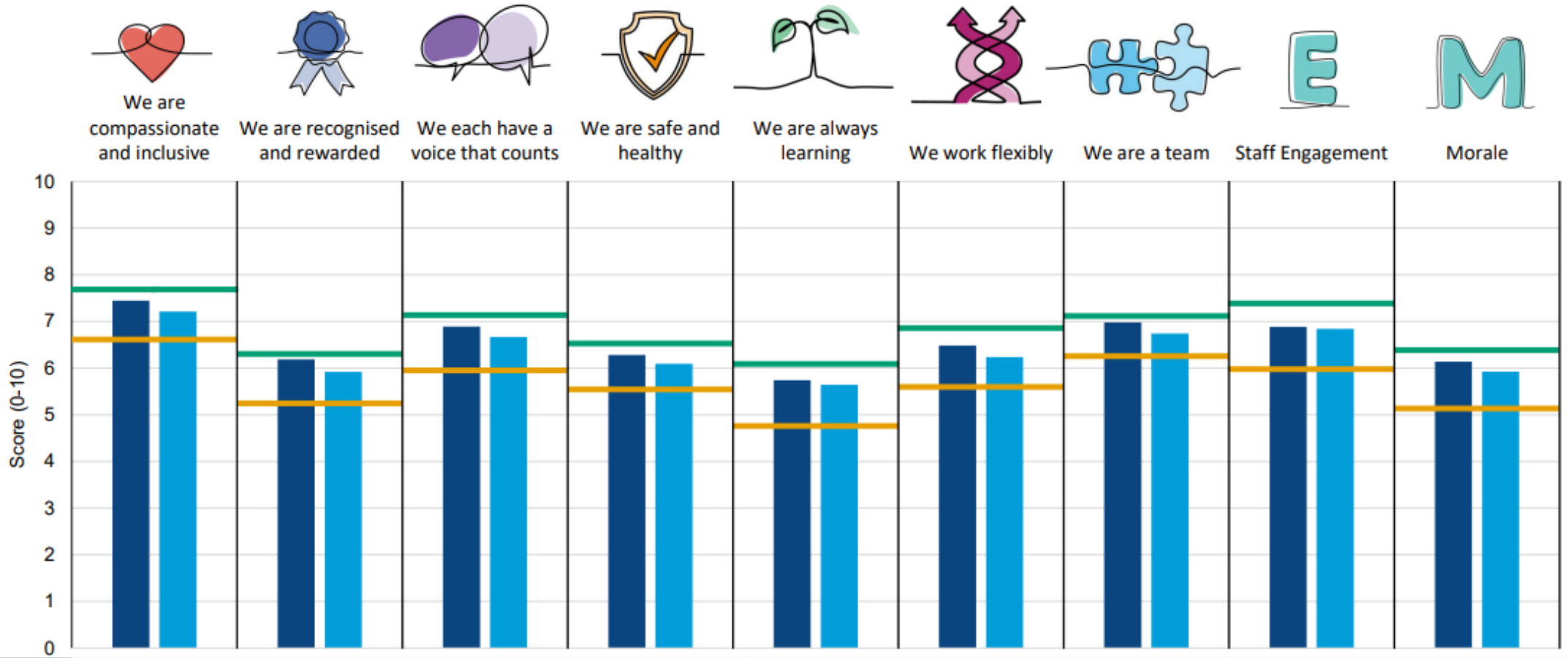
Urgent and Emergency Care (UECC) Senior Leadership Team

People Promise elements and themes: Overview

Survey Coordination Centre

NHS

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



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.45	6.19	6.89	6.28	5.74	6.48	6.98	6.89	6.14
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	3078	3089	3037	3016	2918	3063	3073	3088	3086

Areas of high performance vs peers; most improved scores & link to People Promise area

Top 5 scores vs Organisation Average	Org	Picker Avg	
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	72%	66%	• n/a / quality link
q14c. Not experienced harassment, bullying or abuse from other colleagues	88%	82%	• We are safe and healthy
q23a. Received appraisal in the past 12 months	90%	84%	• We are always learning
q11a. Organisation takes positive action on health and well-being	61%	55%	• We are safe and healthy
q19d. Feedback given on changes made following errors/near misses/incidents	66%	60%	• n/a / quality link
Most improved scores	**Org 2024**	**Org 2023**	
q13d. Last experience of physical violence reported	75%	70%	• We are safe and healthy
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	69%	65%	• n/a
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	77%	74%	• We are safe and healthy
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	55%	53%	• n/a
q12e. Never/rarely worn out at the end of work	21%	19%	• We are safe and healthy

Areas of high performance vs peers; most improved scores & link to People Promise area

The Rotherham NHS Foundation Trust

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	61%
q23b. Appraisal helped me improve how I do my job	23%	26%
q24b. There are opportunities for me to develop my career in this organisation	51%	54%
q2a. Often/always look forward to going to work	52%	54%
q12c. Never/rarely frustrated by work	20%	22%

- Engagement – advocacy / quality link
- We are always learning - appraisal
- We are always learning - development
- Engagement – motivation
- We are safe and healthy - burnout

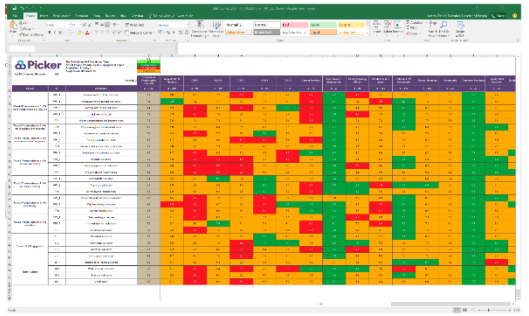
Most declined scores	Org 2024	Org 2023
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	60%	65%
q3e. Involved in deciding changes that affect work	52%	56%
q24e. Able to access the right learning and development opportunities when I need to	59%	63%
q24d. Feel supported to develop my potential	57%	61%
q20a. Would feel secure raising concerns about unsafe clinical practice	73%	76%

- Voice that counts – raising concerns / quality link
- Voice that counts - autonomy
- We are always learning - development
- We are always learning - development
- Voice that counts – raising concerns / quality link

Staff survey breakdown and variation opportunity

The Rotherham NHS Foundation Trust

- Senior leaders have been provided with breakdowns of the staff survey results at different levels to inform local ‘We said we did’ action planning.
- Triangulation with team context and demands is vital to understand opportunities and challenges.
- The free text comments also paint a picture of variation of staff experience, for example;



1. People feeling valued, included and supportive – and others setting out that they have been received poor treatment and felt excluded
2. People feeling well managed – and others feeling underappreciated and questioning the recognition they receive for loyalty/long service
3. People citing that they can make improvement to work – and others feeling their suggestions are ignored and/or they are not communicated with well enough
4. People feeling they are supported in their health and wellbeing – and others feeling stressed, burnt out and identifying staffing shortages
5. People feeling they can develop – and others expressing frustration as to the lack of development options or career progression
6. People feeling that they can work flexibly – and others citing inconsistency with policy application and debating the merits of flexible working for some roles
7. People identifying a positive team spirit and camaraderie – and others citing poor team dynamics, favouritism and feeling understaffed and overworked

- MS Co-pilot has identified the following for senior leaders to work to level up the staff experience across each care group and corporate team to ensure that everyone has a positive experience - work to promote (not in any order); managerial support; team dynamics; job satisfaction; health and wellbeing and a quality experience of appraisal.
- Trust wide We said we did plan end of year 24/25 position and 25/26 priorities are being considered at Executive Team meeting on the 1st May and a verbal update will be provided.

The needs of our people

The Rotherham NHS Foundation Trust

Extract from Trust People and Culture strategy p17

Achieve potential
- I can achieve my potential
- I inspire and support others
- I deliver excellent services and quality patient care

Esteem
- I do a great job
- I am recognised and valued
- I make improvement happen

Belonging
- I belong to an inclusive team
- I can develop and learn
- I am treated fairly as a unique individual

Safety and security
- I know my shifts at least 6 weeks in advance
- I have any reasonable adjustments in place and my wellbeing is supported
- I have the tools to do my job
- I know there is zero tolerance of bullying, violence, discrimination and harassment

Core needs
- I have access to; parking / transport options, lockers, toilets, decent food, water and wifi
- I know there are enough people on the shift, the temperature is ok, there are decent rest areas and I can take my break

One of our new colleagues Dr Catherine Anderson has updated Maslow's hierarchy of needs for the 21st Century for TRFT. The idea behind the model is that as humans we have different types of need that we wish to have fulfilled - the headings in the model. The higher needs and outcomes begin to emerge when people feel the previous needs have been satisfied. For us all to achieve our potential we need to make sure that the needs of each level are met.

We have developed this further based on feedback from our people when creating this strategy and from the staff survey free text comments. We will use it to continue to improve our approaches to meeting the needs of our people across the Trust.

Adapted from Dr Catherine Anderson, 2024

Public Board of Directors' Meeting
2nd May 2025

The Rotherham NHS Foundation Trust

Agenda item	P71/25
Report	**Freedom to Speak up Guardian Quarter 4 and Annual Report 24/25**
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. 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 the Quarter 4 update and the annual update of the concerns which have been raised through the Freedom to Speak up Guardian in 2024-2025 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 • The appointment of a new Freedom to Speak Up Guardian in March 2024 • Increase from 0.4 to 0.6 WTE for New FTSUG Lead role • National Freedom to Speak up Policy for the NHS available on the internal and external website • Increase in number of staff raising concerns • Changes in the role and network of the Freedom to speak Up Champions
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Quarterly report was received at People Committee on 25th April 2025 and the Annual Report was received at Audit and Risk Committee on the same date. Discussions were held within both meetings regarding how future reports could be strengthened through the inclusion of triangulation data.
Board powers to make this decision	The Board of Directors are asked to note the developments within the FTSU service over the last year and support the proposals to strengthen triangulation of data.

Who, What and When (what action is required, who is the lead and when should it be completed?)	The FTSU Guardian will liaise with individuals investigating concerns to ensure this happens going forward and will incorporate any themes identified into future reports.
Recommendations	It is recommended that the Board note the contents of this report.
Appendices	None

Freedom to Speak up Guardian Annual Report 24/25

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 FTSU in 2015, with a FTSUG lead appointed in October 2016.

2. Background

2.1 The report aims to provide the ARC with a high-level overview of the activity undertaken by the FTSUG during 2024-25, highlighting the number of concerns raised, actions taken and resultant learning**.**

3. Policy, Reporting and Governance

3.1 The National Guardian's Office (NGO), in collaboration with NHS England (NHSE), developed a National FTSU policy template. All NHS organisations are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of both patients and workers.

3.2 The policy was approved by the Operational Workforce Group and the Joint Partnership Forum in July, and subsequently ratified by the Trust's Document Ratification Group in August 2024. The National Policy is now available on The Rotherham NHS Foundation Trust's internal and external web pages, ensuring compliance with national requirements and promoting a culture of openness and transparency across the Trust.

3.3 The FTSUG lead has remained the responsibility of the Chief Nurse. The FTSUG lead during this reporting period was Harjot Khaira who covered the role on a 0.6 WTE since March 2024. The FTSUG role is a standalone role.

3.4 During the 2024-2025 reporting period, a total of 47 individuals raised concerns directly with the FTSUG. These concerns resulted in the management of 38 separate cases, as 9 concerns were addressed collectively as 2 grouped cases.

3.5 Of the 38 FTSU cases managed, 21 were successfully closed. Among the closed cases, one required a formal investigation process. The remaining 20 cases were closed following other resolution processes. These resolution processes included discussions with individuals, mediation, appropriate signposting to existing services, and support in managing professional working relationships. This approach underscores our commitment to addressing concerns promptly and effectively. By collaborating with staff, we ensure that the most appropriate approach is utilised for each individual concern, making sure that everyone feels supported and heard throughout the process.

3.6 Currently, there are 17 ongoing FTSU cases from 2024-2025 reporting period. These cases are being managed through a combination of informal support processes. It is important to note that while some of these cases may eventually necessitate a formal process, the need for such escalation remains uncertain at this stage. This approach ensures that each case receives the appropriate level of attention and support, tailored to its specific circumstances.

3.7 The FTSUG lead meets regularly with the Chief Executive, Chief Nurse and Director of People, which provides an opportunity for discussion regarding issues raised, and potential learning opportunities. The FTSUG lead has regular support from the Non-Executive Director for FSTU regarding issues and themes.

3.8 Figure 1 shows the Trust's overall compliance rating of 90.4% for FTSU MaST e-learning training with every care group being above the Trust set target of 85%.

Figure 1: FTSU MaST Compliance

Freedom to Speak Up - for all workers MAST	
Care Group	**Sum of % Compliance**
Care Group 1	**89.6%**
Care Group 2	**94.4%**
Care Group 3	**91.0%**
Care Group 4	**90.7%**
Corporate	**86.3%**
Grand Total	**90.4%**

4. Summary of FTSU Concerns for TRFT

4.1 During the 2024-2025 reporting period, the FTSUG received concerns across several key themes. 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.

The distribution of these cases is as follows:

- Inappropriate Attitude or Behaviour: 30 cases
- Worker Safety & Wellbeing: 25 cases
- Harassment & Bullying: 15 cases
- Patient Safety & Quality in Care: 10 cases

4.2 The largest number of concerns were related to Inappropriate Attitude or Behaviour, with 30 cases reported. This indicates a significant area for potential improvement. Addressing these concerns has been an ongoing focus for the FTSUG who is working in collaboration with Senior Leadership Teams and the OD&I team to implement targeted support focussing on professional conduct, enhancing communication skills, and fostering a respectful workplace culture.

4.3 There is also a notable number of cases related to Worker Safety & Wellbeing, with 25 cases reported. This suggests a correlation between inappropriate behaviour and

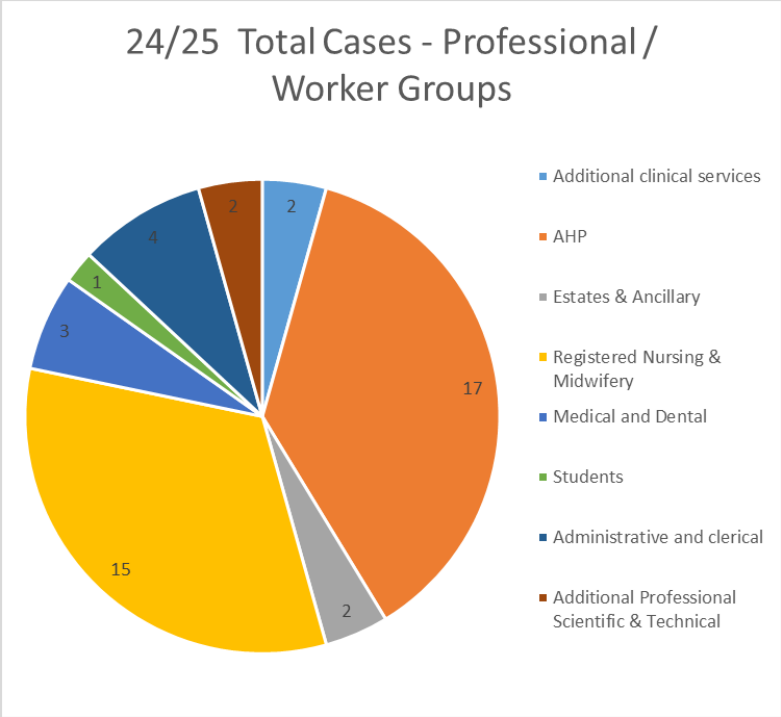
overall worker safety and wellbeing. Improving workplace behaviour could have a positive impact on the safety and wellbeing of staff.

4.4 During the 2024-2025 reporting period, there were 10 concerns raised relating to Patient Safety and Quality in Care. One of these concerns was escalated and reviewed by the Trust Incident Review Panel. Although this concern did not lead to a further investigation, it did result in the identification of learning and improvement recommendations.

4.5 By focusing on these areas, particularly the largest category of inappropriate behaviour's, and understanding the correlations with worker safety and wellbeing, the Trust can implement targeted interventions to create a safer and more supportive working environment.

4.6 The FTSUG is committed to ensuring that all staff groups within the Trust are represented and that the message of speaking up reaches every corner of our organisation. The FTSUG is assured that concerns are being received from across the board, reflecting a diverse range of staff groups accessing the FTSU route, figure 2 shows the number individuals accessing the FTSUG by professional/ worker group.

Figure 2: 2024-2025 Total Cases Raised by Professional / Worker Groups



4.7 To address the needs of hard-to-reach and less engaged groups, targeted face-to-face sessions have been conducted. These sessions are designed to encourage open communication and ensure that every staff member feels empowered to raise their concerns. This proactive approach helps to bridge any gaps and ensures that the speaking up message is effectively communicated to all staff categories.

4.8 A key element in achieving this representation is the establishment of a network of FTSU Champions. The Champions are visible and accessible across various care groups, providing a supportive presence and acting as points of contact for their

colleagues. Their visibility and active engagement ensure that the speaking up message is reinforced and that staff feel represented and supported.

4.9 The network of Champions, combined with targeted face-to-face sessions, ensures that the Freedom to Speak Up culture has a broad reach and that staff groups are adequately represented. This approach helps foster a culture of openness and transparency, whereby staff feel confident and supported in raising their concerns.

5. Feedback following Raising a FTSU Concern

5.1 During the 2024-2025 reporting period, eight feedback forms were completed for FTSU cases where resolution has been achieved. Collecting feedback has proven challenging, as individuals tend to disengage once a case is closed. Despite this, the overall feedback received was positive, with all respondents indicating that they would speak up again. This question is a core component of the quarterly data submission to the National Guardian's Office.

5.2 To improve the feedback process, the FTSUG is planning to introduce anonymised feedback forms accessible via a QR code. This approach will improve the feedback process by:

Anonymity: By ensuring anonymity, staff may feel more comfortable providing honest and constructive feedback without fear of repercussions.

Convenience: QR codes offer a quick and easy way for individuals to access the feedback form, increasing the likelihood of participation.

Accessibility: The use of QR codes allows for feedback to be collected at any time and from any location, making it more accessible to all staff members.

Efficiency: Anonymised digital feedback forms will make it easier to compile and analyse feedback for reporting purposes.

5.3 By introducing digitalised feedback forms, the FTSUG aims to increase engagement and obtain more comprehensive insights into the effectiveness of the FTSU process. This will ultimately contribute to continuous improvement and a more supportive environment for all staff members.

6. Raising the Profile of FTSU within TRFT and FTSU Champions

6.1 In addition to the Lead Guardian, the Trust now has 13 FTSU Champions. The Champions represent a broad spectrum of staff groups, including Additional Clinical Services, Medical, Professional Scientific, Registered Nursing, Allied Health Professionals (AHP), and Administrative and Clerical workforce.

6.2 The recruitment process for Champions is ongoing and in-line with the standards set out by the National Guardian’s Office (NGO), efforts to raise the profile of FTSU continue, there has been increasing interest in the role across the Trust. The FTSUG aims to expand the number of Champions to 20, aligning with other local and similarly sized organisations.

6.3 While there is already representation across the main staff groups, the FTSUG seeks to further diversify the Champion profile. The goal is to ensure a more reflective

representation of the Trust's staff demographics, including those with protected characteristics, thereby ensuring that the Champions truly represent the entire workforce population. By having a diverse and representative FTSU champion network, this helps address some of the barriers to speaking up that organisations face.

7. National Guardian Office Data

7.1 The Trust has submitted data on a quarterly basis to the NGO.

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 demonstrates a slight deterioration in scores compared to last year, however, this remains above the national average. This relates to:

Question 25e - *I feel safe to speak to about anything that concerns me in this organisation* (65.26% compared to average score of 60.29% and 66.89% last year)

Question 25f – *If I spoke up about something that concerned me I am confident my organisation would address my concern* (53.16% compared to average score of 48.23% and 55.46% last year).

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 2024/2025.

10. Conclusion

10.1 The 2024-2025 reporting period has demonstrated progress in fostering a culture of openness and transparency within TRFT. The appointment of a new FTSU Guardian and the expansion of the FTSU Champion network have been pivotal in ensuring that all staff groups are represented and that the speaking up message reaches every corner of the organisation.

10.2 The Trust has seen an increase in the number of concerns raised in this reporting period (47) compared to 2023-2024 (7), reflecting growing confidence among staff to voice their issues. The majority of these concerns have been resolved through informal processes, underscoring our commitment to addressing issues promptly and effectively. The introduction of anonymised feedback forms via QR codes is expected to further enhance the feedback process, providing valuable insights for continuous improvement.

10.3 Moving forward, the Trust remains dedicated to supporting a transparent and open culture where all staff, including agency workers, temporary workers, contractors, students, volunteers, governors, and other stakeholders, feel encouraged and confident to speak up. By continuing to collaborate with the Organisational

Development & Inclusion team and leveraging the insights from staff surveys, FTSUG aims to implement targeted interventions that will further improve workplace culture and behaviours.

10.4 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.

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Freedom to Speak up Guardian Quarter 4 update

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.

2. Background

2.1 The report aims to provide the PCC with a high-level overview of the activity undertaken by the FTSUG during quarter four, highlighting the number of concerns raised, the themes that underpin the concerns and resultant learning**.**

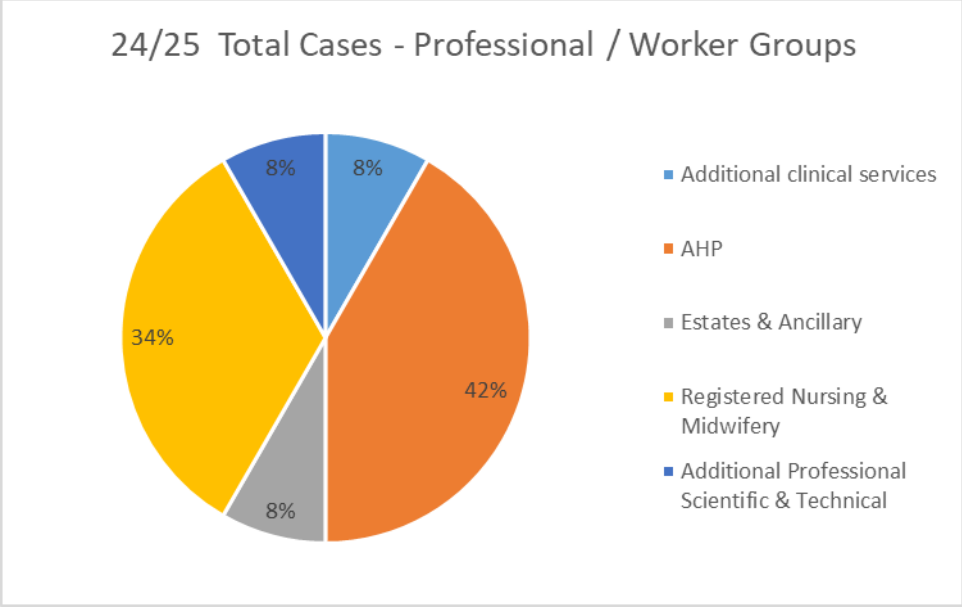
2.2 FTSU will help our organisation deliver on the People Promise for workers, by ensuring they have a voice that counts and that our staff to feel 'safe and confident to speak up', the FTSUG and Champions take the time to really listen to understand to the concerns that are raised. By developing a speaking up culture in which leaders and managers value the voice of their staff FTSU is 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. The National Policy is available on TRFT's internal and external web page.

3.2 During this reporting period 12 individuals have raised concerns directly with the FTSUG.

Figure 1: Total Number of Individual Concerns across Professional/Worker Groups Q4 24/25

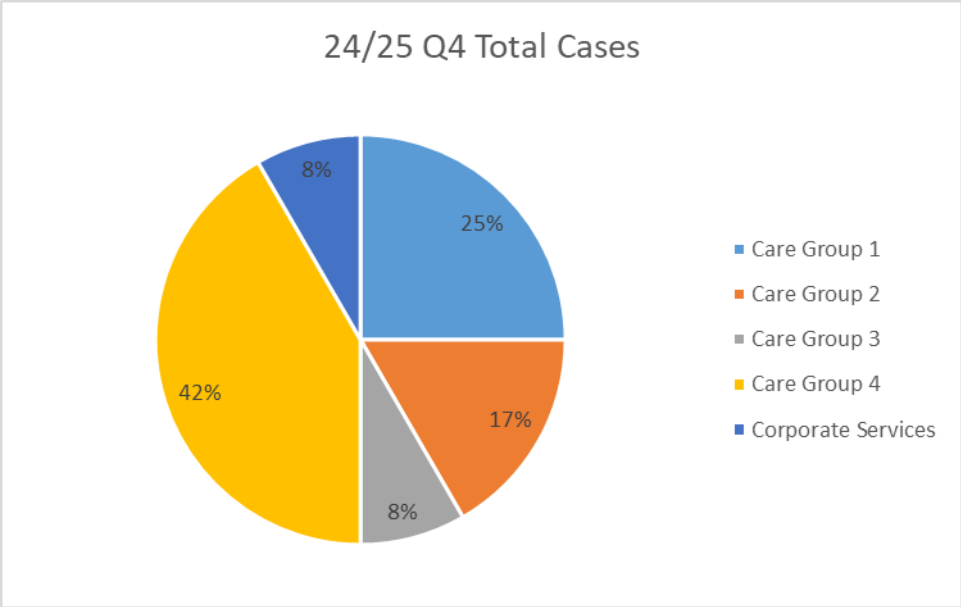


3.3 Figure 1 represents the 12 individual concerns raised across professional / worker groups within the Trust in Q4. The largest number of concerns raised are from within the AHP and Registered Nursing & Midwifery staff groups. For the purpose of the Q4 report each person that has raised a concern has been counted as a separate case, even where several individuals may have spoken up about the same matter, this is due to each worker having different desired outcomes and feedback requirements in Q4 which differs from the Q3 report.

3.4 NHS England's National Workforce Data set incorporates 9 professional and worker group categories. The concerns raised across the Trust during all reporting quarters (1st April 2024 – 31 March 2025) incorporates cases from all of the respective 9 professional and worker group categories. As such, the FTSUG is assured that this reflects the awareness and reach of the FTSU route as a mechanism for speaking up across the organisation.

3.5 For the purpose of this report the figures represented in Figure 2 reference the 12 FTSU cases raised split across the Care Groups.

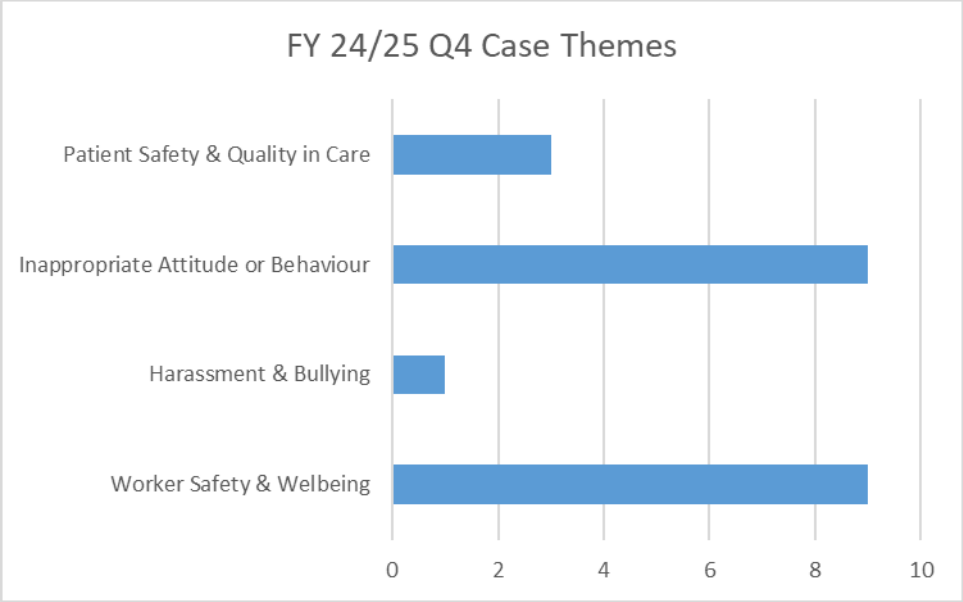
Figure 2: Total Cases Raised Across Care Groups



3.6 For this reporting period 5 of the 12 cases raised with the FTSUG occurred within Care Group 4. Although this represents approximately 40% of all total cases for Q4 the FTSUG feels that having a newly appointed Freedom to Speak up Champion from an AHP background has helped raise the profile of speaking up within Care Group 4. This correlates with the data shown in Figure 1 which shows the largest number of concerns being raised from the AHP professional / worker group.

3.7 A breakdown of the themes underpinning the concerns can be seen in Figure 3. 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.

Figure 3: Number of Cases with Associated Theme Q4 24/25



3.8 Inappropriate attitudes and behaviours and worker safety and wellbeing are the most common themes found in 9 of the 12 cases reported. The FTSUG finds that for many of the individuals raising concerns, inappropriate attitudes and behaviours experienced has a direct link with their wellbeing. This is a theme which has been identified throughout the quarterly reports for 2024-2025. The FTSUG recognises that inappropriate behaviours and attitudes has an impact on staff wellbeing, and although it continues to be a reoccurring theme throughout 2024-2025, the concerns raised have not required formal HR management processes.

3.9 Of the 12 cases raised in Q4, none of which resulted in formal HR process management. Only 1 of the 12 concerns raised in Q4 has been closed during the time the report was completed.

3.10 During the 2024 -2025 reporting period 47 individuals raised concerns directly with the FTSUG, this led to 38 separate cases as two cases were managed as a grouped concern. Of the 38 FTSU cases, 21 are now closed. Of the cases closed 1 required formal investigation process and the remaining 20 cases resolution was achieved by informal processes. This may have involved informal discussion with individuals, mediation, appropriate signposting to existing services, and support with managing professional working relationships.

3.11 The FTSUG meets regularly with the Chief Nurse, Chief Executive and Head of OD&I, which provides an opportunity for discussion regarding concerns raised, and potential for learning and improvement opportunities. The FTSUG lead has regular support from the Non-Executive Director responsible for FSTU regarding issues and themes.

3.12 Figure 4 represents the Trust's overall compliance rating of 90.4%, the training compliance has increased since the appointment of the new FTSUG from Q1 of 79.9% for FTSU MaST e-learning training. This is above the Trust set target of 85%.

Figure 4: FTSU MaST Compliance

	Freedom to Speak Up - for all workers MAST
Care Group	**Sum of % Compliance**
Care Group 1	**89.6%**
Care Group 2	**94.4%**
Care Group 3	**91.0%**
Care Group 4	**90.7%**
Corporate	**86.3%**
Grand Total	**90.4%**

4. Summary of FTSU Concerns for TRFT

4.1 It remains difficult to identify common themes and trends across the quarterly concerns. Concerns raised with themes of inappropriate behaviours and attitudes and staff wellbeing continue to be seen throughout the quarterly reports, this is not specific to Care Group's or Staff Group's and is experienced by many of the individuals raising concerns. This remains a focus for the FTSUG, the Guardian is encouraged that individuals continue to access the FTSU route to raise concerns, in order for these to be addressed. This provides an alternative avenue for staff to raise concerns where usual escalation processes may not be appropriate.

4.2 The number of FTSU concerns raised each quarter has varied over the 2024 -2025 reporting period. The FTSUG is not concerned with the fluctuation in numbers each quarter but is assured that concerns continue to be raised. Having a diverse and representative FTSU Champion network has helped raise the profile of speaking up in the organisation, this is reflected by concerns continuing to be raised across the Care Groups and Staff Groups each quarter.

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 are sent to individuals once resolution has been achieved, for Q4 2 forms were returned. For the 2024-2025 reporting period of the cases closed 8 feedback forms have been received. Due to the reluctance in completing the feedback forms it is often challenging to quantify the support provided by the FTSUG and Champion network. However, one feedback received directly by a FTSU champion via email stated 'You made me feel listened to and validated' going on to add 'signposting me to other services also made me aware of where management support was lacking'.

5.2 The feedback received during the 2024-2025 reporting period was positive with individuals stating that they would speak up again. The response to the question 'based on your experience of raising a concern, would you do it again?' is part of the data set required by the National Guardian's Office provided by all FTSUG's. The

feedback stated that all 8 individuals felt that their concern had been taken seriously and that they were treated with confidence.

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. During Q4 the FTSUG limited the delivery of their face to face training sessions and walk around due to the seasonal operational pressures and restrictions applied to training during January and February 2025.

6.2

Date	Area	Method of delivery	Participants	Staff Group	Quarter
21/01/2025	Research Team	Face to face	13	Nurses, Medical, HCSW, Admin and Clerical	4
04/03/2025	Student Nurse's Induction	Face to face	43	Pre-registration nurses	4

The activities undertaken by the FTSUG relating to increasing FTSU visibility can be seen in the table below:

6.3 In addition to the lead guardian, there are now 13 Freedom to Speak Up Champions within the Trust. The Champions provide representation across the staff groups, with Champions from the Additional clinical, Medical, Professional scientific, Registered Nursing, AHP, Admin and Clerical workforce. The recruitment process for Champions and raising the profile of FTSU is on-going with interest in the role continuing to increase as the profile raises across the Trust. The FTSUG wishes 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 main staff 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.

6.4 The FTSUG currently has Champion representation across the Care Groups with the exception of Care Group 1. This will be escalated at the April CG1 Performance Meeting by the Chief Nurse as an ongoing issue.

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, 2 and 3 data has been submitted for 24/25. Q4 data is due to be submitted by May 2025.

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 is not currently available.

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 four.

10. Conclusion

10.1 The number of cases for Q4 (12) have decreased from the number of individuals raising concerns in Q3 (23), Q3 was reported across the region as having notably higher number of concerns raised. The FTSUG considers it is worth noting that concerns being raised is reflective of a positive reporting culture not focusing on the number of concerns raised. The increase in cases raised from 2023-2024 (7) to 2024-2025 (47) is aligned with the work undertaken by the FTSUG and Champions in raising awareness of FTSU. The profile raising of FTSU can be reflected in the 47 individuals across the care groups and staff groups that spoke up during 2024-2025. 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 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
2 May 2025

The Rotherham NHS Foundation Trust

Agenda item	P15/25
Report	**National, Integrated Care Board and Rotherham Place Update**
Executive Lead	Bob Kirton, 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 latest SYB ICB CEO report • New CEO for the council • Final draft of the Health and Well Being Board Strategy
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Executive Team receives a weekly verbal update covering key Place and South Yorkshire Integrated Care Board (SYICB) level activities in addition to specific papers periodically, as and when required.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Board note the content of this paper.
Appendices	Chief Executive Report, Integrated Care Board Meeting – March 2025

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 NHS England has announced the team who will help lead the organisation's transition into the Department of Health and Social Care. The team – called the NHS Transformation Executive Team – will replace the current NHS England Executive Group and will support ongoing business priorities, statutory functions and day to day delivery. Except for the Deputy Chief Executive Officer, all colleagues will be in post on 1 April 2025 to support this critical work.

The new team – drawn from the existing executive and the wider NHS on secondment – has been appointed following discussion with the Secretary of State, Department of Health and Social Care senior officials, incoming Chair Dr Penny Dash and NHS England's Board. All appointments are subject to the approval of the Board. Permanent recruitment and appointments will be made when the future form and structure is more clear.

3.0 South Yorkshire Integrated Care Board (SYICB)

3.1 An update from the Chief Executive on key matters to members of the Integrated Care Board is included with this report.

3.2 The Trust's work with the SYB Pathology Partnership is progressing and the relationship is maturing. The Trust has had a key focus on the governance arrangements between the Pathology Partnership, with the Head of Nursing & Governance (Corporate Operations) taking a lead for the Trust. The governance arrangements are becoming embedded and cross-partnership working is progressing. The Head of Nursing and Governance (Corporate Operations) is holding monthly Operational and Governance meetings with senior members of the SYB Pathology Partnership Team. A more detailed update will be shared at the May Finance and Performance Committee.

4.0 Rotherham Place

4.1 Discussions have focused on recent announcements regarding the NHS, Department of Health and ICBs. What is expected to change and how this will be managed?

4.2 The RMBC cross-party Senior Officer Appointments Committee will be recommending John Edwards, Director General at the Department for Education, as their next Chief Executive. A teacher by profession, John previously spent 14 years in local government, culminating in a role as Director at Manchester City Council. He then went on to become Regional Schools Commissioner and Chief Executive of the Education and Skills Funding Agency at the Department for Education.

4.3 The Rotherham Together Partnership held a showcase event at the Maltby Learning Trust on the 29th April. The session focused on: Children's Capital of Culture, family hubs, and building stronger communities. The Trust Managing Director was asked to close the event and promote the work of TRFT.

4.4 The latest Health and Wellbeing Board was held on 26th March at the Town Hall. The focus of the session was on the new strategy which was signed off with some further work to be done on priorities for 2025-26. The final draft is attached.

Bob Kirton
Managing Director
May 2025

Draft Health and Wellbeing Strategy for Rotherham 2025-2030

To be published as a live, maintained web page with hyperlinks to additional material.

Vision
Our vision is to enable the people of Rotherham to live happy, healthy, independent lives within thriving communities, regardless of background and personal circumstance.

Foreword from the Chair
TBA

Overview

Our mission is to enhance and support the good health and wellbeing of our residents by empowering individuals and communities, building resilience, providing access to resources and opportunities, and tackling health inequalities.

Our aims are to:

1. Enable all **children and young people** up to age 25 to have the best start in life, maximise their capabilities and have influence and control over their lives.

2. Support the people of Rotherham to live in good and improving **physical health** throughout their lives, accessing and shaping the services and resources they need to be able to do so.

3. Support the people of Rotherham to live in good and improving **mental health** throughout their lives, accessing and shaping the services and resources they need to be able to do so.

4. Sustain an environment where detrimental impacts from **commercial and wider determinants of health** are reduced, and opportunities for healthier living are nurtured.

Introduction

The Health and Wellbeing Board believes that everyone in Rotherham has the right to live a happy, healthy and fulfilled life. The purpose of this strategy is to set out our aims to enable people to live in good and improving health, and to enable effective partnership working to commission and deliver services to realise these aims.

Reflections on the 2020 Health and Wellbeing Board Strategy

This refresh updates the previous 2020 strategy which supported delivery of some important milestones in Rotherham. A selection of these is shared below, with more detail in the appendix.

We have seen the introduction of Family Hubs in Rotherham which provide a range of support and advice services to help families live well and children have the best start in life. Rotherham has pledged to become a Breastfeeding Friendly Borough.

The strategy transformed key care pathways and established new health services to support patients, such as developing state-of-the-art orthopaedic surgery pathways to reduce patient waiting and recovery times and the introduction of lung health checks to detect lung cancer early.

The positive impacts of our suicide prevention and loneliness work have been nationally recognised, and the Board recently approved the Prevention Concordat for Mental Health. We have also implemented targeted mental health support for children and young people.

Rotherham continues to be a national leader in the design and delivery of social prescribing and voluntary sector initiatives to support good health in communities and patient groups. The **Rotherhive** website was launched to facilitate access to a range of services and groups for residents and the workers who support them.

The Health and Wellbeing Board has built a coherent strategic approach to tackle the socioeconomic determinants of health. This includes Rotherham's Sustainable Food Places Bronze award-winning food network, and promotion of physical activity through Healthwave and the voluntary sector. We have also developed a multitude of initiatives to support staff and carers in the Borough, such as workplace health checks and mental health support offers.

However, there have been huge challenges to our society since the last strategy was written. This includes the Covid-19 pandemic and significant pressures on the cost of living. Both have had an impact on general population health and the affordability of services and resources which can support healthy living. This requires us to take stock of our direction and to refocus our efforts.

There have also been new opportunities. This includes the establishment of Integrated Care Systems, which offer more ways of collaborating to join up and co-ordinate our services as we deliver improved population health.

Partnership working in Rotherham is strong. We are in a good position to maintain the momentum needed to be able to face the challenges set out in the context of declining public sector funding. The work that needs to be done will be supported by the South Yorkshire Mayoral Combined Authority, the Rotherham Together Partnership, Rotherham Place Board and the strong bonds between individual organisations in the Borough. Links to the strategies and plans of these organisations can be seen in the Appendix.

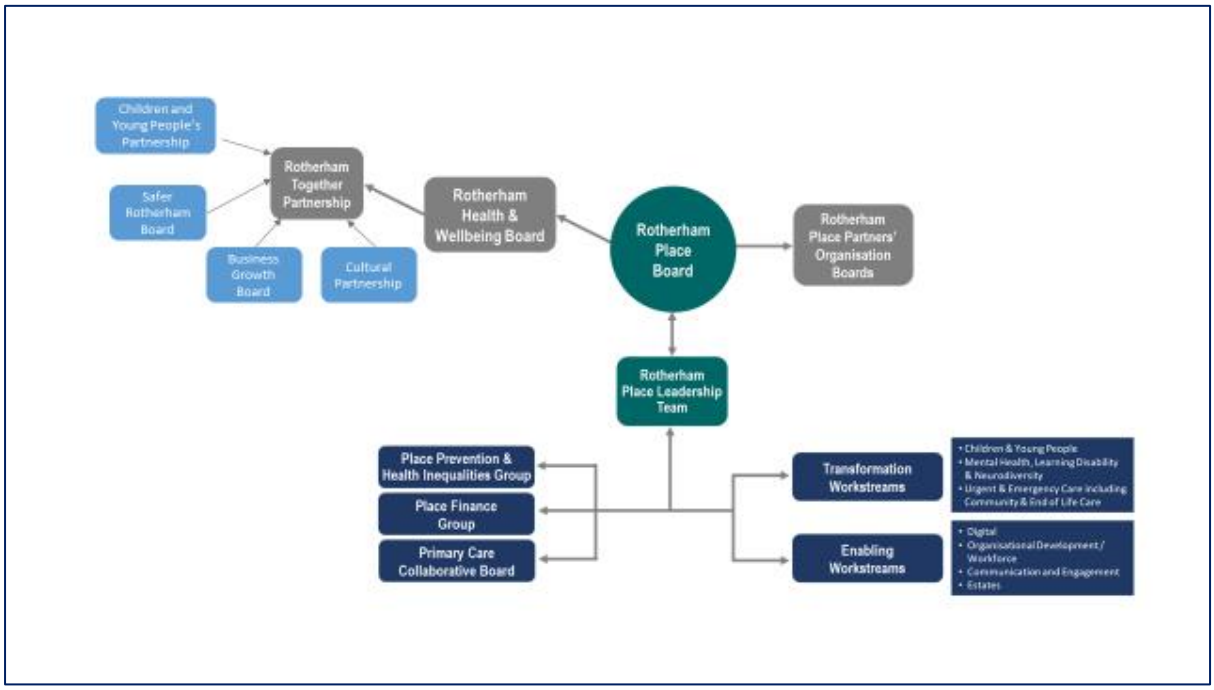


Fig 1. The Rotherham Health and Wellbeing Board in partnership

Developing the 2025-2030 Health and Wellbeing Strategy

We have used several sources of evidence to inform the refresh of the strategy, which are set out in more detail in the next three sections of this page

Partners have used the Joint Strategic Needs Assessment (JSNA) to understand the underlying needs of the population across a range of health-related issues. To this, we added an extensive review of population engagement and consultation activity over the past three years to understand the views and experiences of residents, service users and patients about their health and wellbeing.

We also developed a number of questions to ask residents around the existing Health and Wellbeing Strategy and how it could change in order to promote and maintain good health in Rotherham.

In addition, stakeholder organisations have been consulted about the effectiveness and focus of the strategy in supporting and enabling the delivery of services in the borough.

A summary of this evidence and how it has shaped the development of the strategy is presented below. More detail on each of these evidence bases is available in the appendix.

The needs of our population

The Health and Wellbeing Board has a statutory duty to commission a Joint Strategic Needs Analysis of the local population to highlight health inequalities that need to be addressed. The JSNA looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, wellbeing and social care services.

Rotherham borough covers an area of 110 square miles and has a population of 268,400. Around half of the population lives in the central part of the Borough. Others live in many outlying small towns, villages and rural areas. Rotherham is a diverse borough with a mixture of people, cultures and communities. There are densely populated multi-ethnic inner urban areas, large Council housing estates, leafy private residential suburbs, industrial areas, rural villages, and farms.

There has been significant investment in the health of our population in recent years, but some substantial challenges remain. The points below give a sense of the challenges and opportunities facing us over the next decade. Tools to explore this and further information can be found in the **Rotherham JSNA**.

Population

- Rotherham has an age structure that is slightly older than the national average and a below-average percentage of people aged 18 to 29 because of students leaving Rotherham to study elsewhere, and young adults leaving the area for work
- The population is growing due to there being more births than deaths, and more people moving to Rotherham to live.

Health Inequality

- 36% of the population live in the most deprived quintile. Deprivation is a major cause of health inequalities
- English is not the main language of 4.1% of the population
- Almost nine in ten eligible two-year olds are taking up a place in early education, and nearly three quarters engage with children's centres
- Over 11,000 children in Rotherham are living in absolute poverty
- Over 3,700 people are currently accessing adult social care services, with around half of these over the age of 75
- Over 23,000 people provide unpaid care, with over half of these doing so for more than 35 hours per week. A third of adult carers feel socially isolated
- In 2023, 1,236 families were identified as being at risk of homelessness.
- Life expectancy is lower than the national average for the people of Rotherham, and there is an inequalities gap of over 10 years between the most deprived and least deprived
- Our residents develop poor health earlier than average and live longer in poor health than average. The age to which a female born in Rotherham today can expect to live healthily (without chronic, life-changing illness) is 56.5 years old, and for a male, healthy life expectancy is 58.7 years.

Mental Health

- The prevalence of depression has risen to 17% in 2022, and 25% of school children report issues with mental wellbeing
- Deprivation significantly impacts patient experience and outcomes of chronic pain, mental health, diabetes, cardiovascular and other long term conditions.

Access to care

- Screening uptake rates have generally been good in Rotherham compared to England, but for breast and cervical cancer, screening rates have not yet returned to pre-Covid-19 levels
- Those in the most deprived areas are more likely to miss appointments and experience difficulties in accessing healthcare.

Health behaviours

- Smoking is still the primary cause of morbidity and early mortality. Although smoking rates remain high (14%), every year more people are successfully quitting
- Despite an increase in physical activity rates to 64% of adults in 2021, conditions such as stroke, heart disease and hypertension remain higher than regional and national comparators
- 40% of 11 year-old children and 72% of adults are overweight or obese
- Adult community substance and alcohol services are able to support more people and now reach 950 people per year
- Around 800 people engage in problem gambling, and around 3,200 in moderate risk gambling.

What people are telling us

The themes emerging from the public consultation work were as follows.

Prevention and the importance of accessing support to make and maintain healthy life choices were deemed to be very important, alongside good communication and information.

Access to healthcare and sufficient provision of staff and services was a recurring request from members of the public. Alongside this was a clear message that people want to manage their physical and mental health in a more proactive way, rather than simply being recipients of care from our providers.

The importance of tailoring our services to meet the needs of specific groups was also seen to be important, whether that be through considering protected characteristics, language, stigma, individual access to resources or individual needs.

There was also a strong sense that some of the answers to better health lie in strengthening our community networks and resources, and investing in our natural and built environments. Health at work, poverty reduction and access to healthy food were also identified as key areas for development.

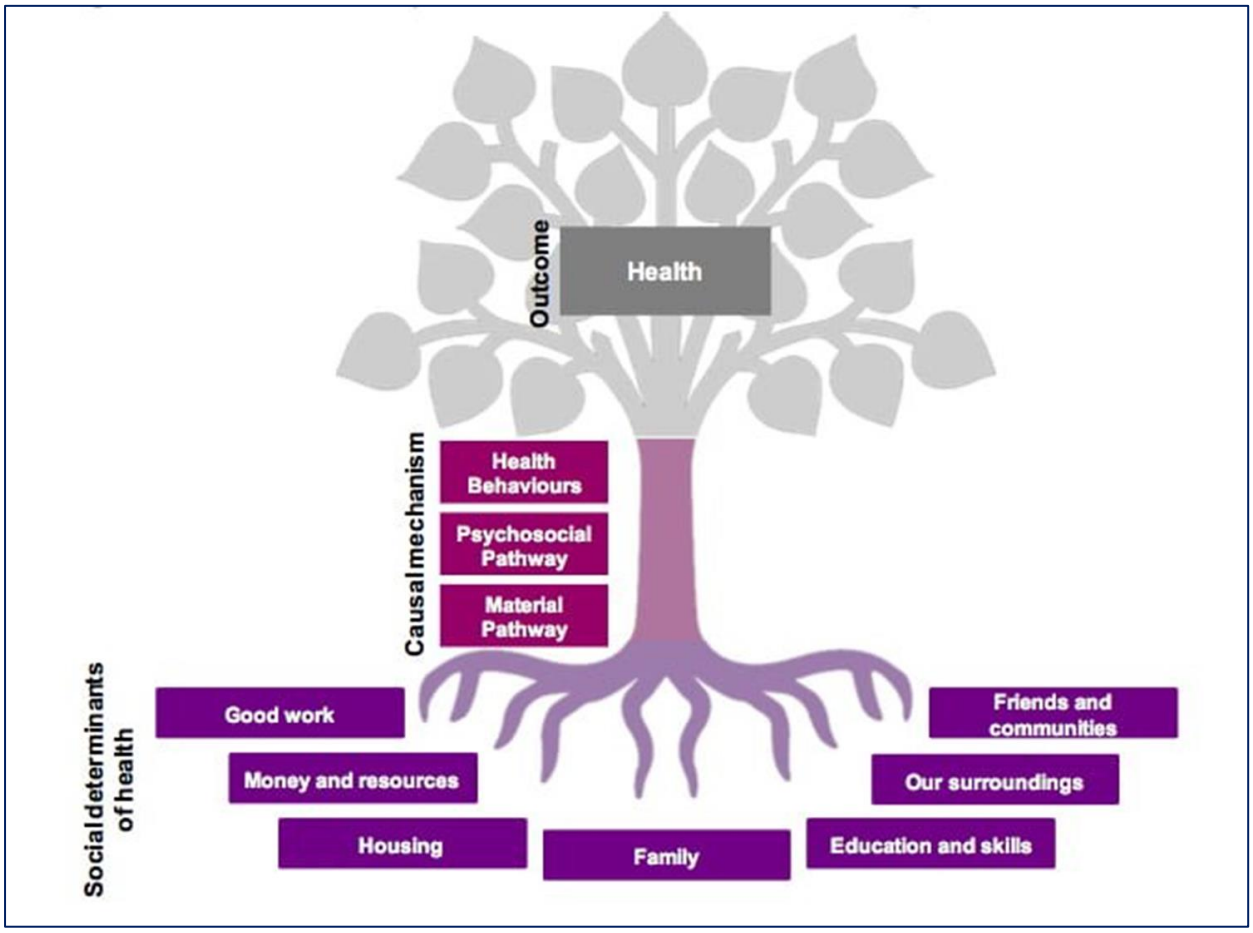


Fig 2. Wider determinants and the causes of the causes of health

Stakeholders and partner organisations identified similar themes, recognising the importance of the wider determinants of health (see picture above), the need to co-produce our plans with our population, and to work towards adopting the Marmot Principles to tackle the social determinants of health (see Box 1). There was also a call for greater visibility of the Health and Wellbeing Strategy and for the system to facilitate joined up collaborative working against clear goals.

Box 1: The Marmot Principles

The recommended actions, covering the main social determinants of health in places are developed in the following areas (known as the 'Marmot Eight' principles):

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together.

Based on these eight principles, Marmot Places develop and deliver interventions and policies to improve health equity; embed health equity approaches in local systems and take a long-term, whole-system approach to improving health equity. Places commit to improve health equity over the short, medium and long term by:

A. Developing and delivering approaches, interventions and policies to improve health equity.
B. Strengthening their health equity systems.
C. Involving communities in the identification of the drivers of poor health and in the design and implementation of actions to reduce them.
D. Broadening advocacy on health equity and engaging with other Marmot Places to share knowledge, roll out best practice alongside partners in local regions and nationally.

What we will do

The Health and Wellbeing Board met in January 2025 to review the aims and priorities of the previous strategy. While the aims were broadly felt to be useful, recommendations were made to update them in order to be clearer about our areas of priority focus over the next five years. The aims and our methods to deliver them have emerged from the evidence and engagement described above.

Our aims now cover - children and young people; physical health; mental health and the wider determinants of health. Alongside the aims we have identified, through consultation, seven ways of working to guide and enable efforts across the partnership to deliver the aims. These are shown below.

Rotherham Health and Wellbeing Strategy 2025-30

Our vision is: *to enable the people of Rotherham to live happy, healthy, independent lives within thriving communities, regardless of background and personal circumstance.*

We will achieve this by:

- Enabling all **children and young people** up to age 25 to have the best start in life, maximise their capabilities and have influence and control over their lives
- Supporting the people of Rotherham to live in good and improving **physical health** throughout their lives, accessing and shaping the services and resources they need to be able to do so
- Supporting the people of Rotherham to live in good and improving **mental health** throughout their lives, accessing and shaping the services and resources they need to be able to do so
- Sustaining an environment where detrimental impacts from **commercial and wider determinants of health** are reduced, and opportunities for healthier living are nurtured

And by working in the following ways:

- Ensuring our practice is evidence-informed
- Applying a strong emphasis on prevention
- Strengthening population independence and resilience
- Tackling health inequality
- Taking a compassionate approach
- Making the most of community assets
- Taking joint responsibility across the system

Fig 3. Plan on a page*: *Our Vision, Aims and Ways of Working

<NB – work in progress - final version to be done professionally and more legibly.>

The ways of working mean that across Rotherham, we commit to the following:

- **Ensuring our practice is evidence informed**
  - Continue to seek high-quality evidence and apply to commissioning and management of services
  - Ensure that community voice is captured and acted upon
  - Follow best practice, but also innovate and share good practice and research back to the wider system
  - Using tools such as the JSNA, Core20 plus 5 and the inclusion framework to ensure that we allocate our resources according to need

- **Applying a strong emphasis on prevention**
  - Developing prevention-promoting environments
  - Developing good educational interventions and information resources for residents and the workforce
  - Promoting screening and vaccine uptake
  - Support to manage long term conditions
  - Consider opportunities for 'upstream' intervention
  - Support early identification of need and intervene with holistic approaches

- **Strengthening population independence and resilience**
  - Supporting individual ownership of health and wellbeing
  - Co-production and co-design approaches to make sure services match need
  - Develop models of care which make the most of non-medical support, such as peer support and voluntary and charity sector services

- **Tackling health inequality, and provide help to those that need it most**
  - Ensure additional support and attention given to groups and individuals who have higher need, have poor experience of services or have poorer health outcomes
  - Seek out and remove physical, social and economic barriers to accessing services
  - Collect the right information to understand these patterns
  - Engage directly with the people of Rotherham to ensure that we understand need
  - Apply Marmot principles to tackle health inequalities across all partnership activity where possible

- **Taking a compassionate approach**
  - Address the social, economic and environmental drivers of health
  - Support people to form healthy habits
  - Recognise and challenge systemic barriers to positive behaviours

- **Strengthening and making the most of community assets**
  - Ensure communities are involved in local decision making
  - Capitalise on the role of strong social connections in health outcomes
  - Encourage communities to support those most at risk

- **Taking joint responsibility across the system to tackle difficult challenges**
    - Strengthen our 'health in all policies' approach
    - Use the power and resources of existing partnership boards and groups to deliver the health and wellbeing agenda
    - Identify gaps and aim to design in joined-up services
    - Empower place partnerships to prioritise pooled resources
    - Deliver joined up multiagency solutions

How we will do it

In the context of increasing demand and stretched public resources, it is clear that our priorities, whilst ambitious for residents, need to be achievable and need to support the wider partnership in applying sufficient focus. The delivery of our aims and priorities will be resourced from the pooled capacity of our individual organisations working together. In addition to supporting and enabling a broad range of projects and interventions, we have chosen to adopt a streamlined prioritisation system for the actions supporting the current strategy.

We will adopt three or four short-term priorities over the five-year period 2025-2030. It is proposed that these priorities are shortlisted and chosen through stakeholder and public workshop events in Spring 2025 and reviewed in 2027.

The criteria for inclusion to the priority shortlist are:

a) Is it an issue which would benefit from cross-partner intervention?
b) Would tackling this issue have a significant impact on our population as a whole, or on one of our key vulnerable groups?
c) Is it possible to make substantial, measureable progress within the given timeframe?

The chosen priorities will be built into a live action plan and a Board level champion will be identified for each priority. Through implementation of a regular cycle, progress will be reported and discussed at Board meetings, including updates from supporting groups and other work associated in the delivery of the plan. Progress on our aims, priorities and action plan will be reported through the HWB website.

How we will see the impact

We will track our success in improving health and wellbeing in Rotherham through monitoring existing outcomes frameworks. The **Rotherham JSNA** will continue to provide insight into the detail of the health of our population. In addition, we will be monitoring the high-level outcomes of the **South Yorkshire ICB Outcomes Framework**.

As part of the public consultation about the strategy, a range of questions have been developed to ask residents which, alongside various engagement events, will be

used to gauge changing needs and priorities in the community. These will be regularly presented to Health and Wellbeing Board for discussion and challenge.

Live Action Plan

<This section is not part of the strategy *per se*, but will be linked on the website as a live document>

Placeholder section for when the priority/ horizon scanning workshop is held in April, but structure will be:

1. One page each on our three priorities with a brief paragraph as to why chosen, SMART outcomes and expected impact.

2. The full action plan split by aim (similar to current action plan)

Glossary

Core20PLUS5: a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Health Inequalities: avoidable, unfair and systematic differences in health between different groups of people. There are many kinds of health inequality, and many ways in which the term is used. This means that when we talk about a specific 'health inequality', it is useful to be clear on which measure is unequally distributed, and between which people.

HWB: Health and Wellbeing Board. This is the statutory body with responsibility to set the strategic direction for local population health and wellbeing.

ICB: Integrated Care Boards are NHS organisations responsible for planning health services for their local population. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which says how the NHS will contribute to the integrated care strategy.

ICS: Integrated Care Systems are local partnerships that bring health and care organisations together to develop shared plans and joined-up services.

JSNA: The Joint Strategic Needs Assessment looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services. It takes a wide view of health and is concerned with wider social factors that have an impact on people's health and wellbeing, such as housing, deprivation and employment, it can be used to identify health inequalities, and it identifies gaps in health and care services, documenting unmet needs.

Stakeholders: Everyone with an interest in supporting and improving the health and wellbeing of the people of Rotherham.

Wider Determinants of Health: The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. Systematic variation in these factors constitutes drives health inequalities.

Appendices

<to link>

JSNA slide deck
Consultation slide deck
Links to associated groups
Links to Rotherham inclusion framework, Core 20+5, and other documents
Successes of the 2020-25 strategy slide deck

Board of Directors' Meeting
2 May 2025

Agenda item	P/73/25
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 March 2025 (Month 12 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 was the requirement to improve the 2024/25 planned deficit from £6,302K to £584K

	• Section 2 – Income & Expenditure Account for March 2025 (Month 12 2024/25: o Financial results for March 2025. - A control total surplus to plan of £1,042K in month and £883K year to date against the plan deficit of £584K. In-year, the Trust agreed within the SY ICS to work to a target control total deficit of £184K, the Trust has achieved a £299K surplus in 2024/25 and met its requirement to breakeven. - 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 £1,059K). • Section 3 – Capital Expenditure for March 2025 (Month 12 2024/25) o Results for March 2025 show expenditure of £9,673K in month and £16,940K year to date. The Trust delivered its capital expenditure plan. The under-spend of £249k was forecast and is required to meet the SY ICS' overall capital spending limit. • Section 4 – Cash Flow 2024/25 o A cash flow graph showing actual cash movements between April 2023 and March 2025. A month-end cash value as at 31st March 2025 of £15,912K, which is £14,446K favourable to plan, in part due to the deficit funding, additional Public Dividend Capital being received for the infrastructure development of the Urgent and Emergency Care Centre and the timing of payments falling due after 31st March 2025.
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 Managing Director. 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 April 2025. • CIP performance was discussed at the Efficiency Board meeting held on 16th April 2025. • Capital expenditure was reviewed at the Capital Monitoring Group held on 28th April 2025. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 30th April 2025, 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			Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Forecast variance £000s
I&E Performance (Actual)	(102)	781	884	(1,949)	(760)	1,189	(1,809)
I&E Performance (Control Total)	(41)	1,001	1,042	(584)	299	883	(2,279)
Capital Expenditure	8,156	9,673	(1,517)	17,189	16,940	249	0
Cash Balance	(2,261)	5,123	7,384	1,466	15,912	14,446	4,718

1.2 The Trust has under-spent against its I&E control total in March 2025 by £1,042K and year to date by £883K. The Trust agreed within the SY ICS to work to a target control total deficit of £184k, the Trust has achieved a £299k surplus in 2024/25 and met its requirement to breakeven. 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 £1,459K, it is expected that this will improve prior to the deadline for 2024/25 data (data is currently at flex for month 11 and an estimate for month 12).

1.4 Capital expenditure is ahead of plan in month and delivered its plan for 2024/25. The under-spend of £249K was forecast and notified to the SYICS to meet the requirements for the overall system capital spend. The capital programme has continued to be monitored by the Capital Monitoring Group chaired by the Director of Finance.

1.5 The cash position at the end of March 2025 is £15,912K and is favourable to plan by £14,446K. This is due to the receipt of deficit funding, additional Public Dividend Capital for specific schemes, the most significant being for the infrastructure development of the Urgent and Emergency Care Centre, and the timing of payments falling due after 31 March 2025.

2. Income & Expenditure Account for March 2025 (Month 12 2024/25)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered a surplus to plan in March 2025 of £1,042K and £883K year to date. The Trust received surge funding in month 12 which has supported the improvement in the financial position.

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	351,008	30,302	50,590	20,289	351,008	375,594	24,585	
Other Operating Income	26,740	3,376	4,288	912	26,740	32,408	5,668	
Pay	(248,447)	(22,378)	(38,329)	(15,951)	(248,447)	(278,091)	(29,644)	
Non Pay	(115,123)	(14,125)	(16,967)	(2,841)	(115,123)	(126,399)	(11,277)	
Non Operating Costs	(4,743)	(373)	(507)	(134)	(4,743)	(4,271)	472	
Reserves	(11,385)	3,096	1,706	(1,391)	(11,385)	0	11,385	
Retained Surplus/ (Deficit)	**(1,949)**	**(102)**	**781**	**884**	**(1,949)**	**(760)**	**1,189**	
Adjustments	1,365	61	219	158	1,365	1,059	(306)	
Control Total Surplus/ (Deficit)	**(584)**	**(41)**	**1,001**	**1,042**	**(584)**	**299**	**883**	

2.2 Clinical Income is ahead of plan in-month and year to date due to a year end disclosure relating to pension payments of £15,286K (2023/24: £9,499K). These are paid centrally by NHSE during the year and are disclosed in provider accounts at year end, within income and pay, with the overall impact being net neutral. Excluding this, the year to date position would be an over performance of £9,299K. This is largely due to the true up position on the 2023/24 ERF of £1,250K, consultants pay reform £800K, Industrial Action funding £604K, Community Diagnostic Centre (CDC) income of £1,311K, Advice and Guidance £750K, Surge Funding of £1,900K and settlement of income from commissioners. These figures include an adverse year to date position on ERF in 2024/25 of £1,459K (Appendix 3). 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 (£1,107K), which will be an offset to the pay over-spend, and increased research, education and training income (£3,796K) and clinical and non-clinical services (£1,142K).

2.4 Pay costs are over-spending by £15,951K in month and £29,644K year to date. The impact of the pension payment disclosure referred to in clinical income above of £15,286K explains most of the in-month variance. The year to date is further impacted by bank and agency expenditure which is not currently being maintained within the gross establishment budget, and contributing to this is £2,167K under-delivery against the planned cost improvements.

2.5 Non Pay costs are over-spending by £11,277K year to date. The over-spend is largely related to Drugs and Clinical Supplies £7,536K and Premises £1,655K. There is also a year end disclosure adjustment of £700k in respect of the apprenticeship levy (an equal and opposite amount is also included in Other Operating Income).

2.6 The positive performance in Non-Operating Costs is due to the inflationary uplift on the Carbon Energy Fund (Service Concession) lease of £426K.

2.7 Reserves is a favourable position, these have been used to fund the under delivery of ERF, efficiencies and overspends referred to above including the additional capacity over and above funded bed capacity.

3. Capital Programme

3.1 During March 2025 the Trust incurred capital expenditure of £9,673K, and year to date it is £16,940K

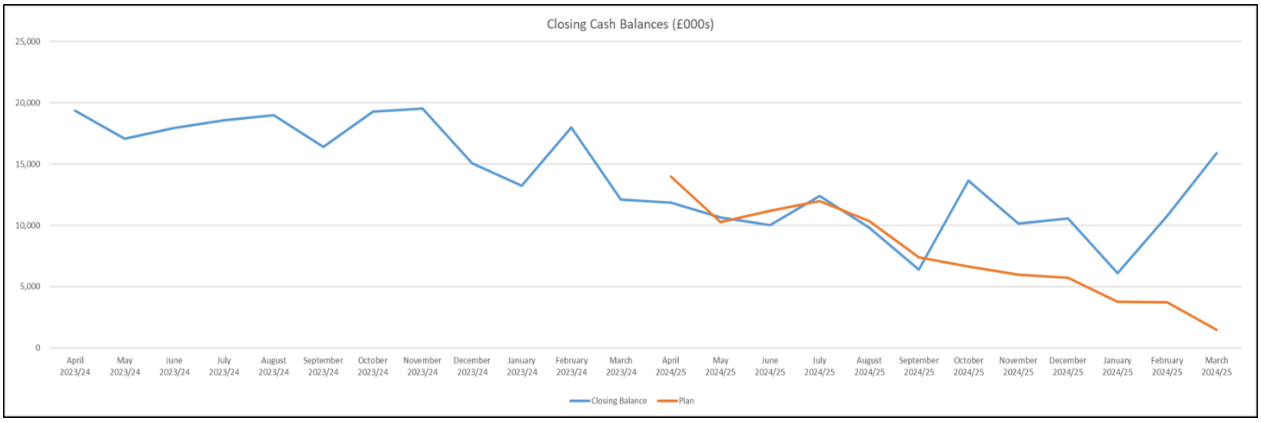
Capital Expenditure	Month			Year to date			Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Forecast Variance £000s
Estates Strategy	5,701	4,028	1,673	8,548	6,340	2,208	0
Estates Maintenance	346	2,744	(2,398)	3,720	4,353	(633)	0
Information Technology	584	1,388	(804)	2,173	3,289	(1,116)	0
Medical & Other Equipment	405	1,513	(1,108)	1,494	2,958	(1,464)	0
Other	1,120	0	1,120	1,254	0	1,254	0
TOTAL	**8,156**	**9,673**	**(1,517)**	**17,189**	**16,940**	249	0

3.2 The forecast capital spend for the year at month 11 was £16,941K. This included an additional £5,904K of capital PDC which was agreed in-year after the plan submission and also an additional capital allocation of £400k from SY ICS.

3.3 Additional PDC capital funding was agreed in Dec 2024 of £7m. This is split over 2024/25 (£5.5m) and 2025/26 (£1.5m). This has been agreed from the Additional Capacity Targeted Investment Fund (ACTIF) to expand our Urgent and Emergency Care Centre (UECC). The funding is to be used to increase our patient capacity for urgent care and minor injuries, medical same day emergency care (SDEC), and to improve our work towards the national four-hour emergency care standard.

4. Cash Management

4.1 The cash position at the end of March is £15,912K and is favourable to plan by £14,446K. This is due to the receipt of deficit funding, additional Public Dividend Capital for specific schemes, the most significant being for the infrastructure development of the Urgent and Emergency Care Centre, and the timing of payments falling due after 31 March 2025. This has allowed the Trust to earn interest on its daily cash balances of £813K year to date.



Steve Hackett
Director of Finance
23 April 2025

Board of Directors Meeting
May 2025

The Rotherham NHS Foundation Trust

Agenda item	P77/25
Report	**Integrated Performance Report**
Executive Lead	Bob Kirton, Deputy Chief Executive
Link with the BAF	D5, D6, P1, R2
How does this paper support Trust Values	The Integrated Performance Report supports the Trust's *Ambitious* value in ensuring we are constantly striving to deliver stronger performance across all of the core domains.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Integrated Performance Report (IPR) provides a monthly overview of the Trust's performance across four key areas: Operational Delivery, Quality, Finance, and Workforce. This report covers data from March 2025, where available, and outlines performance in relation to established national, local, or benchmarked targets. Statistical Process Control (SPC) charts are used throughout this report. A brief explanation of the main features of these charts is provided at the back for your reference.
Due Diligence	The Finance and Performance, Quality Committee Committees and People Committee have received the relevant elements of the Integrated Performance Report or identical information, with the Executive Directors approving the content for their domain.
Board powers to make this decision	In order to be assured of the performance of the organisation, the Board needs to have visibility of the Trust's performance against core metrics.
Who, What and When	The Managing Director is the Lead Executive for reporting on the performance of the organisation through the Integrated Performance Report on a monthly basis.
Recommendations	It is recommended that the Board of Directors note the Trust's performance against the metrics presented in the Integrated Performance Report and receive assurance on the basis of this report.
Appendices	Integrated Performance Report – March 2025

Board of Directors Meeting

Integrated Performance Report - March 2025

Performance Matrix Summary

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • Urgent 2 Hour Response • Turnover (12 month rolling)	**GOOD: CELEBRATE AND UNDERSTAND** • Medication Incidents (Moderate and above) – Acute • FDS	**CONCERNING: CELEBRATE BUT TAKE ACTION** • 1:1 Care in Labour • RTT • Appraisal Rates
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • SHMI • MAST - Core • MAST – Job Specific • Vacancy Rate (total	**STATIC: INVESTIGATE AND UNDERSTAND** • Readmissions • Care Hours per Patient Day • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Patient Falls (Moderate and above) - Community • Medication Incidents (Moderate and above) – Community • Pressure Ulcers (Cat 3 and above) – Acute and Community • C. diff infections • Patient Falls (Moderate and above) – Acute • VTE Risk Assessments • Breast milk first feed • First Outpatients (%Plan) • Inpatients (%Plan) • Daycases (%Plan) • 12hr Trolley Waits • Waiting List Size • 52+ weeks - CYP • 65+ weeks • OP to PIFU • Overdue Followups • DM01 • 31 Day Treatment Standard • 62 Day Treatment Standard • >12 hours in A&E • LoS >21 Days • Date of Discharge = Discharge Ready Date • Patients on Virtual Ward • LoS >7 Days • Mean LoS (Elective) • Mean LoS (Non-Elective) • A&E Attendances from Care Homes	**CONCERNING: INVESTIGATE & TAKE ACTION** • 4 Hour Performance • Average time to be Seen • Criteria to Reside is No • Admissions from Care Homes • Clinic Utilisation • Capped Theatres Utilisation • Did Not Attend • Discharged <5pm • 52+ weeks • Ambulance Handovers >30min • Appraisal Rates (12 month rolling)
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • Stillbirth rate	**CONCERNING:INVESTIGATE & TAKE ACTION** • Combined Positivity Score • Bed Occupancy	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • Sickness Rates (12 month rolling) • Sickness Rates

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	-	-	H		C
Number of 52+ Weeks	200	678	Feb-24	✗	F	H		VC
Number of 65+ Weeks	37	74	Feb-24	✗	?			S

Performance Matrix Summary - Quality

NHS
The Rotherham
NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE**	**GOOD: CELEBRATE AND UNDERSTAND** • Medication Incidents (Moderate and above) – Acute • 1:1 Care in Labour	**CONCERNING:CELEBRATE BUT TAKE ACTION**
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • SHMI	**STATIC: INVESTIGATE AND UNDERSTAND** • Readmissions • Care Hours per Patient Day • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Patient Falls (Moderate and above) - Community • Medication Incidents (Moderate and above) – Community • Pressure Ulcers (Cat 3 and above) – Acute and Community • C. diff infections • Patient Falls (Moderate and above) – Acute • VTE Risk Assessments • Breast milk first feed	**CONCERNING: INVESTIGATE & TAKE ACTION**
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • Stillbirth rate	**CONCERNING:INVESTIGATE & TAKE ACTION** • Combined Positivity Score	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

Quality

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
SHMI	"As expected"	"As expected" (104.8)	Nov-24	N/A	P		-	G
Readmissions (%)	-	5.5	Feb-25	-	-			S
VTE Risk Assessments (%)	95.0	96.4	Mar-25	☑	?			S
Care Hours per Patient Day	7.2	6.8	Mar-25	☒	?			S
Combined Positivity Score (%)	95.0	91.8	Mar-25	☒	?	L	-	C
Complaints (per 10k Contacts)	8.0	13.9	Mar-25	☒	?		-	S
Patient Safety Incident Investigations	3	0	Mar-25	☑	?		-	S
Patients Falls (Moderate and Above per 1000 bed days)	0.2	0.35	Mar-25	☒	?		-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 1000 bed days - Acute	0.8	1.3	Mar-25	☒	?		-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 100 contacts - Community	0.1	0.1	Mar-25	☑	?		-	S
Medication Incidents - Moderate and Above per 1000 bed days – Acute	0.1	0.1	Mar-25	☑	?	L	-	G
Medication Incidents - Moderate and Above per 100 contacts - Community	0.0	0.0	Mar-25	☑	?		-	S
C. difficile Infections	4	2	Mar-25	☑	?			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 Mar 2025

Data, Context and Explanation

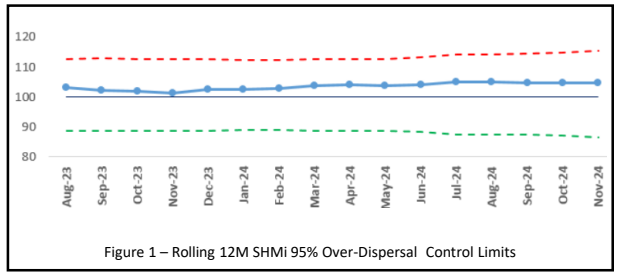


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

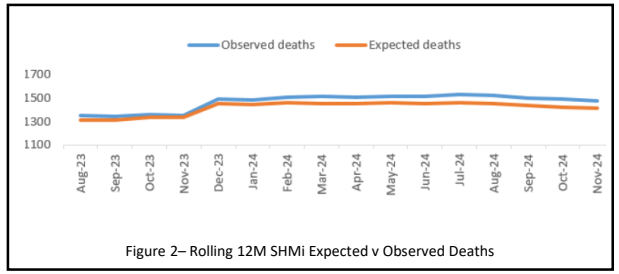


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

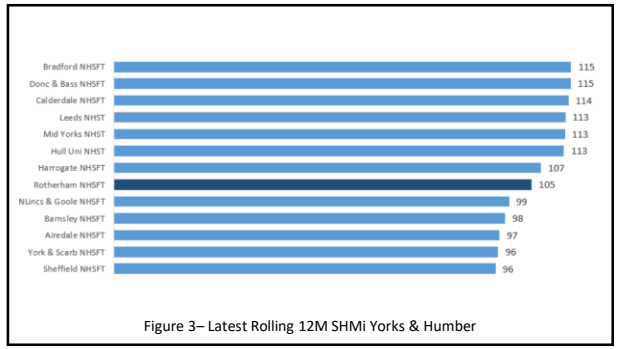


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

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 -Nov 24	104.8	-	Jo Beahan	John Taylor
Expected Deaths	1410	-		
Observed Deaths	1475	-		
Trust Banding	Expected	-		

What actions are planned?

- To highlight when SHMI values are in the higher than expected band (95% Over-dispersion Control Limit) or if a VLAD (Accumulated Risk) Alert has been triggered
- 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?

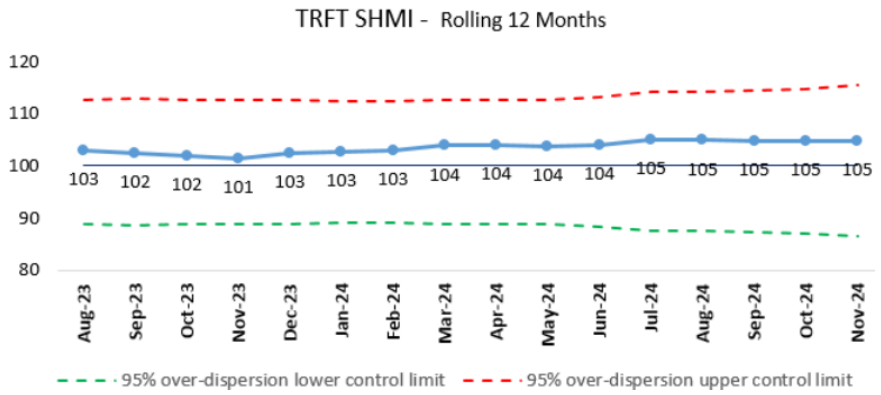
- Investigations or reviews resulting from SHMI investigations will give the Trust Assurance when there are significantly more deaths observed than expected
- Intelligence from SHMI investigations/reviews may lead to changes/improvements in practice

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

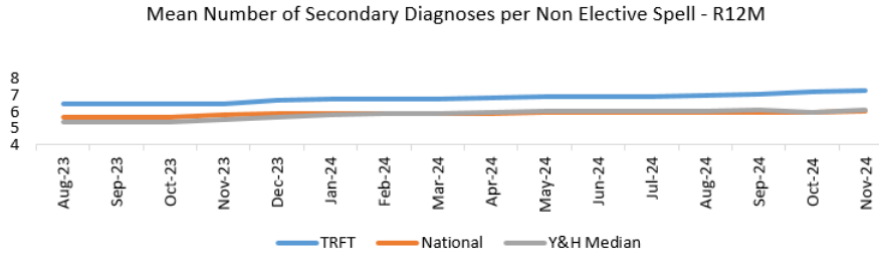
SHMI Update



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: Summary Hospital-Level Mortality Indicator

SHMI: Coding & Alerts

SHMI - Diagnostic Group Alerts

TRFT currently has no alerts for its diagnostic groups.

The last alert was for Fluid & Electrolyte Disorders for the SHMI release in Sept 2024.

Diagnosis Group	SHMI Banding	VLAD Alert (Accumulated Risk)
Acute bronchitis	As Expected	No
Acute myocardial infarction	As Expected	No
Cancer of bronchus; lung	As Expected	No
Fluid and electrolyte disorders	As Expected	No
Fracture of neck of femur (hip)	As Expected	No
Gastrointestinal hemorrhage	As Expected	No
Pneumonia (excluding TB/STD)	As Expected	No
Secondary malignancies	As Expected	No
Septicaemia (except in labour), Shock	As Expected	No
Urinary tract infections	As Expected	No

SHMI Changes – Methodology, Process or Specification

No new changes

SHMI Coding Metrics –

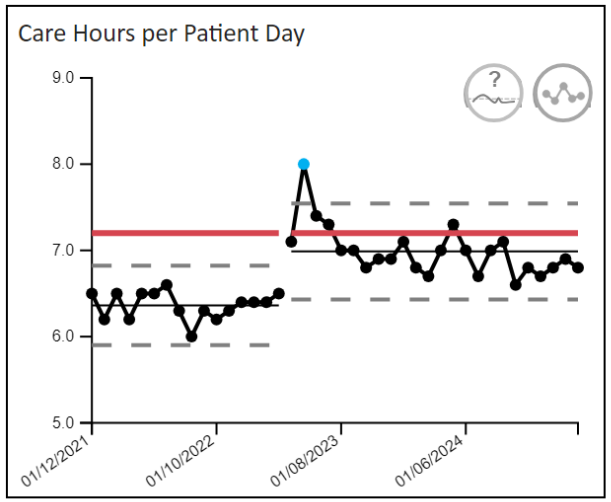
TRFT continue to have a high rate of spells with an Invalid Primary Diagnosis Code and where the code is a Sign or Symptom.

TRFT continue to have a high depth of comorbidity coding for its non elective spells.

TRFT Rank of 13	3rd Highest	2nd Highest	2nd Highest	7th Highest	4th 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**	**% of Spells with palliative care**	**% of deaths with palliative care**
Harrogate NHSFT	35.9	25.0	4.1	1.6	29
Rotherham NHSFT	16.1	3.2	7.2	2.0	45
Bradford NHSFT	8.6	1.5	4.0	1.3	42
Mid Yorks NHST	8.8	0.5	6.8	2.3	44
Donc & Bass NHSFT	12.7	0.1	5.1	2.2	51
NLincs & Goole NHSFT	17.4	0.1	4.7	1.3	28
Barnsley NHSFT	14.6	0.0	7.7	2.5	49
Sheffield NHSFT	9.9	0.0	5.2	1.8	38
Hull Uni NHST	8.3	0.0	6.2	2.3	37
Leeds NHST	5.6	0.0	6.5	2.2	36
York & Scarb NHSFT	13.5	0.0	6.1	1.2	27
Calderdale NHSFT	6.7	*	7.1	3.2	50
Airedale NHSFT	15.0	*	4.7	1.2	24
England	14.8	2.7	6.0	2.1	44

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 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.
- CHPPD for March was 6.8 against planned 7.2
- Percentage of fill rate against funded establishment is below;
- Fill rates for RN days was 92%
- Fill rates for HCSW days was 88%
- Fill rates for RN nights was 97%
- Fill rates for HCSW nights was 109%
- Twice daily staffing huddles continue and actions fed into bronze operational meeting.
- The safe staffing escalation SOP is used to ensure all areas are safely staffed.
- All staff redeployments, unavailability's and bank and agency use are picked up in roster meetings and weekly bank/agency meeting.

Metric	Target	Value	Exec Lead	Ops Lead
Care Hours per Patient Day	7.2	6.8	Helen Dobson	Cindy Storer

What actions are planned?

- Continued roll out of the Exemplar Accreditation programme to triangulate CHPPD with patient outcomes.
- Recruitment cycle for September NRN/NRM has started
- Retention work still sees sustained improvements in leaver rates
- B4 winter ward on roster

What is the expected impact?

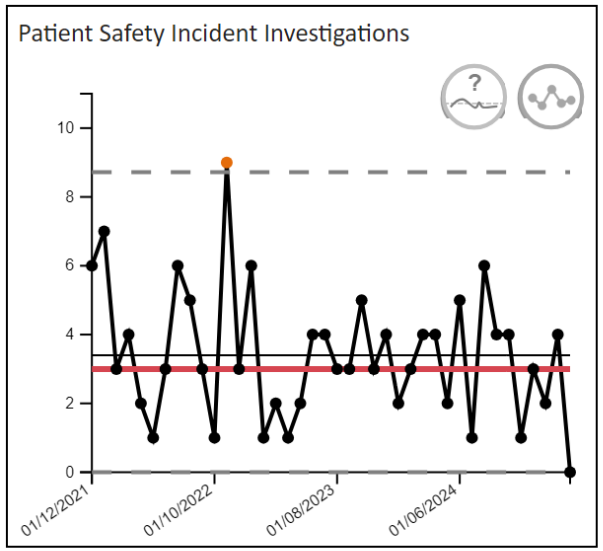
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.

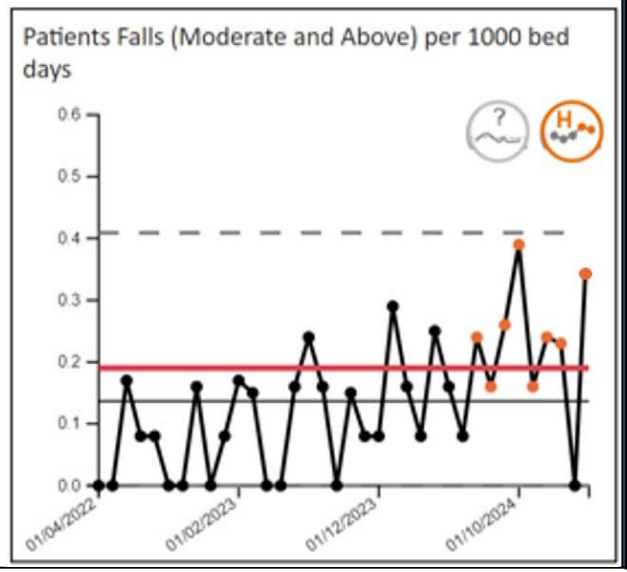
Potential risks to improvement?

- Needing to open additional beds due to operational pressures using existing establishments and temporary NHS staff
- Roster KPI not being met
- High rates of sickness absence.

Subtheme: Care Incidents (1)

Data, Context and Explanation





•Patient Safety Incident Investigations are completed when a patient has been involved in a moderate harm incident and significant learning identified. Number of PSII's has reduced to 0 in month in line with adhering to the Trust and national guidance in criteria.

•The updated Patient Safety Incident Response plan now provides clear guidance on what the national criteria is for PSII and the Trust guidance for the type of incident response required when a patient safety incident occurs.

•The number of patient falls at moderate harm has risen in month. However, this was a total of 5 and none of those had any opportunities for improvement or learning.

•The moderate and above falls rate remains below national average.

Metric	Target	Value	Exec Lead	Ops Lead
Patient Safety Incident Investigations	3	0	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.2	0.35	Helen Dobson	Victoria Hazeldine

What actions are planned?

•A Falls Prevention Lead has now been agreed for the Trust to help reduce the total number of all falls and moderate harm falls through Qi projects and education. This recruitment has taken a slight pause due to external factors.
•There has been a focused deep dive into the moderate harms falls.
•The Patient Safety Incident Response Plan has now been published with a clear direction on when a PSII is warranted.

What is the expected impact?

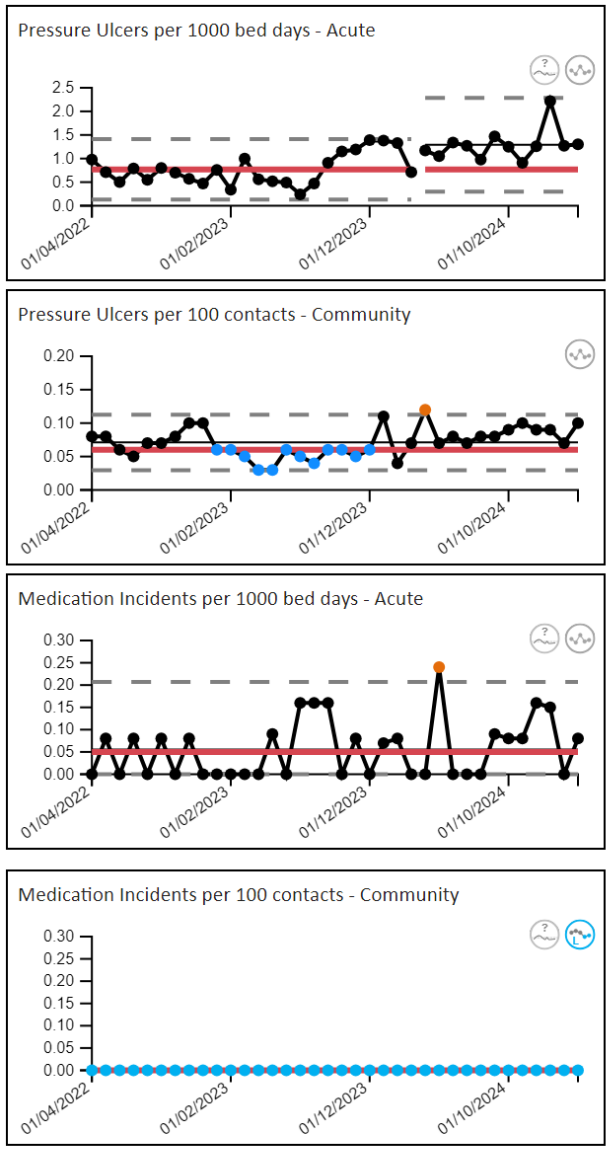
- Stabilisation of PSII's with adequate evidence of shared learning
- There is likely to be an increase in the number of After Action Reviews due to the new categorisation for when a PSII is warranted.
- Reduction in the total number of falls
- Key themes identified from moderate harm falls will drive a Qi initiative

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



•Pressure ulcers (PU) remain a concern and are considered, in the main, an avoidable harm associated with healthcare delivery.

•The rate of Pus in Acute has fallen and those in Community have now stabilised.

•The reported Cat 3 and 4, SDTI's and unstageable damage are all reviewed and graded by Tissue Viability, some are downgraded when assessed even though this assessment work has shown an improvement in initial grading by the community staff.

•There were only 2 incidence of Category 3 and above PU's that identified opportunities for improvement.

•Medication incidents in both Community and Acute remain in common cause, although Community the rate persists at 0 whilst in Acute it fluctuates with a mean of 0.05.

Metric	Target	Value	Exec Lead	Ops Lead
Pressure Ulcers per 1000 bed days - Acute	1.76	1.3	Helen Dobson	Victoria Hazeldine
Pressure Ulcers per 100 contacts - Community	0.1	0.1	Helen Dobson	Victoria Hazeldine
Medication Incidents per 1000 bed days - Acute	0.1	0.1	Jo Beahan	Victoria Hazeldine
Medication Incidents per 100 contacts - Comm...	0.0	0.0	Jo Beahan	Victoria Hazeldine

What actions are planned?

- Medication incidents at moderate harm and above remain low, however actions to address those incidents related to critical medication have been identified and will be presented at the next Medication Safety Committee.
- Pressure Ulcer Identification Tool audit has demonstrated improved compliance and started to see improvements in the Acute.
- •Business case currently being completed for a full mattress replacement program.
- .

What is the expected impact?

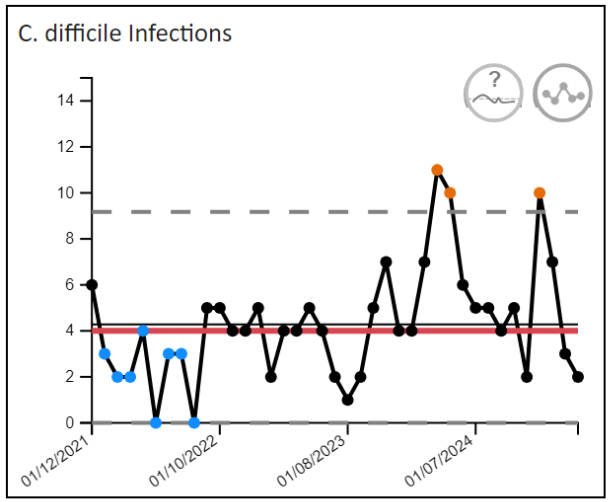
- Reduction in the number of critical medication incidents.
- Removal of the SDTI category.
- There will be an increase in Category 3 PU's as under the new guidance, SDTI will now be Category 3.
- Converting to hybrid mattresses will mean that patients requiring pressure relieving equipment will have it immediately and reduce the incidence of PU's.

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.
- April, May, December and January 24/25 showed higher than expected rates.
- Nationally there is a trend for increasing rates of C. diff with a renewed focus on AMR. The UKHSA safety alert has been shared with clinicians
- 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.

Metric	Target	Value	Exec Lead	Ops Lead
C. difficile Infections	4	2	Helen Dobson	Jen Hilton

What actions are planned?

- Microbiology support through ward rounds on AMU three times a week to advise on antimicrobial prescribing. Supported by antimicrobial guide on the EOLAS app
- New process to acquire a code for prescribing ciprofloxacin in response to new guidance around fluoroquinolone antibiotics
- Monthly Harm Free panel continues with shared learning on timely stool sampling and antibiotic prescribing main themes.
- Launch of SY SIGHT campaign to promote good hygiene practices

What is the expected impact?

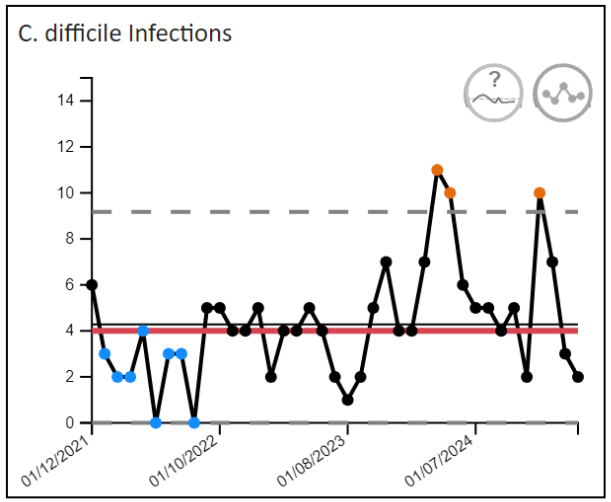
- A stabilisation of C. diff cases associated per 100,000 bed day rate

Potential risks to improvement?

National patterns of increases in rates of CDI
Antibiotic prescribing practices in primary care for ‘admission avoidance’
Limited availability of single rooms

Subtheme: Infection Prevention & Control

Data, Context and Explanation



- Clostridium difficile infection (CDI) 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.
- Total number of cases for 2024/5 was 71 against a trajectory of 44
- All cases of CDI are reviewed at the monthly harm free care panel. The emerging themes are linked to timely sampling, antimicrobial stewardship and prescribing practices.
- January saw 7 cases of CDI, February 3 cases and March 2 cases.
- Action are in place to address (see planned action box).

Metric	Target	Value	Exec Lead	Ops Lead
C. difficile Infections	4	2	Helen Dobson	Jen Hilton

What actions are planned?

- Microbiology support through ward rounds on AMU three times a week to advise on antimicrobial prescribing. Supported by antimicrobial guide on the EOLAS app
- New process to acquire a code for prescribing ciprofloxacin in response to new guidance around fluoroquinolone antibiotics
- Monthly Harm Free panel continues with shared learning on timely stool sampling and antibiotic prescribing main themes.
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What is the expected impact?

- A stabilisation of C. diff cases associated per 100,000 bed day rate

Potential risks to improvement?

National patterns of increases in rates of CDI
Antibiotic prescribing practices in primary care for ‘admission avoidance’
Limited availability of single rooms

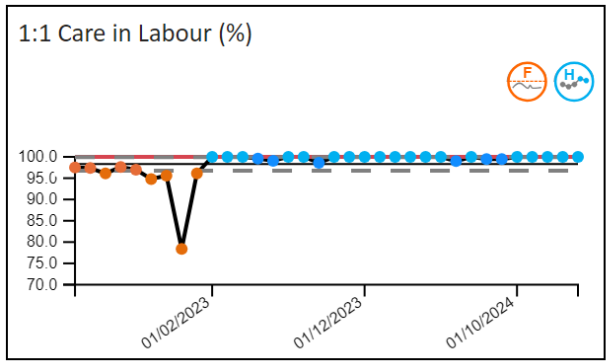
Maternity

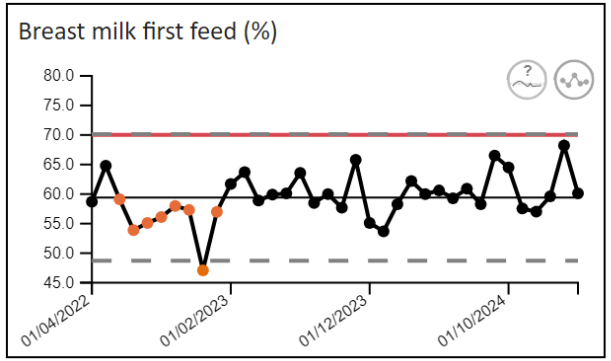
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	100.0	Mar-25	☑			-	CI
Breast milk first feed (%)	70.0	60.1	Mar-25	☒				S
Stillbirth rate (per 1000 births)	3.29	4.1	Mar-25	☒			-	C

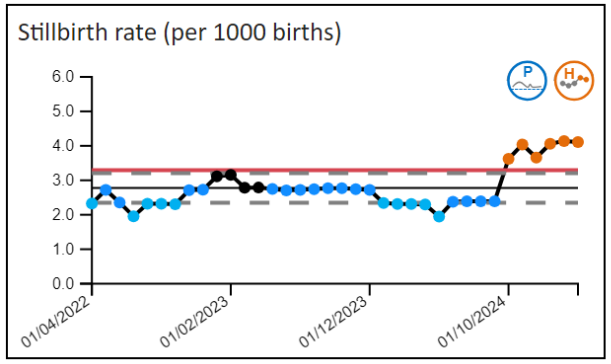
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Maternity

Data, Context and Explanation







- No concerns currently with 1:1 care in labour.
- Breast Milk First Feed continues to be below the Trust target, with an average of 60.1% against a Trust target of 70% in the month of March.
- In March2025 we had no further stillbirths in this month.
- We are aware of an increase in the local stillbirth rate from 2022-2024
- 2022 – 2.68/1000 births
- 2023 – 2.88/1000 births
- 2024 – 3.66/1000 births
- ONS data showed a 25% reduction nationally in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic.

National rate 2021 – 3.52 per 1000 births
- 2022 – 3.33 per 1000 births
- 2023 – 3.9 per 1000 births

(ONS) 2024 data not yet published

Metric	Target	Value	Exec Lead	Ops Lead
1:1 Care in Labour (%)	100.0	100.0	Helen Dobson	Sarah Petty
Breast milk first feed (%)	70.0	60.1	Helen Dobson	Sarah Petty
Stillbirth rate (per 1000 births)	3.3	4.66	Helen Dobson	Sarah Petty

What actions are planned?

- **1:1 care in labour** – continue to monitor for variation.
- **Breast milk first feed** – continue with action plans to move infant feeding status to BFI gold following reaccreditation at TRFT to level 3 accreditation. Work will consider the inequalities and inequities seen in the Rotherham birthing population to attempt to improve rates.
- **Stillbirth rate**: -Continue to work as an MDT to reduce stillbirth rates to meet the national ambition.
- Continue to learn from stillbirths and neonatal deaths and PMRT reviews and listen to families and understand how their experience can change the care moving forwards.
- Sharing actions plans and learning with staff.
- And the wider MDT for learning – LMNS and the Maternity and Neonatal Service Voices Partnership (MNVP).

What is the expected impact?

- Safety of women and babies will be maintained on labour ward
- Rates of first feed breastmilk will increase for all women who are cared for at TRFT.
- Learning from recently released reports and pending national recommendations will inform the work undertaken at TRFT to monitor, learn and improve services for woman at risk of suffering a stillbirth.

Potential risks to improvement?

- If staffing levels were not maintained, 1 to 1 care in labour may be impacted.
- Lack of focus on public health work streams for pregnant women. Women are often disadvantage within the Rotherham's birthing population. TRFT maternity need to maintain focus on the health promotional needs of all women to inform of the benefits of breastfeeding.
- Stillbirth national targets need to be re-set so that trusts have clear trajectories.

Performance Matrix Summary – Finance and Performance

NHS The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • Urgent 2 Hour Response	**GOOD: CELEBRATE AND UNDERSTAND** • FDS	**CONCERNING: CELEBRATE BUT TAKE ACTION** • RTT
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND**	**STATIC: INVESTIGATE AND UNDERSTAND** • Waiting List Size • 52+ weeks - CYP • 65+ weeks • OP to PIFU • Overdue Followups • DM01 • 31 Day Treatment Standard • 62 Day Treatment Standard • >12 hours in A&E • LoS >21 Days • Date of Discharge = Discharge Ready Date • Patients on Virtual Ward • First Outpatients (%Plan) • Inpatients (%Plan) • Daycases (%Plan) • LoS >7 Days • Mean LoS (Elective) • Mean LoS (Non-Elective) • A&E Attendances from Care Homes • 12 hour Trolley Waits	**CONCERNING: INVESTIGATE & TAKE ACTION** • 4 Hour Performance • Average time to be Seen • Criteria to Reside is No • Admissions from Care Homes • Clinic Utilisation • Capped Theatres Utilisation • Did Not Attend • Discharged <5pm • 52+ weeks • Ambulance Handovers >30min
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION** • Bed Occupancy	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

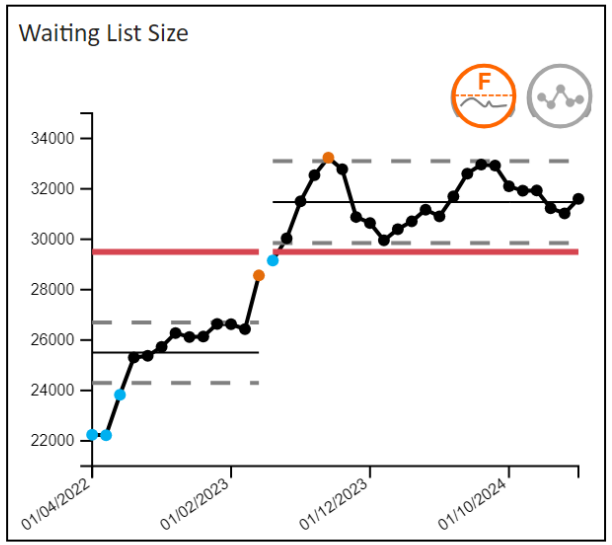
Elective Care and Cancer

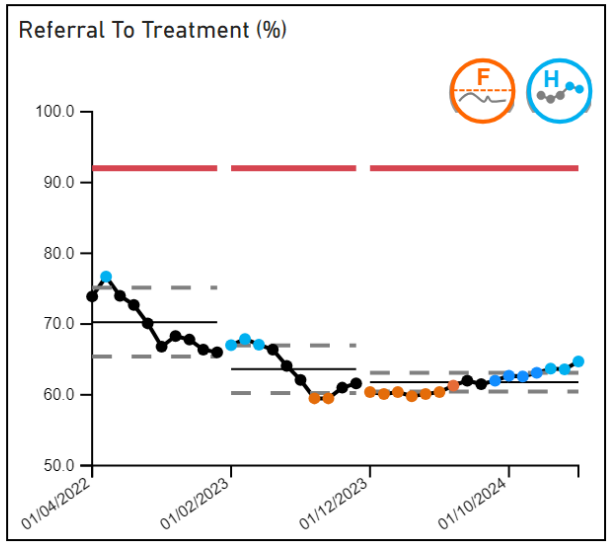
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	29,500	31,601	Mar-25	✗	F			S
Referral To Treatment (%)	92.0	64.7	Mar-25	✗	F	H		CI
Number of 52+ Weeks	380	790	Mar-25	✗	F			C
Number of 52+ Weeks - CYP	0	60	Mar-25	✗	F			C
Number of 65+ Weeks	0	0	Mar-25	✓	?			S
OP Activity moved or Discharged to PIFU (%)	2.5	2.9	Mar-25	✓	?			S
Overdue Follow-ups	-	18,330	Mar-25	-	-	H	-	S
DM01 (%)	1.0	0.6	Mar-25	✓	?			S
Faster Diagnosis Standard (%)	77.0	84.8	Feb-25	✓	?			S
31 Day Treatment Standard (%)	96.0	96.1	Feb-25	✓	?			S
62 Day Treatment Standard (%)	70.0	68.7	Feb-25	✗	?			S

*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Waitlist & RTT

Data, Context and Explanation





- The Trust had committed to reducing the elective waiting list to 29,500 by March 2025. Due to significant operational pressures over winter, which impacted on our ability to increase activity, the waiting list sits at 31,601 in March 2025. Despite these challenges, we have seen an 4% improvement from 32,920 in August 2024 where the waiting list peaked.
- We have seen a 4.9% improvement in the RTT Standard over the year with the Trust achieving 64.7% in March 2025 compared to 59.8% in March 2024.
- The RTT standard was achieved across several specialties, including General Medicine, Geriatric Medicine, Respiratory, Paediatrics, and Paediatric Cardiology, as well as sub-specialties such as Diabetes & Endocrine, Stroke, and Rheumatology.

Metric	Target	Value	Exec Lead	Ops Lead
Waiting List Size	29,500	31,601	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	92.0	64.7	Sally Kilgariff	Andrea Squires

What actions are planned?

- Implementation of Super Clinics in key specialties (Orthopaedics, ENT, OMFS and Gynaecology) in May to increase outpatient and surgical throughput
- All specialties to standardise clinic templates by 30th May 2025 – templates have been reviewed and variation shared with services; Orthopaedics already implemented
- Implement high flow theatre lists in key specialties (Orthopaedics, ENT, OMFS and Gynaecology) in May – Orthopaedic high flow list planned for 24 April
- Establishment of weekly task and finish group for 6 weeks to streamline pre-op slot booking

What is the expected impact?

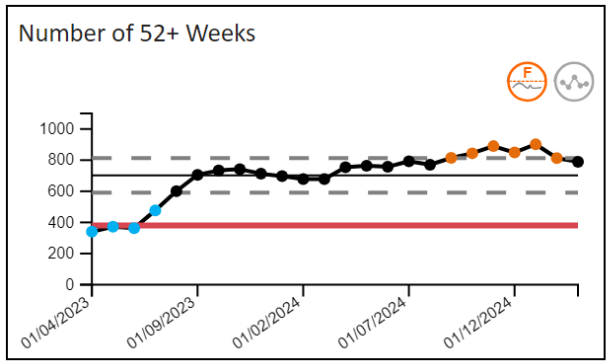
- The super clinics will boost clinic capacity and treatment volumes, thereby directly reducing RTT and waiting lists in May 2025
- Standardisation of clinic templates will improve consistency and efficiency in appointment allocation, supporting quicker patient access and reduced backlogs
- High flow lists will maximise surgical productivity and reduce the volume of long-wait patients, improving RTT
- Pre-operative process improvements will minimise

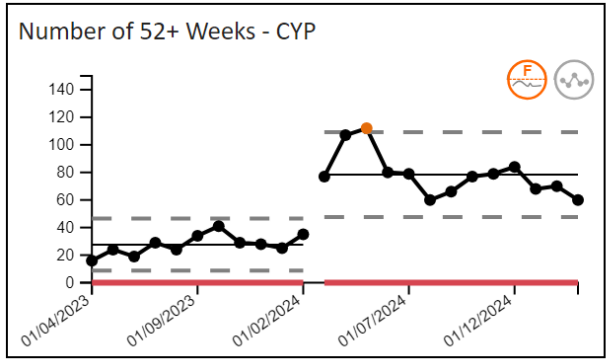
Potential risks to improvement?

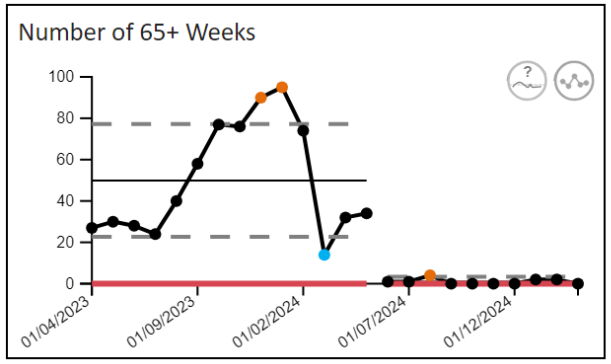
- Operational pressures (e.g. HDU capacity, elective demand) may delay planned actions
- Waiting list additions continue to exceed removals
- Limited financial resources may restrict delivery of additional activity
- Enhanced validation may uncover further long waits

Subtheme: Long Waiters

Data, Context and Explanation







- The Trust had committed to reducing the number of patients waiting over 52 weeks by 50% by March from 755 to 380. Due to significant operational pressures over winter, we saw an increase to 902 in January 2025, however this has now reduced to 790 in March which places the Trust in second quartile nationally.
- Particular growth in patients waiting over 52 weeks has been noted in OMFS, Gynaecology, T&O, General Surgery and ENT. Insourcing and outsourcing options continue to be prioritised for these specialties.
- Similar growth was noted in children and young people waiting over 52 weeks for treatment in orthopaedics, ENT and OMFS; though these continue to reduce.
- 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. We submitted 2 breaches in Jan-25 and Feb-25; and successfully achieved 0 patients waiting more than 65 weeks in March 2025.

Metric	Target	Value	Exec Lead	Ops Lead
Number of 52+ Weeks	380	790	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks - CYP	0	60	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	0	0	Sally Kilgariff	Andrea Squires

What actions are planned?

- Implementation of Super Clinics for high volume specialties (Orthopaedics, ENT, OMFS and Gynaecology) in May to fast-track patients through treatment pathway
- Implement standardised clinic templates by 30th May 2025 – variation analyses completed; implementation underway
- Delivery of high flow theatre lists in key specialties (Orthopaedics, ENT, OMFS and Gynaecology) in May – Orthopaedic high flow list planned for 24 April
- Strengthen Theatre list validation and booking controls – weekly huddles with services to proactively resolve booking gaps

What is the expected impact?

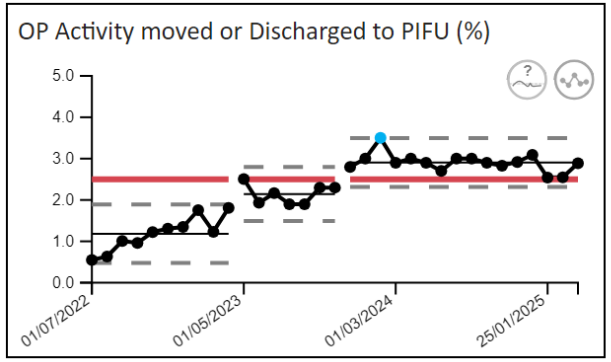
- The super clinics will accelerate assessment and scheduling for long-wait patients in May 2025
- Standardisation of clinic templates increase outpatient capacity and scheduling efficiency, supporting earlier intervention for patients approaching or exceeding 52 weeks
- High flow lists will increase surgical throughput, targeting long-waiting patients and reducing >52-week breaches
- Theatre list booking improvements will ensure maximum use of available theatre time for long-waiting patients

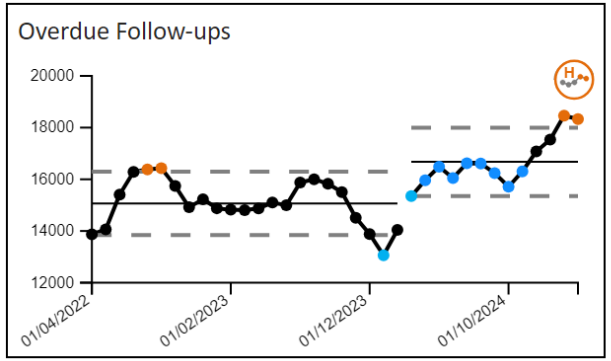
Potential risks to improvement?

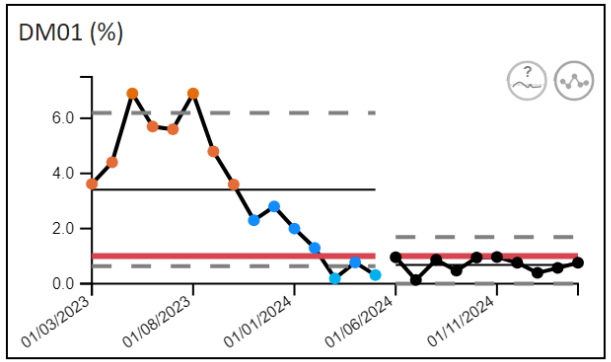
- Operational pressures (e.g. HDU capacity, elective demand) may delay implementation of planned actions.
- Limited staff availability, high sickness rates, and change fatigue may affect uptake of new processes and technologies.
- Financial constraints may limit delivery of additional activity.
- Enhanced validation may identify further long-wait patients.

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 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 from Dec-23, achieving 2.9% in March 2025
- The last 12 months have seen a step change in the average number of overdue follow ups, with recent increases seen in Cardiology, Gastroenterology, Respiratory, ENT, OMFS, Orthopaedics, Urology and Gynaecology. Work is ongoing to reduce the number of patients waiting for a follow up appointment.
- 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%. The Trust consistently exceeded this standard, also achieving its internal ambition to maintain performance at 99% for 24/25. The Trust has maintained this achievement since Mar-24.

Metric	Target	Value	Exec Lead	Ops Lead
OP Activity moved or Discharged to PIFU (%)	2.5	2.9	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	-	18,330	Sally Kilgariff	Andrea Squires
DM01 (%)	1.0	0.8	Sally Kilgariff	Andrea Squires

What actions are planned?

- Develop PIFU clinical protocols following agreement of the PIFU SoP and cascading to clinical leads
- Establish T&F Group to target and reduce the number of patients waiting for an overdue follow-up appointment, working with clinical colleagues to ensure appropriate clinical management including PIFU where appropriate
- Implementation of virtual fracture clinic – clinical lead in place, simple 3-step process drafted, and patient letter (with helpline) ready
- Review and align clinic templates, targeting slot allocation and reduce unnecessary follow-up appointments

What is the expected impact?

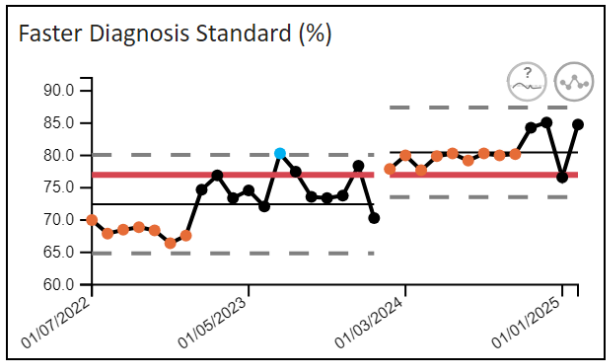
- PIFU clinical protocol will enable consistent and safe application of PIFU across services, facilitating more patients being moved appropriately to PIFU pathways
- Direct intervention will reduce backlog volumes and improve follow-up timelines
- The virtual fracture clinic will reduce unnecessary follow-up appointments and facilitate use of PIFU in MSK pathway

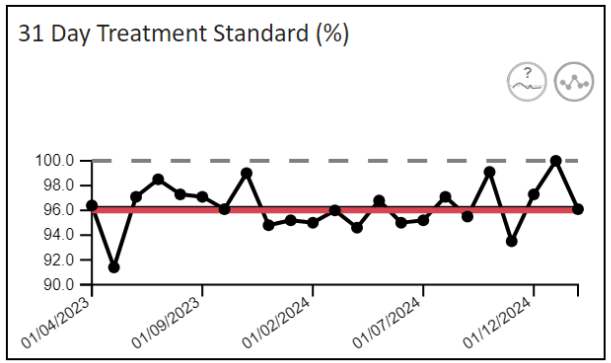
Potential risks to improvement?

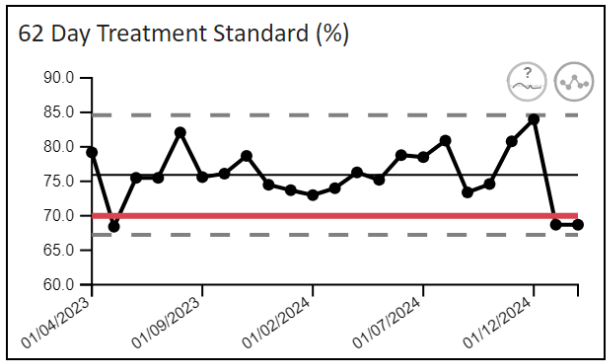
- Inclusion of overdue surveillance patients in Endoscopy DM01 from September 2024 and Audiology patients from July 2025 may impact performance due to additional capacity requirements
- Financial constraints may limit delivery of additional activity
- Transfer of long-wait DM01 patients under mutual aid agreements may affect local performance.
- Limited staffing, high sickness rates, and change fatigue may hinder adoption of new processes and technologies.

Subtheme: Cancer

Data, Context and Explanation







- In 2024/25, the national target was to achieve 77% against the 28-day Faster Diagnosis Standard by March 2025. We met this in 11 of the last 12 months, averaging 79% since February. A local ambition of 80% by March was also set and successfully achieved.
- The 31-day standard continues to show normal variation patterns. The Cancer Improvement Team are focusing support in the Lower GI tumour site to improve this standard.
- The national planning guidance also sets the objective to improve the 62-day performance to 70% by Mar- 25.
- The Trust also set a further ambition to improve performance to 77% by March 2025. We met this in 5 of the last 12 months, averaging 75% across the year.

Metric	Target	Value	Exec Lead	Ops Lead
Faster Diagnosis Standard (%)	77.0	84.8	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	96.0	96.1	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	70.0	68.7	Sally Kilgariff	Andrea Squires

What actions are planned?

- Establish robust surveillance pathways for at-risk patients as part of the Failsafe Liver (HCC) and Prostate (PSA) Surveillance programme
- Launch of Netcall Converse Cx to streamline patient communication and booking of Endoscopy patients
- Develop Patient Letters Using Behavioural Science - refine communication to improve patient engagement and attendance
- Undertake 62-Day Pathway Analysis for Head and Neck – include detailed review of delays

What is the expected impact?

- Robust surveillance pathways will enable timely monitoring and escalation, supporting faster diagnosis and treatment within 62-day standard
- Netcall will improve diagnostic coordination, support earlier appointments for Lower Gi, and enable delivery of FDS
- Patient letters using behavioural science will reduce delays from DNAs and late responses, improving performance across FDS and 31-day treatment metrics
- Pathway analysis will Identify improvement opportunities, with learning applicable to Gynaecology and Lower GI

Potential risks to improvement?

- Limited capacity in diagnostics, clinics, and workforce, particularly in urology, may constrain delivery of targeted interventions
- Operational pressures and emergency demand (e.g. HDU capacity for LGI) may delay planned actions
- Change fatigue and competing priorities may affect engagement with new processes and service changes
- Cancer Alliance funding for the Cancer Service Improvement Team has not been secured for 2025/26, reducing the capacity to support delivery of planned improvements

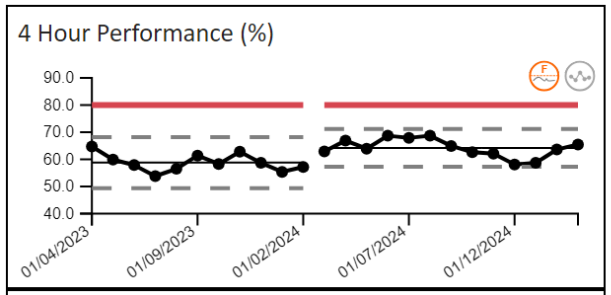
Non-elective and Flow

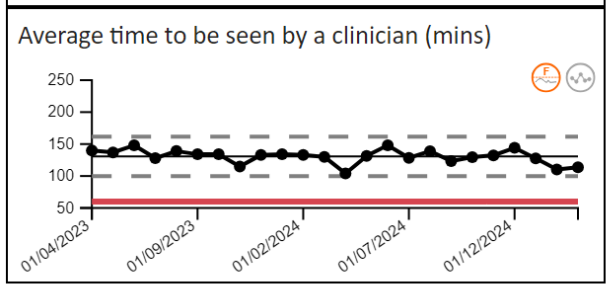
Metric	Trust Target	Latest Data	Period	Achieved (in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	80.0	65.5	Mar-25	☒	F			C
Ambulance Handover Times >30 mins (%)	0.0	16.7	Mar-25	☒	F			C
Average time to be seen by a clinician (mins)	60.0	113.8	Mar-25	☒	F		-	C
Patients spending >12 hours in A&E from time of arrival (%)	2.0	4.4	Mar-25	☒	?			S
12hr Trolley Waits	0	35	Mar-25	☒	?		-	S
Bed Occupancy (%)	92.0	94.3	Mar-25	☒	?	H		C
Length of Stay over 21 Days	64	62	Mar-25	☑	?		-	S
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	81.8	Feb-25	☒	?		-	S
Criteria to Reside is No (%)	10.0	19.1	Mar-25	☒	F		-	C

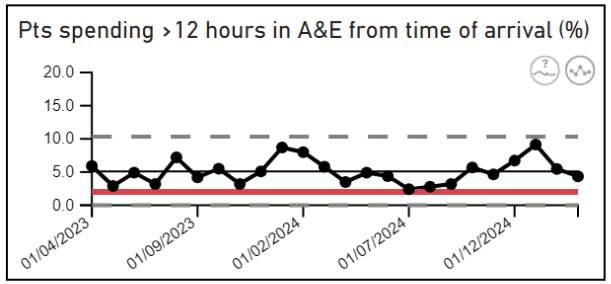
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

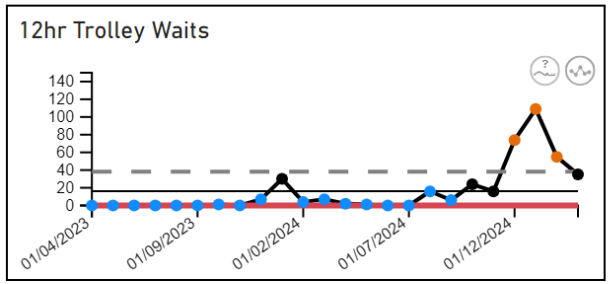
Subtheme: Emergency Care - Waiting Times

Data, Context and Explanation









- National 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. The consistent increase in demand alongside workforce challenges continues to impact the ability to sustain improvements.
- The number of patients spending more than 12 hours in the department is a key national focus. The number of patients spending more than 12 was increasing but has reduced in recent months.
- The Trust has set a standard to achieve zero trolley waits in line with national guidance. Following a number of challenging winter months, performance is now improving.

Metric	Target	Value	Exec Lead	Ops Lead
4 Hour Performance (%)	80.0	65.5	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	60.0	113.8	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	2.0	4.4	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	0	35	Sally Kilgariff	Lesley Hammond

What actions are planned?

- For April “every minute counts” to support flow through the organisation.
- This will bring the day forward for by leaving empty beds on assessment areas to enable flow through the peak demand times in the Trust.
- The Community ready unit will support early transfer of patients for discharge and wards highlighting patients over night that can be transferred the next morning.
- Utilisation of NHS responders to take patients medications out to patients if there is a delay between sending patients home and medication ready

What is the expected impact?

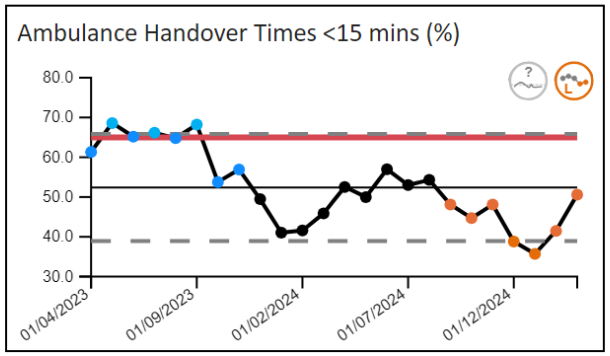
- Reduce delays waiting for admission to wards
- Reducing patients spend over 12 hours in the department
- Reduce the average time spent in the department by admitted patients
- Improvement in 4 hour performance
- Reduction in over crowding
- Empowerment of ward managers to support flow and patients home in a timely fashion

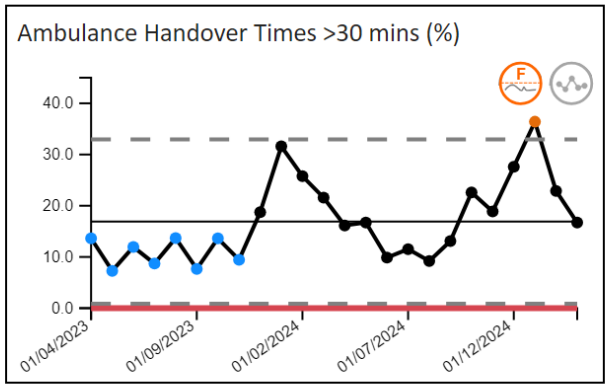
Potential risks to improvement?

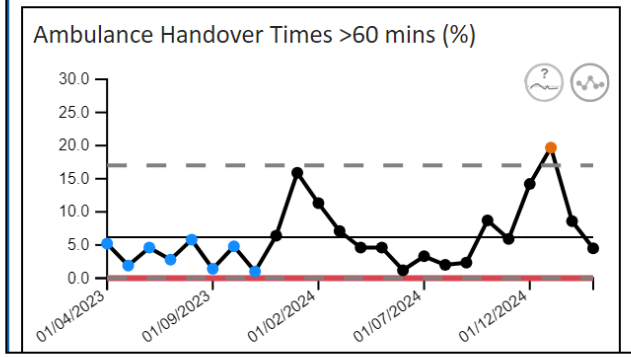
- Increase in demand will impact the Trust ability to achieve the 4 hour performance standards.
- Medical workforce staffing availability
- Sickness across medical and nursing workforce
- Infection control challenges in relation to bed occupancy

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%. The last couple of months have begun to see performance back in line with 50% of patients being handed over in less than 15 mins.
- For handover times >30mins, average times are coming back in line with previous performance levels of 17%.
- Ambulance handover times >60 did not meet the standard of 0%. Current performance trends indicate that we should expect an average of 5% in any given month, we have been just below our current average in month at 4.5%.

Metric	Target	Value	Exec Lead	Ops Lead
Ambulance Handover Times <15 mins (%)	65.0	50.6	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >30 mins (%)	0.0	16.7	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	0.0	4.5	Sally Kilgariff	Lesley Hammond

What actions are planned?

- YAS working along side Transfer of care team to reduce conveyance to hospital
- Key focus on ambulance handover by Operational managers and Nursing workforce
- Text Messages will alert Operational Managers and Clinical Site Managers to delays with Ambulance Handovers as well as alerts on MS Teams
- Visit STH “Good Practice” of streaming of ambulance patients April /early May
- Ongoing work with YAS around fit to sit patients
- Workshop to look at direct referral to SDEC for the new build with YAS and community teams

What is the expected impact?

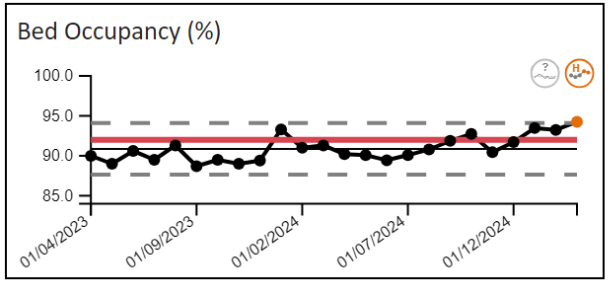
•There will be an improvement in ambulance handover times and TRFT sustained high levels of performance.
•Pilots will support reduction in conveyance to ensure all pathways in and out of hospital are utilised by March 2025
•Patients seen by the right clinician at the right time in the right place first time

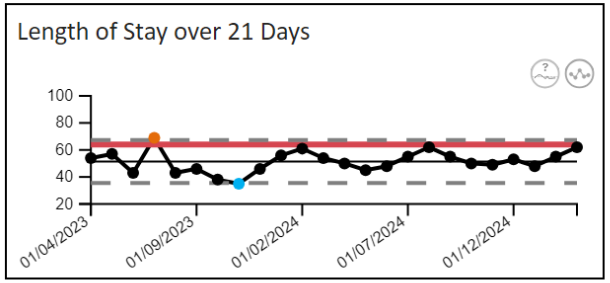
Potential risks to improvement?

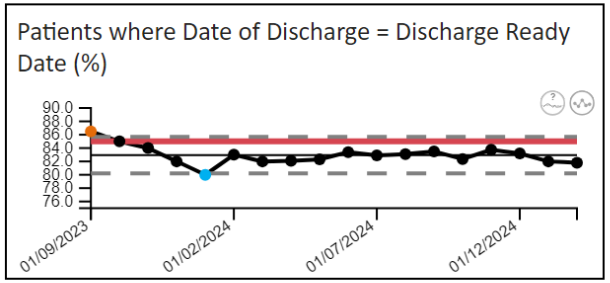
•High demand resulting in possible increase in ambulance attendances or batching of ambulances
•Ongoing demands for UEC services
•Peaks in demands for services
•Flow within the Trust/organisation and Place
• IPC challenges in relation to bed occupancy

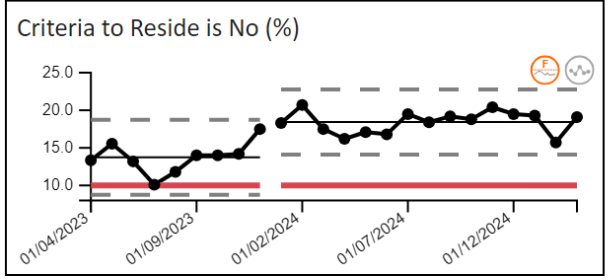
Subtheme: Inpatient Flow

Data, Context and Explanation









- Bed occupancy for March 94.3% this includes both core and escalation capacity in line with national reporting requirements. If the escalation beds were excluded General and Acute bed occupancy would be 95.17%. (B5 101% and SU 111.69%).
- 92% is recognised as optimum bed occupancy. It should be expected that we would see values fluctuate between 87% and 94% based on current patterns and Winter pressures. This month has seen the highest occupancy seen over the last two years, at 94.3%, which is significantly higher than normal.
- 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%. Nationally there is variation in recording process, TRFT has been acknowledged via the regional team to be reporting accurately and work continues to focus on place based collaboration to achieve a reduction.

Metric	Target	Value	Exec Lead	Ops Lead
Bed Occupancy (%)	92.0	94.3	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	64	62	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	81.8	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	10.0	19.1	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Plan to de-escalate additional inpatients beds on B6 to maximise SDEC throughput
- Length of Stay meetings – Actions discussed in operational meeting with ward managers
- Focus on criteria to reside and internal delays
- Board round standardisation across medical wards with support from Ward managers and Clinical Nursing lead for patient flow
- Pilot of a new discharge form for IDT

What is the expected impact?

- Increase patients streamed through SDEC in April
- Continued reduction in patients in hospital over 21 days in April
- Reduction in those patients that have been an inpatient over 7 days in April
- Reduction in delays of paper work to IDT from wards – approve pilot end April
- Empowerment of ward base teams to own their patients to improve patient experience

Potential risks to improvement?

- Increase demand through UECC sustained
- Continued pressures across the system in health and social care and discharge delays become more frequent
- De-escalation of inpatient beds not possible due to ongoing pressures

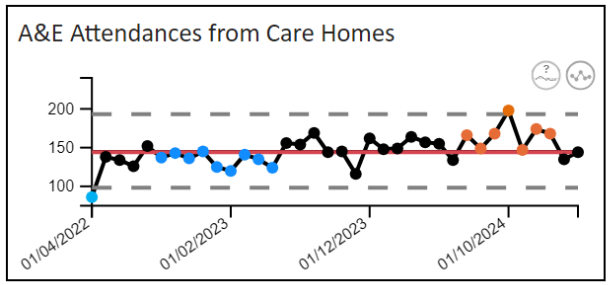
Community

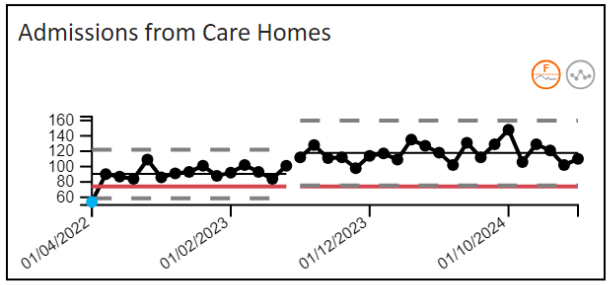
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	144	144	Mar-25	☑			-	S
Admissions from Care Homes	74	110	Mar-25	☒			-	C
Number of Patients on Virtual Ward	80	55	Mar-25	☒			-	S
Urgent 2 Hour Community Response (%)	70.0	74.0	Jan-25	☑			-	VG

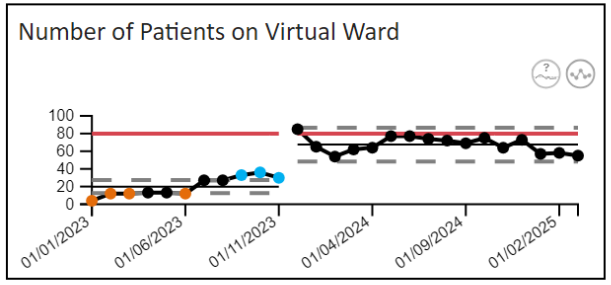
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

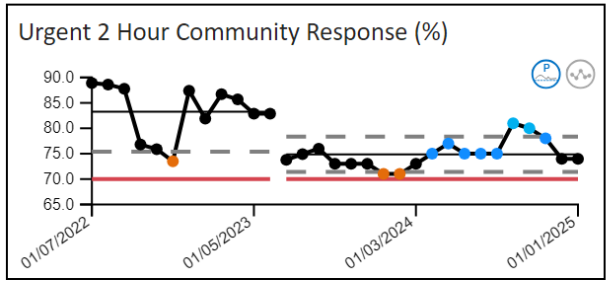
Subtheme: Community

Data, Context and Explanation









- The Community Teams, including the Trusted Assessors, continue to in reach into the Acute setting to facilitate early supported discharges for care homes residents.
- Community Teams continue to work with YAS. YAS colleagues to join the TOCH early January
- All care homes attendances and admissions are analysis each month. The average number of inpatients from care homes throughout March was 20.
- The number of patients on Virtual Wards has decreased in month. The average occupancy in March was 57 against a Trust standard of 80. Occupancy reached a peak of 69 on the 31 March. Capacity was impacted in month by acuity, sickness and vacancies
- The National standard for the 2 hour urgent community response is 70% of appropriate referrals. The trust is consistently meeting this target, and recent performance indicated this is now at a level where is can sustainably met the standard.

Metric	Target	Value	Exec Lead	Ops Lead
A&E Attendances from Care Homes	144	144	Sally Kilgariff	Lesley Hammond
Admissions from Care Homes	74	110	Sally Kilgariff	Lesley Hammond
Number of Patients on Virtual Ward	80	55	Sally Kilgariff	Lesley Hammond
Urgent 2 Hour Community Response (%)	70.0	74.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Continue to embed the role of Trusted Assessors and monitor impact.
- Undertake a review of capacity and demand – Attain v. SWIFT Model
- Improve sickness and absence rates – Engagement Events in planning stage
- Improve step down admissions to virtual ward
- Test remote technology with a small number of heart failure patients
- 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

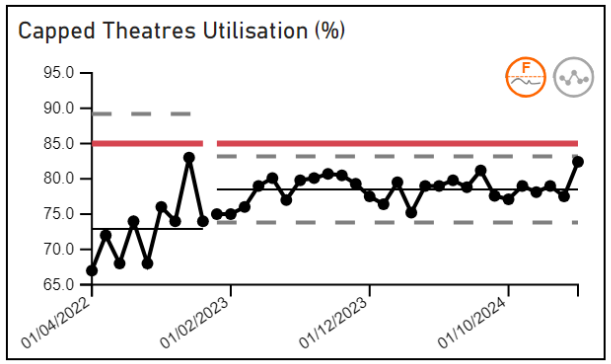
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%)	85.0	77.8	Mar-25	✗	F		-	C
Capped Theatres Utilisation (%)	85.0	82.4	Mar-25	✗	F			C
Did Not Attend (%)	7.0	7.0	Mar-25	✓	?			S
First Outpatients (% of Plan)	100.0	106.0	Mar-25	✓	?			S
Inpatients (% of Plan)	100.0	95.0	Mar-25	✗	?		-	S
Daycases (% of Plan)	100.0	97.0	Mar-25	✗	?		-	S
Length of Stay over 7 days	-	195	Mar-25	-	-		-	S
Mean Length of Stay (Non-elective)	-	5.6	Mar-25	-	-			S
Mean Length of Stay (Elective excluding Daycases)	-	2.5	Mar-25	-	-			S
Discharged before 5pm (%)	70.0	66.2	Mar-25	✗	F			C

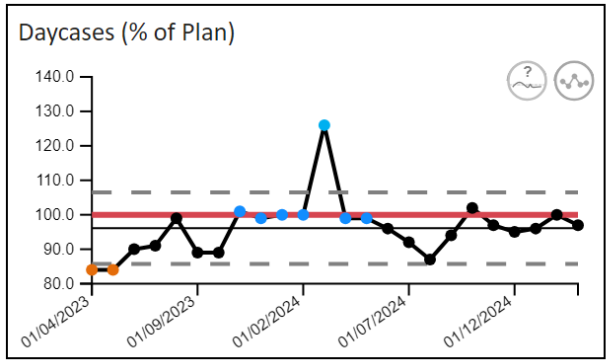
Plan is 19/20 + 3% i.e. *103% of 19/20*, therefore 100% achievement against Plan is 103% of 19/20

*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

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 improving, with current utilisation at 81.7% against the 85% standard. Orthopaedics and Gen Surgery theatre utilisation has improved with increases cases from Jan.
- Working with FF20 national team to improve Theatre utilisation and capacity,
- Model hospital data shows TRFT in the top quartile for utilisation.
- Day case activity had been achieving plan for a number of months. Work continues across a variety of targeted specialties.
- Anaesthetic and theatre staffing sickness has continued through March with the loss of 20.5 sessions lost in month. This has also impacted trauma capacity, with resulting elective cancellations

Metric	Target	Value	Exec Lead	Ops Lead
Capped Theatres Utilisation (%)	85.0	82.4	Sally Kilgariff	Darren Howlett
Daycases (% of Plan)	100.0	97.0	Sally Kilgariff	Darren Howlett

What actions are planned?

- Change in emergency theatre staff shift patterns
- Increased anaesthetic SAS additional session payments for a 6 month period for uncovered theatre sessions
- Improved utilisation of MEOC for simple cases
- Continue to increase cases per list in Ophthalmology
- Theatre Manager appointed and commenced in post
- Stricter policy on scheduling, lists being removed from specialties if non compliant

What is the expected impact?

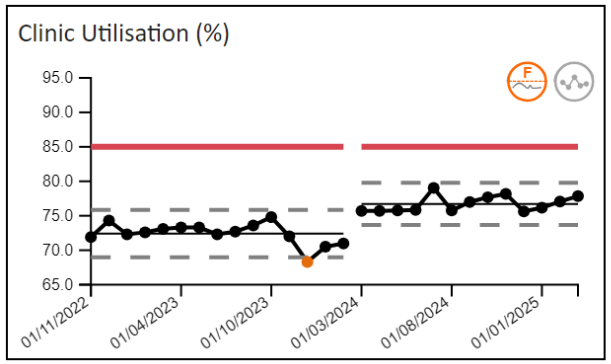
- Reduced gaps in emergency theatre will lead to less cancellations of extended trauma
- Reduced elective and extended trauma theatre session cancellations
- Improved overall utilisation and avoidance of 65 week breaches
- Increased day case rate in Ophthalmology
- Avoidance of 65 week breaches, challenges in scheduling
- More cohesive on the day theatre co-ordination and management of sickness

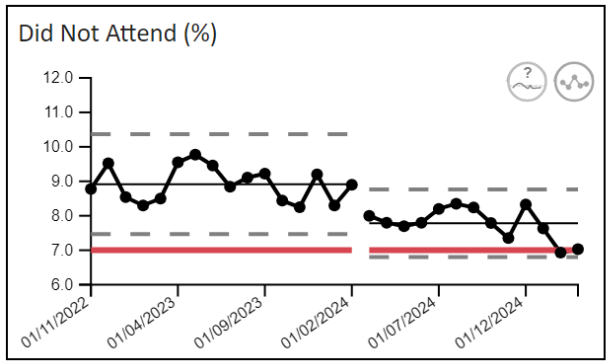
Potential risks to improvement?

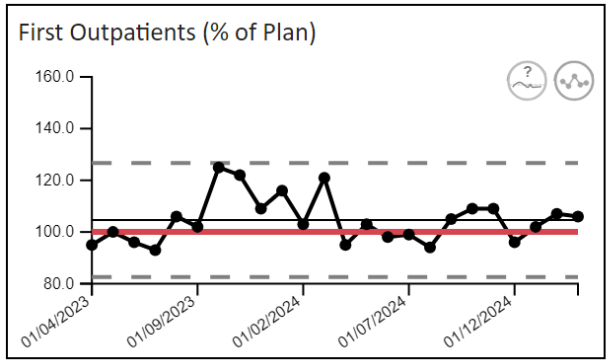
- Anaesthetic rotas may continue to impact on the ability to run theatre activity which significantly impacts on T&O in particular
- Capacity to deliver pre-op assessment may impact on patients available and fit for surgery
- High levels of anaesthetic and theatre staff absence impacting on lists being 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. A 4% improvement step change has been noted since Mar 24, with further work to do to achieve the standard of 85%.
- Our current report includes all clinic types, inclusive of ring-fenced emergency clinics. For those Elective and 2ww wait clinics, that should be fully utilised, the utilisation is 93.77%. This will be reported more clearly into 25/26.
- Trust DNA rates have shown sustained reductions. The target has been met over the last 2 months. 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. The last two months have seen performance exceed plan as previously forecast, with the target to sustain this into 25-26.
- 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	Target	Value	Exec Lead	Ops Lead
Clinic Utilisation (%)	85.0	77.8	Sally Kilgariff	Kevin Wilkinson
Did Not Attend (%)	7.0	7.0	Sally Kilgariff	Kevin Wilkinson
First Outpatients (% of Plan)	100.0	106.0	Sally Kilgariff	Kevin Wilkinson

What actions are planned?

- Increased capacity to deliver first outpatient appointments across numerous specialities to support activity levels are on-going. Funded via ERF.
- Development of PIFU module on Patient Hub to support management of patients in PIFU.
- Review Utilisation capacity and understand un-booked slots.
- Review data on discharged at first appointment to understand where triage may have biggest impact.
- Triage process being improved to enable clinicians to discharge with Advice and Guidance
- Clinic templates review on going to standardise in line with GIRFT action

What is the expected impact?

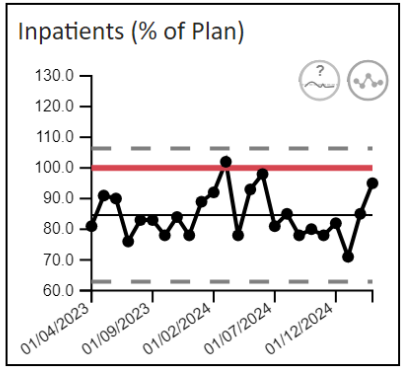
- Continued improvement of clinic utilisation into 2025/26.
- Sustained reduction in patients that DNA to 7% into 2025/26
- Sustained delivery at 100% into 2025/26.

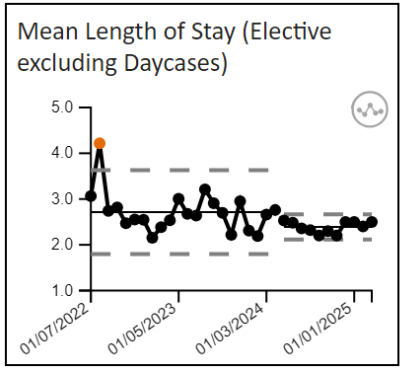
Potential risks to improvement?

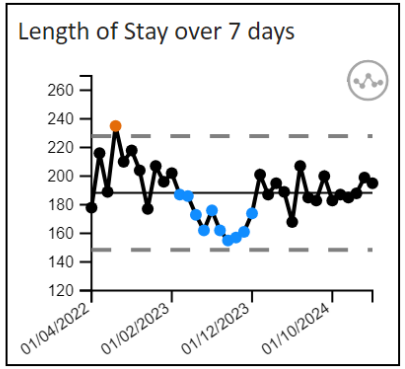
- Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
- Patient availability may impact on the ability to improve clinic utilisation, particularly short notice backfilled appointments.
- GP collective action and impact on referrals to specialities and use of advice and guidance

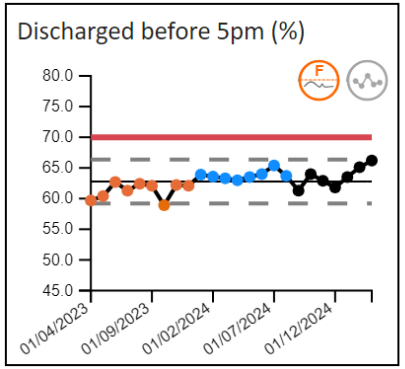
Subtheme: Inpatients

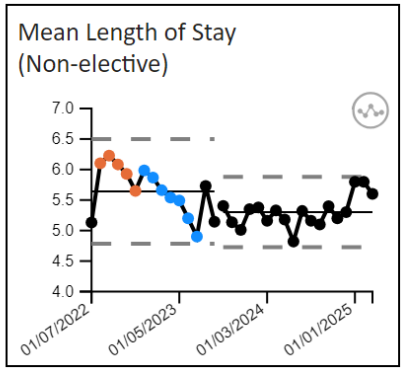
Data, Context and Explanation











- Inpatient have performed to plan for the first time in 7 months, while this remains in normal variation it is a marked in month improvement.
- Mean length of stay for **elective** patients is showing a continued downward trend over the last 6 months. 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.
- The number of patients with a LoS of 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 has showed sustained improvement since Jan 24. Work continues to focus on improving discharge rates earlier in the day. With a new discharge tracker implemented across the trust and enhanced support in the Community Ready Unit to increase usage.

Metric	Target	Value	Exec Lead	Ops Lead
Inpatients (% of Plan)	100.0	95.0	Sally Kilgariff	Jodie Roberts
Length of Stay over 7 days	-	195	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	-	5.6	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	-	2.5	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	70.0	66.2	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increase daily numbers through the Community Ready Unit by 5 further patients.
- Ongoing LLOS reviews focusing on patients not known to IDT and patients under 7days LOS
- Focus on Internal delays to reduce patients with no criteria to reside- pathway 0
- Focus on LOS in surgical specialities
- Focus from PLACE partners to reduce number o f complex patients with NCTR- pathways 1-3
- MDT/partner reviews of community bed bases to create capacity out of hospital.
- Daily board rounds led by senior nurses

What is the expected impact?

- Increase number of patients discharged before 5pm to 70%
- Reduction of 7 day LOS patients by 20 patients
- Continued reduction in average LOS for elective inpatients
- Increased number of discharges before 5pm supported by CRU

Potential risks to improvement?

- Increased complexity of patients and availability of home care and bed based placements
- Increased number of beds open to deal with demand with limited medical support to support discharge planning
- Limited capacity in social care
- Ability for the CRU to manage significant increase in numbers and transport to support earlier discharge (peaks and troughs in demand)

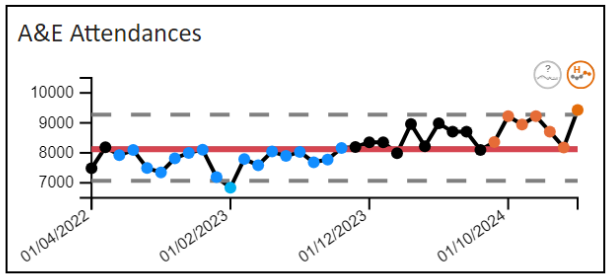
Activity

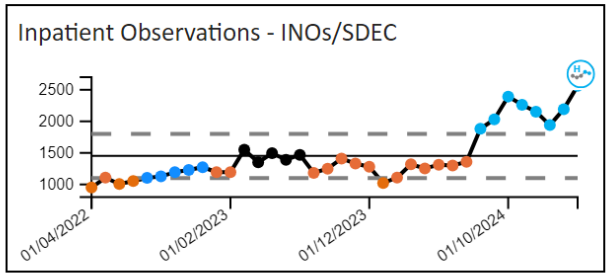
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances [Block]	8,124	9,429	Mar-25	☒	?	H	-	S
Inpatient Observations – INOs/SDEC [Block]	-	2,564	Mar-25	-	-	H	-	G
Non-Elective Inpatients [Block]	-	2,561	Mar-25	-	-	H	-	C
Outpatients Follow Up - Attendances [Block]	14,699	14,836	Mar-25	☒	?		-	S
Daycases [ERF]	1,998	1,928	Mar-25	☒	?		-	S
Inpatients - Electives [ERF]	350	326	Mar-25	☒	?		-	S
Outpatients New - Attendances [ERF]	6,049	6,433	Mar-25	☑	?		-	S
Outpatient Procedures - New and Follow Up [ERF]	4,767	6,328	Mar-25	☑	?	H	-	S
Referrals [Outpatient Demand]	-	8,377	Mar-25	-	-		-	S
2ww Referrals [Outpatient Demand]	-	1,242	Mar-25	-	-		-	S

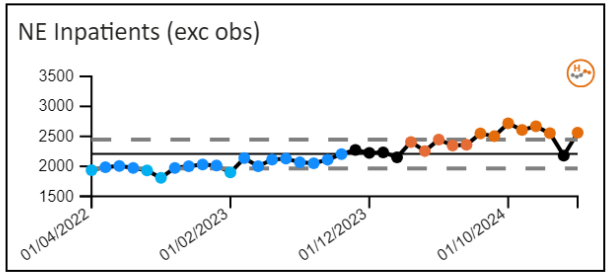
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

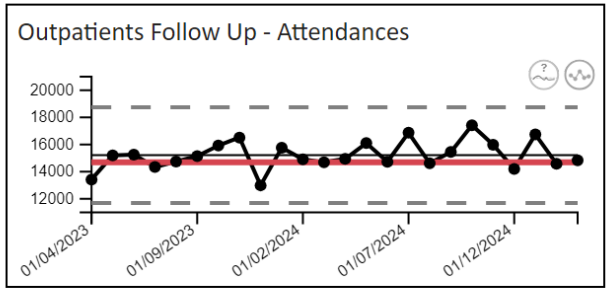
Subtheme: Block

Data, Context and Explanation









- 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 admission reductions are linked to introduction of SDEC from August 24
- Outpatient Follow-ups have increased slightly in-month but look to be sustained at lower levels when compared to previous months. An improvement in performance is linked to a) resolution to the outpatient procedure recording issues, b) introduction of SDEC returners, increased use of Patient Initiated Follow-up (PIFU)
- Despite the improving follow-up position, the Trust continues to experience significant follow-up backlogs therefore over performance in some areas is expected to continue/increase whilst we look to clear these.

Metric	Target	Value	Exec Lead	Ops Lead
A&E Attendances	8,124	9,429	Sally Kilgariff	Jodie Roberts
Inpatient Observations - INOs/SDEC	-	2,564	Sally Kilgariff	Jodie Roberts
NE Inpatients (exc obs)	-	2,561	Sally Kilgariff	Jodie Roberts
Outpatients Follow Up - Attendances	14,699	14,836	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Review of un-coded A&E attendances – work underway to review documentation and recording in MT
- Continue to monitor follow-up performance and benchmark new to follow-up ratios at specialty level and improve level of transfer to PIFU pathways
- Identify any areas of correlation between non-elective pressures and reduction in elective procedures (impacting ERF)

What is the expected impact?

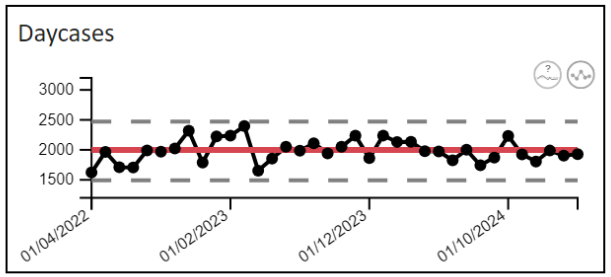
- Confirm SDEC/NEL activity is accurately being reflect in the data submission/contract monitoring. Fully understand the impact of EDS4.
- Ensure accurate record keeping for A&E attendances (should the contract mechanism change in the future this could potentially impact any re-basing)
- Identify areas of above national/peer average new to follow-up ratios and initiate further review to understand why

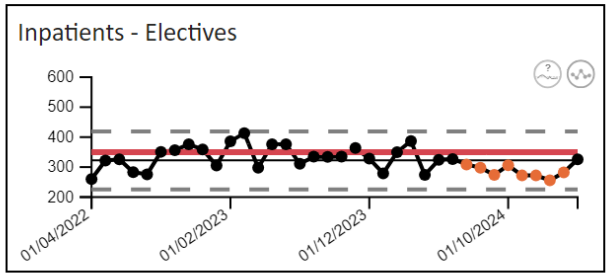
Potential risks to improvement?

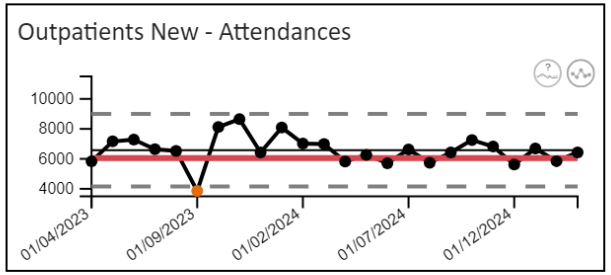
- Despite being on block, all key lines require scrutiny to ensure the Trust a) understands how this is impacting on financial performance b) we maintain an accurate position to safeguard changes to future contracting models
- Continuing increase in non elective demand, which is unfunded due to block contract.
- Switches of activity to SDEC could impact on any future re-basing (contract team aware)

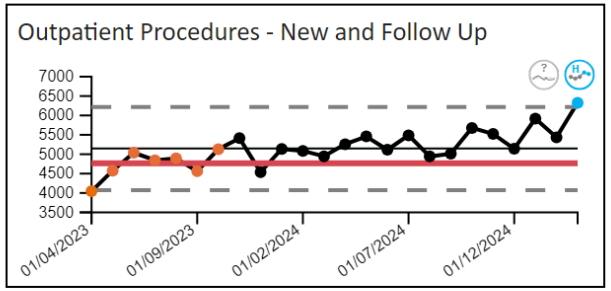
Subtheme: ERF

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
- The updated tariff price uplifts for the pay award were transacted on both plan and actuals in October.
- Daycase activity is 70 below plan in-month . Ophthalmology, General Surgery, T&O, OMFS are the biggest contributors to the year-to-date under performance. Actions are being taken to address the position.
- In-month Elective is 25 below activity plan. General Surgery, T&O, Urology are the biggest contributors to the year-to-date under performance but improvements are in performance have been sustained over the last 2 months and actions continue to be taken to further improve the position.
- In-month Outpatient New Attendances are 384 above planned levels. ERF schemes have contributed to the improved position in Q4
- In-month Outpatient Procedures are 1,561 above activity plan. This is a result of the corrective action taken to address technical system issues.

Metric	Target	Value	Exec Lead	Ops Lead
Daycases	1,998	1,928	Sally Kilgariff	Jodie Roberts
Inpatients - Electives	350	326	Sally Kilgariff	Jodie Roberts
Outpatients New - Attendances	6,049	6,433	Sally Kilgariff	Jodie Roberts
Outpatient Procedures - New and Follow Up	4,767	6,328	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Residual activity recording issues continue to be addressed and corrected in time for month 12 freeze
- 25/26 activity schemes have been agreed in principle
- Alignment of capacity and demand linked to contracted activity is underway

What is the expected impact?

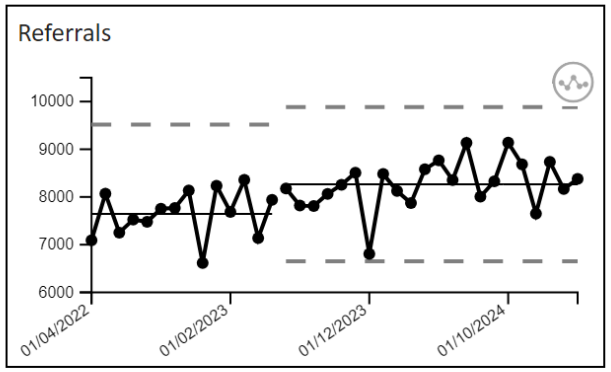
- Correction of activity recording issues for month 12 freeze will ensure activity is correctly aligned and the appropriate income is received.
- Early agreement of activity schemes for25/26 will allow early implementation to support maintenance of performance levels achieved in 24/25
- Aligning capacity/demand and targets will demonstrate areas requiring further support in 25/26

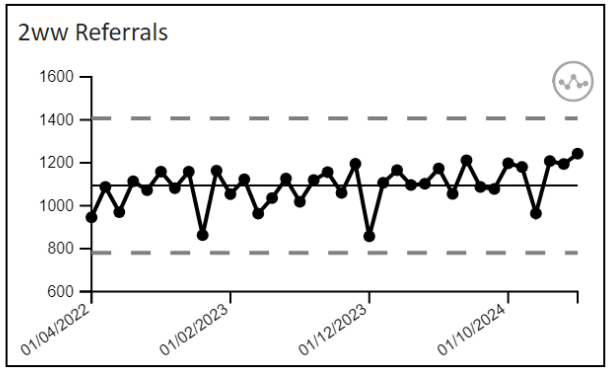
Potential risks to improvement?

- Internal workforce (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)
- Timely rectification of IT system data mapping issues
- Activity fixes are sustained in the position

Subtheme: OP Demand

Data





- 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

Metric	Target	Value	Exec Lead	Ops Lead
Referrals	-	8,377	Sally Kilgariff	Jodie Roberts
2ww Referrals	-	1,242	Sally Kilgariff	Jodie Roberts

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
- Increasing use of Advice & Guidance by GPs
- Capacity and Demand 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
- Greater visibility on gaps to meet demand / activity plans based on Capacity and Demand planning

Potential risks to improvement?

- Analysis does not identify any inappropriate referrals (i.e. demand has genuinely increased)
- Analysis demonstrates sustained decreases in demand with no impact on waiting times or waiting list reductions
- Lack of engagement from Commissioners/Primary Care
- Nationally mandated targets which are non negotiable

Finance

April 24 to Mar 25

Key Headlines	Month			YTD			Prior Month Forecast variance £000s
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	
I&E Performance (Actual)	(102)	781	883	(1,949)	(760)	1,189	(1,809)
I&E Performance (Control Total)	(41)	1,001	1,042	(584)	299	883	(2,279)
Efficiency Programme (CIP)	1,449	4,430	2,981	12,741	10,764	(1,977)	(3,164)
Capital Expenditure	8,156	9,673	(1,517)	17,189	16,940	249	0
Cash Balance	(2,261)	5,123	7,384	1,466	15,912	14,446	4,718

Performance Matrix Summary – People and Culture

NHS 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** • Appraisal Rates
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • MAST - Core • MAST – Job Specific • Vacancy Rate (total)	**STATIC: INVESTIGATE AND UNDERSTAND**	**CONCERNING: INVESTIGATE & TAKE ACTION** • Appraisal Rates (12 month rolling)
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • Sickness Rates (12 month rolling) • Sickness Rates

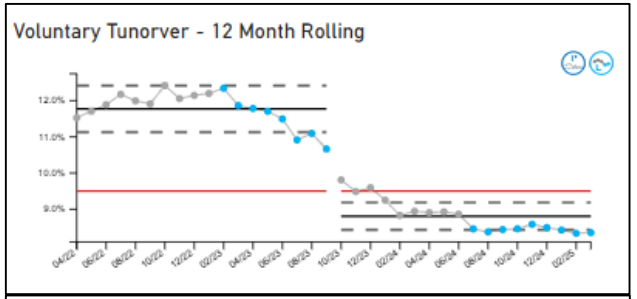
People and Culture

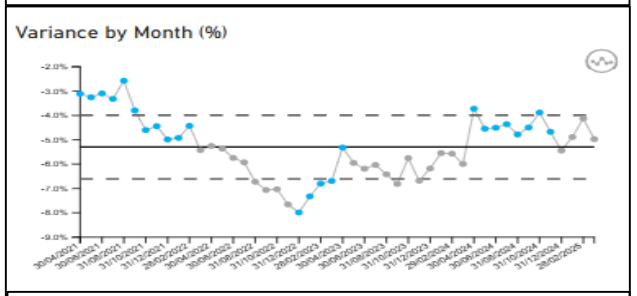
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	8.4	Mar-25	☑	P	L		VG
Vacancy Rate (total %)	-	5.0	Mar-25	-	-		-	G
Sickness Rates (12 month rolling %)	4.8	6.1	Mar-25	☒	F	H	-	VC
Sickness Rates (%)	4.8	6.2	Mar-25	☒	F			VC
Appraisal Rates (12 month rolling %)	90.0	79.7	Mar-25	☒	F		-	C
Appraisals Season Rates (%)	90.0	79.7	Mar-25	☒	F	H	-	C
MAST – Core (%)	85.0	89.9	Mar-25	☑	P		-	G
MAST – Job Specific (%)	85.0	86.7	Mar-25	☑	P		-	G

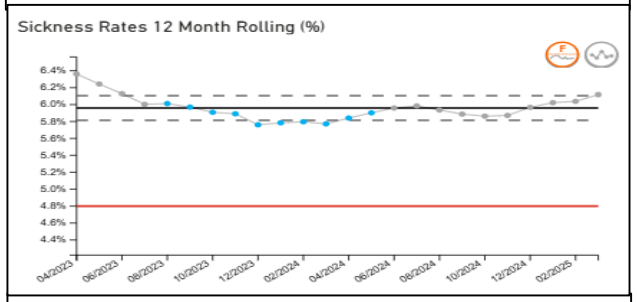
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

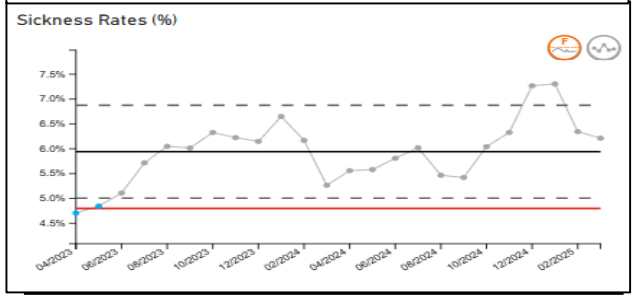
Subtheme: People

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 -the rolling 12 month measure shows a 5% performance (6.1 % vs 5.8%) deterioration from 2023/24 end of year position and as such is a cause for concern with deep dive presented.
- 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	Target	Value	Exec Lead	Ops Lead
Turnover (12 month rolling %)	9.5	8.4	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	-	5.0	Daniel Hartley	Paul Ferrie
Sickness Rates (12 month rolling %)	4.8	6.1	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	4.8	6.2	Daniel Hartley	Paul Ferrie

What actions are planned?

- 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
- Currently out to tender for Occupational Health Service with an emphasis in specification for more support to operational managers
- Launch of new Return to work form and Supporting attendance policy and increased senior leader and manager accountability

What is the expected impact?

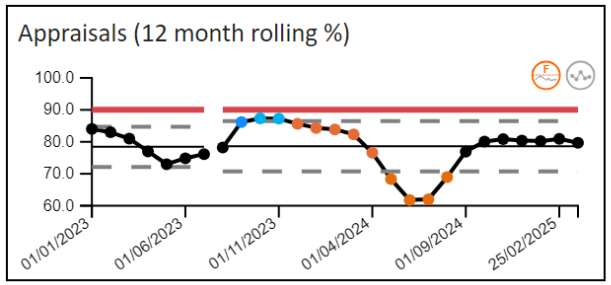
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

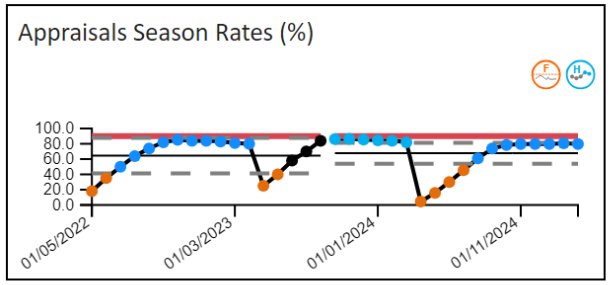
Potential risks to improvement?

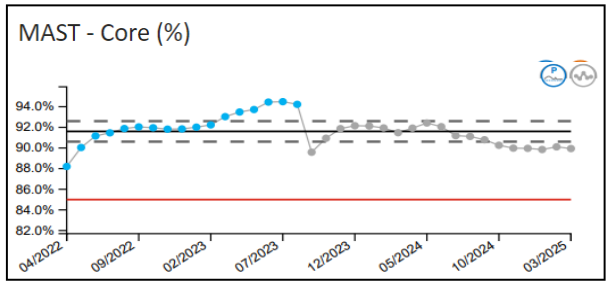
- Continued impact of ill-health of staff on attendance
- Lack of manager compliance with return to work and policy application
- Areas of poor levels of engagement and low morale make insufficient progress

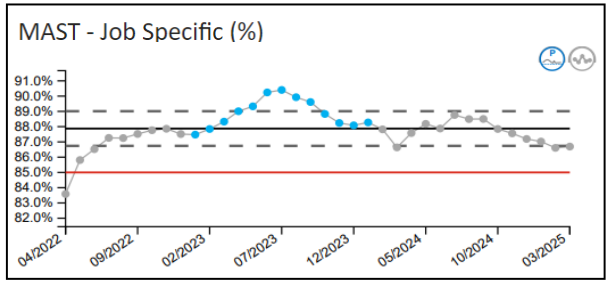
Subtheme: MAST & Appraisals

Data, Context and Explanation









- End of year rolling appraisal completion showing 79.7% which is below Trust target of 90%. 90% of the 3156 respondents to the NHS staff survey stated they have had an appraisal, suggesting not every appraisal is recorded effectively.
- This is a 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	Target	Value	Exec Lead	Ops Lead
Appraisals (12 month rolling %)	90.0	79.7	Daniel Hartley	Paul Ferrie
Appraisals Season Rates (%)	90.0	79.7	Daniel Hartley	Paul Ferrie
MAST - Core (%)	85.0	89.9	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	85.0	86.7	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.
- Importance of appraisal reporting communicated to managers
- Emphasis on senior leader accountability for Appraisal and MAST compliance
- Review of new national guidance around MAST, expected during 2025/26

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
- Improvement in the MAST burden freeing up time to care and improving productivity

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	**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	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.
	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	**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	• 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

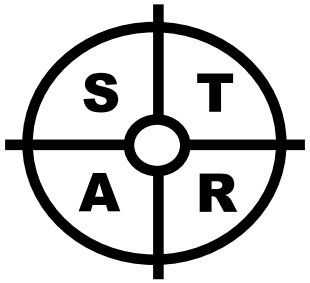
Assurance Icons

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.
	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.
	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
	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?
	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?
	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.
	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	

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 at the end of the month in line with the National Trajectories submission	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	100.0	
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	100.0	
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	100.0	
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	

Agenda item	P/75/25
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 and Neonatal Safety, which goes through Quality Committee and Trust Board. This month's paper is a full maternity and neonatal safety report. • SPC chart for births can be noted to have returned to the usual average following a drop in the birth rate in February 2025. • Staffing and Acuity for Labour Ward show that acuity was met 95% of the time in February and 90% in March. Actions were taken to ensure 100% 1:1 care in labour despite staffing challenges. • Staffing Gaps in February had 11.06 WTE gaps, and March had 10.36 WTE gaps, mainly due to maternity leave and long-term sickness. • The Bi annual Midwifery, Maternity and Neonatal staffing report is included in Appendix 1 highlighting the staffing position for Quarter 3 and 4. • Safety and Incident Reporting: Moderate Incidents: 16 moderate incidents reported, mostly related to postpartum haemorrhage (PPH) and major obstetric haemorrhage (MOH). All incidents were downgraded after MDT review. • Thematic review of obstetric haemorrhage incidents using Patient Safety incident Response Framework (PSIRF) model to inform education and delivery practices. • 1 case was referred to Maternity and New-born Safety investigation (MNSI) in March 2025 for a baby requiring therapeutic cooling. • Perinatal Mortality findings noted to have an Increase in local stillbirth rate from 2022-2024. Regional comparison included.
Due Diligence	This paper has been prepared by the Interim Head of Midwifery and approved by the Director of Midwifery. The report is shared through

	Maternity and Care Group 3 Business and Governance meetings, 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 and neonatal safety work streams.
Who, What and When	Helen Dobson, Chief Nurse, is the Board Executive Lead. The Interim Head of Midwifery attends Quality Committee and The Director of Midwifery attends the Trust Board bi-monthly to discuss the Maternity and Neonatal Safety agenda.
Recommendations	It is recommended that the Trust Board are assured by the maternity and neonatal outcome data and update provided.
Appendices	The Appendices below are in the reading room: Appendix one: Biannual midwifery, Maternity and Neonatal staffing report.

Perinatal Quality Assurance Scorecard

February & March 2025

The Rotherham NHS Foundation Trust Maternity Services

Ambitious Caring Together

NHS The Rotherham NHS Foundation Trust

Contents

Month at a glance: March 2025

16 Moderate Incidents

95 Patient Safety Incidents

0 MNSI Reportable Cases Referred

0 Coroner's Regulation 28

On track for Maternity Incentive Scheme year 7

84% MDT Clinical Simulation Training Compliance

97% Maternity Newborn Life Support Training Compliance

7.6% Smoking at Booking

9.5% Smoking at Birth

100% 1:1 Care in Labour

2 3rd and 4th Degree Tears

10 Full Term Babies Admitted to NNU

12 Blood Loss >1500mls

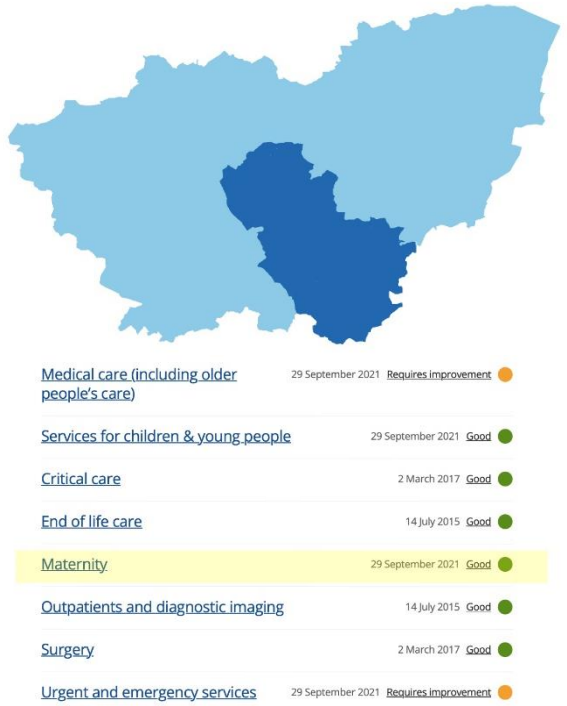
90% Safe Staffing Met

Vacancy Rate: Midwives: Obstetric: 1 WTE

Perinatal Scorecard Summary

Overview

Safety champion meetings occurred in February and March 2025. February's formal meeting involved the Board level Safety Champions reviewing the report in detail. In March, the Non-Executive Director safety champion visited the Neonatal Unit, where staff expressed they felt safe raising concerns. The visiting team noted the staff's pride in their work. Suggestions for improvement included additional protected management time for Band 6 staff to enhance service improvements, which will be addressed at the April 2025 meeting, followed by a newsletter for NNU staff. The Trust are awaiting the outcome of Year 6 Maternity incentive Scheme.



Quality & Safety

- The Avoiding Term Admissions into the Neonatal unit (ATAIN) is evaluated weekly to meet a target of 5%. In February 2025, the rate was 5.3%, dropping to 4.8% in March 2025, with no avoidable admissions noted. Quality improvement efforts continue with the Local Maternity and Neonatal System (LMNS), and there were no concerns about Consultant attendance for Royal College of Obstetricians and Gynaecologist RCOG categories or ward rounds.

Experience

In February and March, there were three formal complaints without common themes. Feedback from FFT was largely positive, with several compliments received through PALS. The Maternity and Neonatal Voice Partnership (MNVP) is collaborating with TRFT to create action plans after a 15-step visit and recent Picker CQC feedback. TRFT has also assisted the MNVP lead in conducting focus groups for non-English speaking communities.

Outcomes

Safety outcomes indicated 16 moderate harms, all downgraded after an Multi Disciplinary Team (MDT)
review. The most frequent harm reported was obstetric haemorrhage, prompting a thematic review for insights that emerged through the Patient Safety Incident Response(PSIRF) model. Currently, there are 4 active Maternity and Newborn safety (MNSI)cases and 2 ongoing Patient Safety Incident Investigations (PSII).

Training

The Year 7 CNST training standards have been released and are mostly unchanged from Year 6, allowing TRFT to continue as usual with maternity Core Competency recommendations included in the monthly maternity MAST. There is a temporary decline in compliance 84% in certain areas due to medical staff rotation on February 25, all relevant staff are scheduled for training therefore this is expected to improve over the year.

Workforce

This Quality Report includes the bi-annual Maternity Safe Staffing paper ,(Appendix 1), showing that the maternity workforce aligns with Birthrate+ recommendations. Sickness and absence rates for maternity and obstetrics staffing are low, with Medical colleagues at 3.57% short-term and 0% long-term, while Maternity staff report 1.53% short-term and 3.42% long-term sickness (as of the end of February 2025).

Overall Monthly Summary

Overall Year to Date Summary

Perinatal Mortality Summary

	2023 Total	2024 total	Cumulative 01/01/2025-31/03/2025	In Month: February 2025	In Month: March 2025	Information
Total Stillbirths (all)	6	9	1	0	0	
Stillbirths >37 weeks	1	5	1	0	0	
Stillbirths 24-36+6 weeks	5	4		0	0	
Intrapartum stillbirths	-	2		0	0	
MTOP Anomaly >24 weeks	2	-		0	0	
Adjusted stillbirths	6	9	1	0	0	
Total Neo-natal deaths (NND)	4	5		0	0	
ENND >24 weeks up to 7 days of life	2	2		0	0	
LNND 7-28 days	1	1		0	0	
Adjusted neo-natal deaths – all gestations (Excl MTOP)	2	2		0	0	
Total Adjusted Perinatal (24wk – 28 days)	8	11	1	0	0	
MTOP ENND	-	-		0	0	
Stillbirths elsewhere (Booked at TRFT)	-	-		0	0	
Neo-natal deaths elsewhere (outside of TRFT)	2	4	1	0	0	
Maternal deaths	1	1		0	0	
NVF <24 weeks	10	14	3	2	1	1) X 1 fetal loss @ 21 weeks gestation. RIP
NPMRT entered	10	14	1	1	0	

In Summary

What is the data telling us?

Local stillbirth rates (Stabilised and adjusted) have seen an increased from 2022 to 2024:

- 2021: 3.22/1000 births MBRRACE data
- 2022: 2.68 /1000 births MBRRACE data
- 2023: 2.88/1000 births MBRRACE data
- 2024: 3.66/1000 births TRFT data

ONS data indicated a 25% decrease in stillbirths in 2020, followed by a 20% rise in 2021 due to the COVID-19 pandemic. National rates were:

- 2021: 3.52/1000 births
- 2022: 3.33/1000 births
- 2023: 3.9/1000 births
- 2024 data not yet available.

What is going well?

- Ongoing learning from stillbirth and neonatal death reviews is communicated through maternity MAST.
- NETCALL has been implemented for triage to support training.
- No themes have been found from MDT and thematic reviews at both local and LMNS levels.

Quarterly Perinatal Mortality Data - Q4

Q4 - Perinatal Mortality all deaths (including congenital anomalies) Adjusted Total Perinatal: 1.76/1000 births		
Type of Death	Number	Rate per 1000 births
Stillbirth	1	1.76
Neonatal death	0	0

Q4 - Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP) Adjusted Total Perinatal: 1.76/1000 births		
Type of Death	Number	Rate per 1000 births
Stillbirth	1	1.76
Neonatal death	0	0

In Summary

What do we need to focus on?

Continue collaborating as a multidisciplinary team (MDT) to lower stillbirth rates in line with national goals. Learn from stillbirths, neonatal deaths, and PMRT reviews while considering family experiences to improve future care. Share action plans and insights with staff and the broader MDT, including LMNS and the Maternity and Neonatal Service Voices Partnership (MNVP).

Where do we want to be?

The goal is to excel in England and regionally by achieving the national target of reducing the 2010 rates of stillbirths, neonatal deaths, maternal deaths, and brain injuries by 2025.

In 2023, local benchmarking stillbirth rates are as follows: (MBRRACE DATA, stabilised and adjusted).

- TRFT: 2569 births, stillbirth rate of 2.88/1000
- Barnsley: 2916 births, stillbirth rate of 2.9/1000
- Sheffield: 5549 births, stillbirth rate of 3.43/1000
- Doncaster and Bassetlaw: 4476 births, stillbirth rate of 3.04/1000

Perinatal Mortality Summary

Maternity (Perinatal) Incentive Scheme
Year 7 – 01/12/2024 – 30/11/2025

CNST Standard 1 requirements	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25
Percentage of eligible perinatal deaths reviewed using PMRT as an MDT (100%)	No cases	1 case	No cases	No cases									
Percentage of eligible perinatal deaths notified to MBRRACE-UK with 7 working days (100%)	No cases	1 case 100%	No cases	No cases									
Surveillance information completed within 1 calendar month	No cases	1 case 100%	No cases	No cases									
Percentage of parents that have had their perspective of care and any questions sough following baby's death (95%)	No Cases	1 case 100%	No cases	No cases									
Percentage of PMRT reviews started within 2 months (95%)	No cases	Met	No cases	No cases									
Percentage of PMRT reports published within 6 months (60%)	No Cases	For review	No cases	No cases									

In Summary

What is the data telling us?

- All cases so far have been examined within the CNST year 7 timeframe.
- Every family that has experienced a loss has been reached out to for their perspectives and experiences.

What is going well?

- PMRT meetings are ongoing with external experts to gain insights and knowledge from their viewpoints.

What do we need to focus on?

- Work towards lowering the stillbirth rate as part of national goals.
- Maintain strong action plans for cases graded B, C, or D.
- Share insights with broader teams and families.
- Assess the governance of PMRT reports provided to families.

Where do we want to be?

Maintain CNST Year 7 Standard 1 to demonstrate continued learning and safety at TRFT.

Safety

Key Performance Indicator	2019-2020	2020-21	2021-22	2022-23	2023-24	2024-25
MNSI Referrals (eligible cases)	1	4	5	1	1	8
MNSI Referrals (Referred & Accepted)	Awaiting data	Awaiting data	Awaiting data	0	1	5
MNSI Referrals (Declined by HSIB/MNSI)	Awaiting data	Awaiting data	Awaiting data	1	0	1
MNSI Referrals (Declined/consent withdrawn)	Awaiting data	Awaiting data	Awaiting data	0	0	2
MNSI Total Safety Recommendations	2	6	9	0	0	3

March 2025

1 case met MNSI criteria for a baby requiring cooling following birth.

0 MNSI Safety recommendations in this month.

0 new PSII declared in this month.

0 Never Events

16 Moderate Incidents (all later downgraded following MDT review)

0 Coroner Regulation 28

What is the data telling us?

- Zero Patient Safety Incident Investigations (PSII) reported.
- One case referred to the Maternity and Newborn Safety Investigation (MNSI) in March 2025 regarding a baby born via category 1 LSCS requiring therapeutic cooling. The case is accepted and under investigation, with support provided to the family and staff.
- Sixteen moderate incidents reported: twelve related to postpartum/major obstetric haemorrhage, two perineal traumas, two low cord gases at birth, and one shoulder dystocia. After a full MDT review, no incidents were deemed to have caused moderate harm.

What is going well?

- 2 ongoing PSIIs are progressing as planned. Families have been included where consent has been gained to contribute to the findings of the investigation.
- All actions from PSII and MNSI reports are monitored via Governance meetings to ensure timely completion.
- Maternity newsletters are published monthly with learning from any cases reviewed at the weekly incident review meeting.

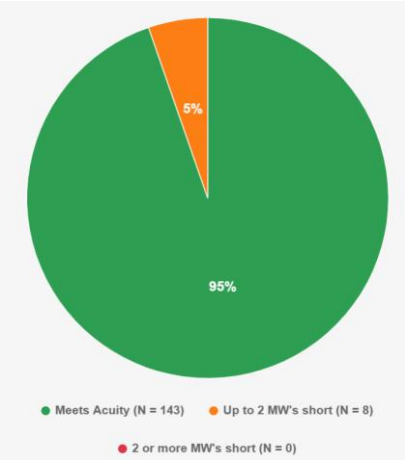
What do we need to focus on?

- Analyze incidents like Post Partum Haemorrhage (PPH) to enhance education and delivery practices through monthly thematic reviews.
- Utilize data to identify improvement priorities and assess the effects of quality initiatives, especially for disadvantaged women.
- Further implement PSIRF to enhance family and workforce engagement.

Where do we want to be?

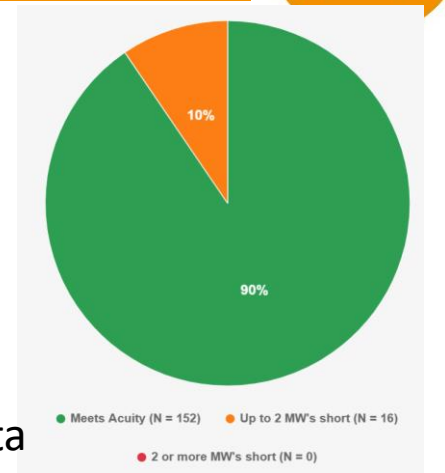
- Strive for zero MNSI Safety Recommendations as part of a culture focused on improvement and learning.
- Provide full support to women and families affected by traumatic births or poor outcomes, maintaining transparency about findings and demonstrating growth.
- Foster a positive work environment where psychological safety is prioritized, allowing concerns to be voiced without fear supporting the Just Culture Principles.

Workforce



February 2025 data

The bi-annual *Safer Maternity Staffing Paper* **will be presented to the Board along with April's Maternity Safety Paper, detailing the Q3 and Q4 MDT maternity and neonatal staffing situation. This section will emphasize the data from February and March 2025** to ensure consistency with prior quality reports.
In February, the labour ward acuity was met 95% of the time, while in March, it was met 90% of the time. When staffing levels fell short of the required acuity, the shift leader took action to reassign staff within the unit to ensure 100% one-to-one care for all women in labour, prioritising safety. (It's important to note that a shortfall in staffing does not always mean rosters were incomplete; it could be due to a temporary rise in service users.) Establishment control forms (ECFs) have been submitted to recruit Early Career Midwives to address turnover and fill gaps in the rota due to maternity leave, which aren't covered by the 21% uplift at TRFT.



March 2025 data

In Summary

What is the data telling us?

- Staffing achieved 100% one-to-one care in labour during both months.
- Community midwifery was called in once out of hours for support in March.
- ECFs are in the process of recruiting 7 WTE early career midwives to cover turnover.
- There were no delays in Induction of labour in February.
- 7 red flags were reported in March for delays in women being offered Artificial Rupture of Membranes (ARM). This is during high acuity periods, as women are awaiting transfer to the labour ward for 1 to 1 care.

What do we need to focus on?

- Staffing in Maternity triage will be closely monitored to ensure coverage with 2 midwives from 11 am to 11 pm during high acuity periods.
- A Quality Improvement project is in progress to enhance service delivery
- Birthrate+ will be recommissioned in 2026 to comply with Year 7 CNST requirements.
- In February, service gaps calculated at 11.06 WTE, slightly decreasing to 10.36 WTE in March due to maternity leave and long-term sickness. NHS professionals are utilized to fill these gaps, with roster challenge meetings overseeing Bank usage.

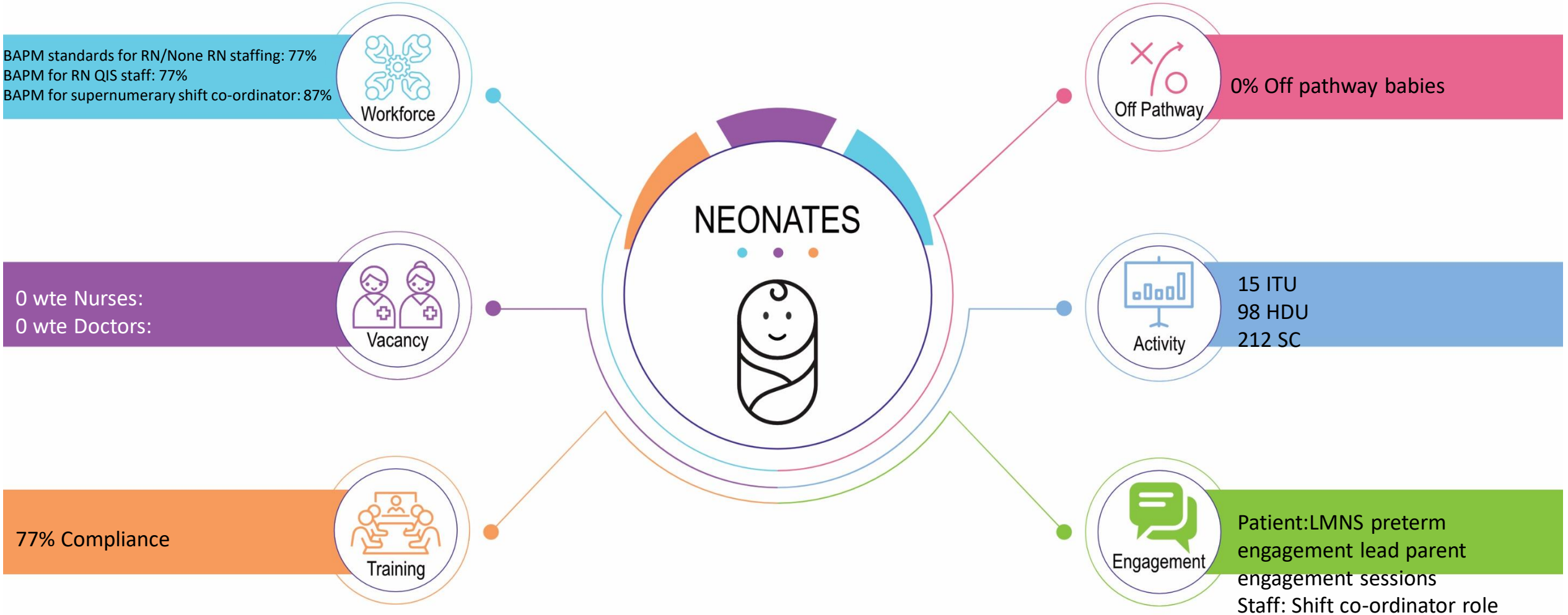
What is going well?

- No red flags were used to escalate that Consultants did not attend when required as per the RCOG guidance for obstetric emergencies.
- No red flags were used to escalate that a Consultant ward round did not take place twice daily on labour ward.
- Permission has been granted to recruit 7WTE early career midwives.
- The unit did not close in the month of February or March 2025.
- Anaesthetic cover for labour ward was rostered in 100% of the time in both months.
- NNU nursing staffing met the Qualitied in Speciality (QIS) BAPM requirements in both months.
- Supernumary labour ward co-ordinator status was maintained in 100% of times for both months.

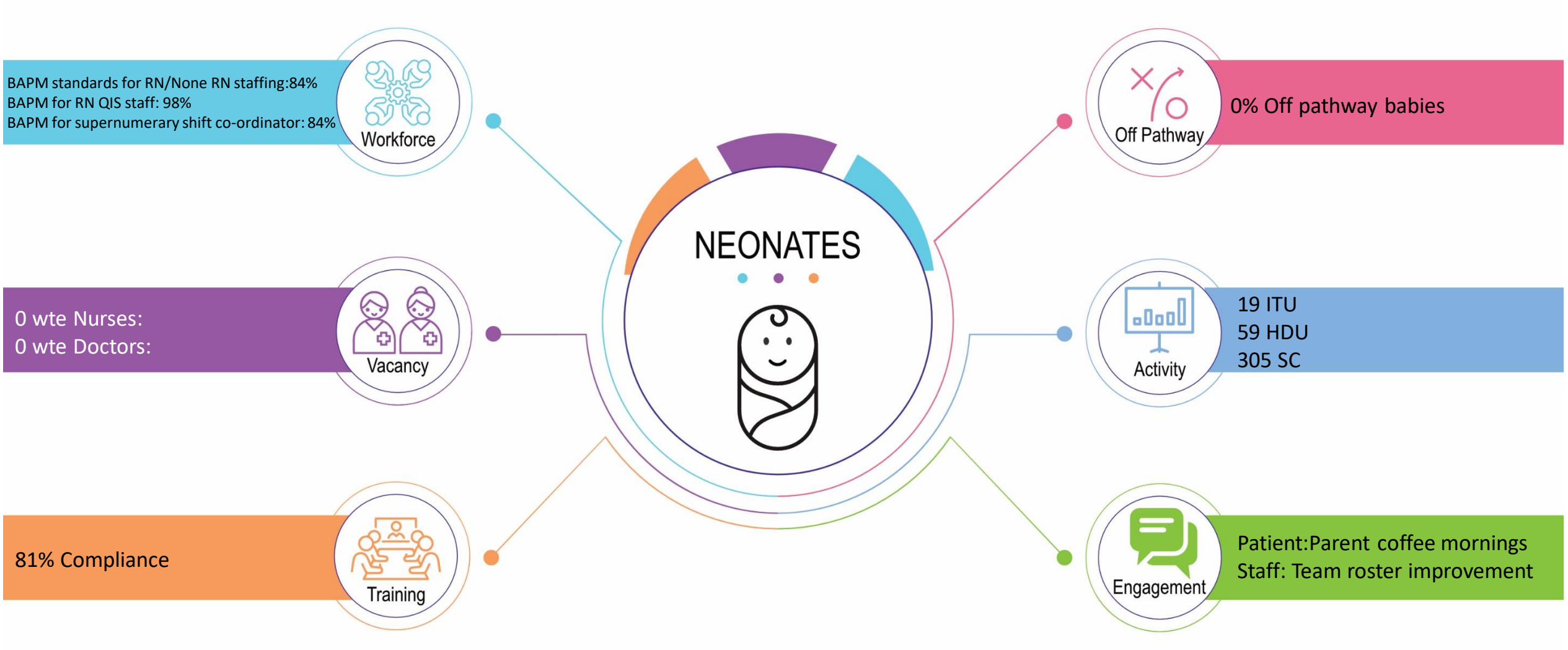
Where do we want to be?

- To cover all gaps via substantive staff with minimal Bank usage to cover last minutes sickness.
- Maintain low sickness and absence levels.
- Continue to have 100% for all CNST year 7 staffing requirements.

Neonates at a glance: February 2025



Neonates at a glance: March 2025



Patient Experience

Patient experience is crucial for the quality of maternity care, making patient feedback a priority at TRFT. A recent Kings Fund paper noted that "organisations with the most developed approaches to feedback have adopted a wide variety of tools, tailored to local needs." (The Kings Fund, 2023). Given this, senior leaders in maternity services believe it's vital to allocate adequate time and resources for feedback activities, especially under service pressure. This month's focus will be on the MNVP's interim report (March 2025) regarding the 15 Steps in acute maternity services, with progress monitored through Maternity Safety Champions meetings.

In Summary

What is the data telling us?

- The event was independently organised by the Chair from the TRFT MNVP.
- Bump, Birth and Beyond, representing the voices of those from deprived areas. Rotherham Ethnic Minorities Alliance representing the voices of those from ethnic minorities, Clifton Learning Partnerships representing the voices of those from the Roma Community attended the walk around in February 25.
- Areas of focus were Environment & First Impressions, Communication & Interaction and Equipment & Facilities Management.
- Areas visited were Wharncliffe Ward, Labour Ward and Greenoaks.

What is going well?

Positive Aspects:

- Friendly and welcoming staff in several units
- Well-maintained and clean environments
- Clear and informative signage in some areas

What do we need to focus on?

Areas for Improvement:

- Signage & Navigation: Some areas had unclear or excessive signage, making navigation challenging for service users.
- Facility Upkeep: Some spaces required maintenance, including improved baby-changing facilities and damaged windows.
- Translation Gaps: Inconsistent translation provision was observed, highlighting the need for improvements to translation of signage, feedback and access information.

Where do we want to be?

- We aim to repeat the MNVP 15 steps with service users with learning difficulties, neurodiversity, and physical disabilities in the future to have a wide range of service users review the service.
- Following completion of action plans we want all service users to feel included and able to easily navigate and feel welcomed within TRFT services.

Staff Feedback

Staff surveys in maternity services are crucial for identifying areas of improvement and enhancing the quality of care. They provide valuable insights into the experiences of staff, allowing TRFT to address concerns and create a more supportive and positive work environment. By gathering this feedback, the staff survey helps us to improve local working conditions, which ultimately leads to better patient care. The 2024 surveys has allowed staff to voice concerns and highlight specific areas within the maternity service that need attention, such as staffing levels, workload, or support systems. Below is a summary of the findings that Matrons are currently working on in their areas. The 'We Said, We Did' feedback is planned to go to the May 2025 CBU 3 Governance meetings for final sign off.

In Summary

What is the data telling us?

- Overall, the maternity services as a whole remains positive.
- The maternity area that has continued to remain overall positive is the Community Midwifery team.
- Area with the most work to be done is the acute maternity services area.

What is going well?

- If friend/relative needed treatment would be happy with standard of care provided by organisation score very well in all areas of maternity with the lowest score being 73% and the highest being 93%. (average 77%).
- Receive the respect I deserve from my colleagues at work 70.3%.
- Team members understand each other's roles 74.7%
- Enjoy working with colleagues in team 83.7%
- Not experienced discrimination from manager/team leader or other colleagues 94%
- Care of patients/service users is organisation's top priority 72.3%

What do we need to focus on?

- Appraisal helped me improve how I do my job 23.7%
- Never/rarely worn out at the end of work 20.7%
- Never/rarely frustrated by work 20.2%
- Have realistic time pressures 26.7%
- Develop 'We said, We did' action plans and share with the wider teams.

Where do we want to be?

- To be a responsive service who listens and responds to staff feedback in a meaningful way.
- To influence positive change that would be reflective in the 2025 staff survey results.

Current Issues and Summary

Staffing and Acuity: Labour Ward Acuity: Acuity was met 95% of the time in February and 90% in March. Actions were taken to ensure 100% 1:1 care in labour despite staffing challenges. Staffing Gaps: February had 11.06 WTE gaps, and March had 10.36 WTE gaps, mainly due to maternity leave and long-term sickness.
Safety and Incident Reporting: Moderate Incidents: 16 moderate incidents reported, mostly related to postpartum haemorrhage (PPH) and major obstetric haemorrhage (MOH). All incidents were downgraded after MDT review. MNSI Cases: 1 case referred to MNSI in March for a baby requiring therapeutic cooling. Investigation is ongoing.
Patient Experience: Formal Complaints: 3 formal complaints in February and March with no identified themes. Positive Feedback: FFT data was overwhelmingly positive, with several compliments received via PALS.
Training Compliance: Maternity Newborn Life Support Training: 97% compliance. MDT Clinical Simulation Training: 84% compliance, with a reduction due to medical staff rotation in February.
Perinatal Mortality: Stillbirth Rates: Noted to have an Increase in local stillbirth rate from 2022-2024 to 3.66 /1000 births for 2024 (TRFT Data). Continuous learning from reviews shared via maternity MAST. Neonatal Deaths: No new neonatal deaths reported in February or March 2025.
Governance and Learning: PSIRF Model: Thematic review of obstetric haemorrhage incidents to inform education and delivery practices. Action Plans: Robust action plans from cases graded as B, C, or D shared with wider teams and families.

In Summary

What is the data telling us?

- That Stillbirth rate require continued focus to understand any learning and continue to improve the service for women who use TRFT maternity Service.
- Training is on track and has learning from local investigation outcomes and service user feedback within it's curriculum.
- Staffing requires ongoing oversight to ensure that Birthrate+ recommendations are sustained.

What is going well?

- Year 6 CNST, 10 safety standards have been met via internal and external review. Board declaration submitted and awaiting feedback from Maternity Incentive Scheme.
- There is a clear route of communication between staff who work within the service and the Neonatal and Maternity Safety Champions.
- The Rotherham MNVP are working in partnership with TRFT to hear the voices of and improve services for the most vulnerable women.

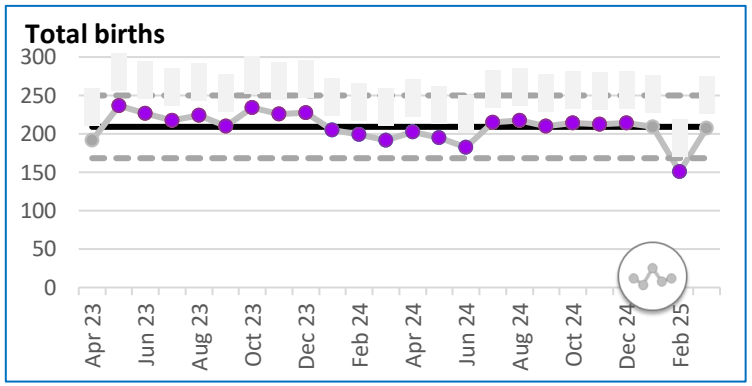
What do we need to focus on?

- The Year 7 CNST standards were released in March 2025. Workstreams continue.
- Feedback from the LMNS visit in February 2025, evaluating TRFT's 3 Year Delivery Plan, will be sent to the service for review.
- Staff Survey improvement work/ engagement with teams ongoing.
- Ongoing monitoring of data outcomes and demographics of women experiencing moderate or greater harm.

Where do we want to be?

- An outstanding Maternity Service who offer personalised care to all women and families who use our services.

SPC Charts


Total births
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250
200
150
100
50
0
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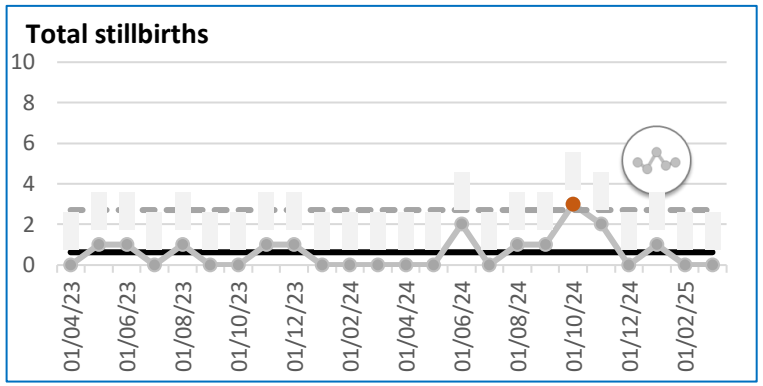
Jun 23
Aug 23
Oct 23
Dec 23
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Dec 24
Feb 25


Total stillbirths
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8
6
4
2
0
01/04/23
01/06/23
01/08/23
01/10/23
01/12/23
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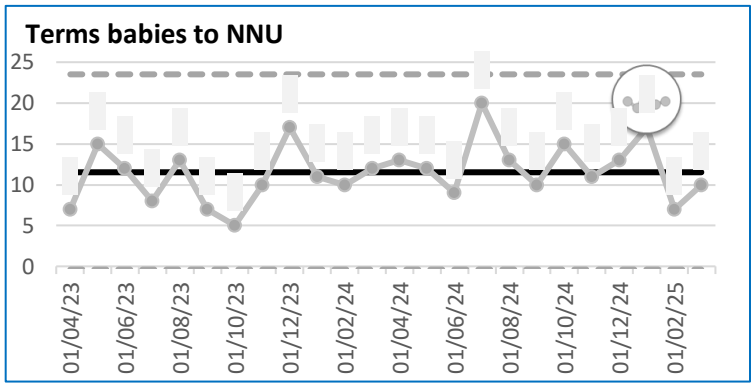
01/04/24
01/06/24
01/08/24
01/10/24
01/12/24
01/02/25


Terms babies to NNU
25
20
15
10
5
0
01/04/23
01/06/23
01/08/23
01/10/23
01/12/23
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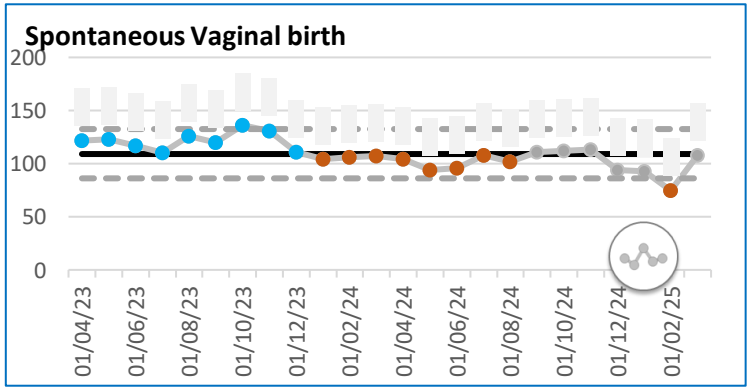
01/02/25


Spontaneous Vaginal birth
200
150
100
50
0
01/04/23
01/06/23
01/08/23
01/10/23
01/12/23
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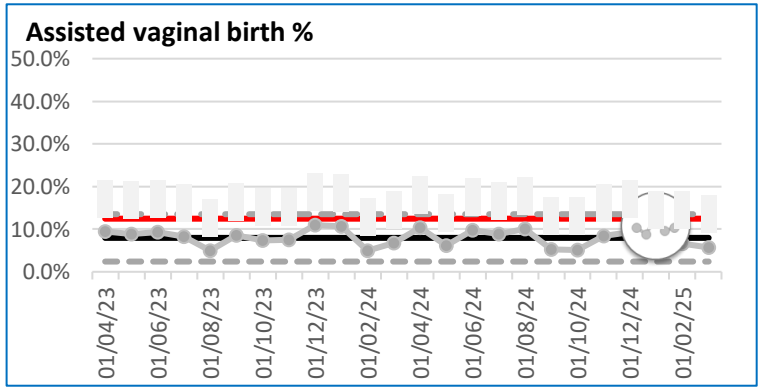
01/04/24
01/06/24
01/08/24
01/10/24
01/12/24
01/02/25


Assisted vaginal birth %
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40.0%
30.0%
20.0%
10.0%
0.0%
01/04/23
01/06/23
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01/04/24
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01/08/24
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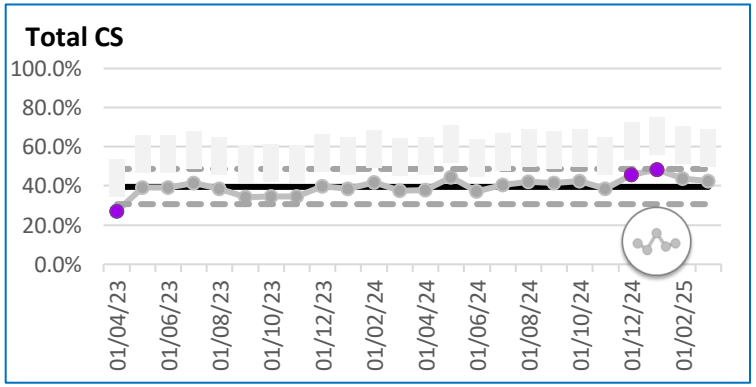
01/12/24
01/02/25


Total CS
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60.0%
40.0%
20.0%
0.0%
01/04/23
01/06/23
01/08/23
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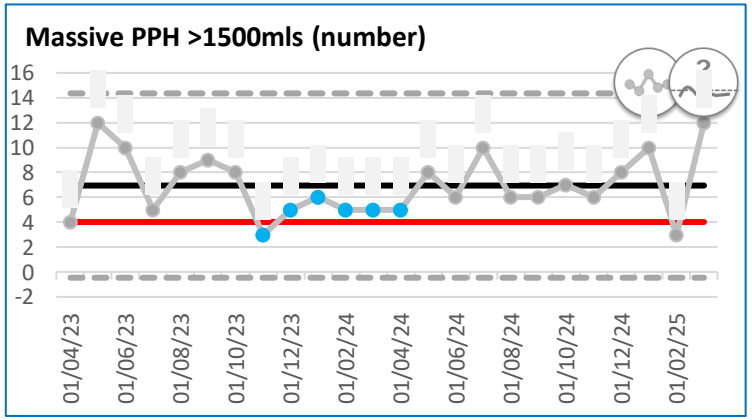
01/04/24
01/06/24
01/08/24
01/10/24
01/12/24
01/02/25


Massive PPH >1500mls (number)
16
14
12
10
8
6
4
2
0
-2
01/04/23
01/06/23
01/08/23
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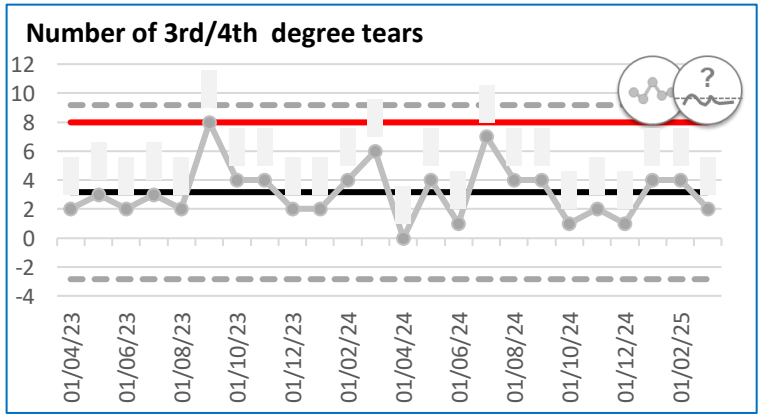
01/04/24
01/06/24
01/08/24
01/10/24
01/12/24
01/02/25


Number of 3rd/4th degree tears
12
10
8
6
4
2
0
-2
-4
01/04/23
01/06/23
01/08/23
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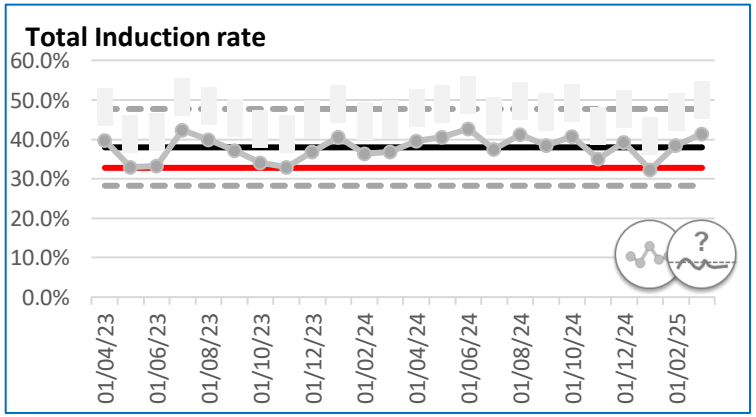
01/04/24
01/06/24
01/08/24
01/10/24
01/12/24
01/02/25


Total Induction rate
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
01/04/23
01/06/23
01/08/23
01/10/23
01/12/23
01/02/24
01/04/24
01/06/24
01/08/24
01/10/24
01/12/24
01/02/25

Maternity Incentive Scheme: Year 7

Safety Action 1:
Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?

Safety Action 2:
: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Safety Action 3:
Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

Safety Action 4:
Can you demonstrate an effective system of clinical workforce planning to the required standard?

Safety Action 5:
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Safety Action 6:
Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Safety Action 7:
Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Safety Action 8:
Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?

Safety Action 9:
Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Safety Action 10:
Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025

Saving Babies Lives v3

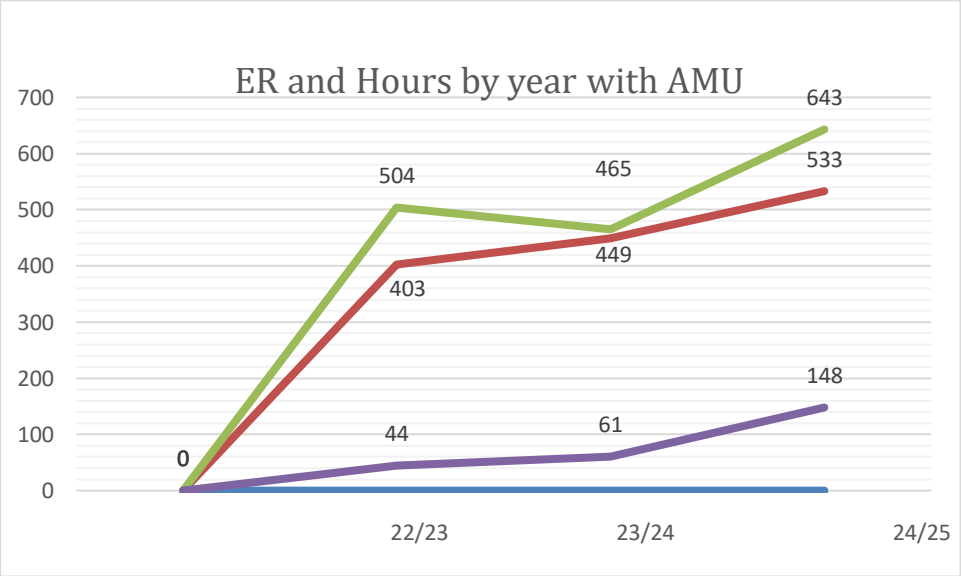
Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	90%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	96%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	96%	Partially implemented	97%	CNST Met

Board of Directors' Meeting
2nd May 2025

Agenda item	P80/25
Report	**Guardian of Safe Working - Annual Report 2024/25 incorporating Q4 data**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	
How does this paper support Trust Values	**Ambitious** - for improvement in working conditions and patient safety. **Caring** - for colleagues and patients. **Together** - solutions are proposed after discussion has identified problems.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	Under the 2016 Junior Doctor Contract, a quarterly and annual report from the Guardian of Safe Working is required to provide assurance to the Board that working in the trust is safe. The contract specifies maximal shift durations, total hours per week and hours worked without breaks. The UK's resident doctors have reached agreement with the DHSC on major changes to the exception reporting process. The introduction of national Statutory Mandatory training should streamline induction and improve conditions for residents. At The Rotherham NHS Foundation Trust (TRFT), workload and staffing are sometimes felt to be unsafe, especially by the most junior trainees. Exception reports demonstrate significant pressure on the on call teams in Medicine, who are understrength compared to hospitals with similar bed numbers.
	The report collates information from the Allocate system for exception reporting, the Junior Doctors' Forum monthly meetings, the Datix system, personal communication and assorted email correspondence. It has been prepared by Dr Gerry Lynch, TRFT Guardian for Safe Working, and sponsored by Dr Jo Beahan, Medical Director.
Board powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	*From May 1st, NHS staff will be able to move statutory and mandatory training between hospitals.* *By 12th September, significant changes to the exception reporting process need to be implemented. These briefly comprise Onboarding to ER system within 2 weeks of starting work*

	Additional hours reports will go to HR and the GOSWH, and educational exception reports to DMEs, with the requirement for meetings with supervisors removed. *Clinical judgement around working additional hours will not be challenged.* *Fine amounts will increase.*
Recommendations	The Board is asked to note this report and to support strengthening of the on-call teams in Medicine in particular.
Appendices	**Appendix 1-Annual data 2024/25** **Total exceptions by year**

Year	22/23	23/24	24/25
Total ER	403	449	533
Hours	504	465 (-7.7%)	643 (+ 38%)
AMU ER (% total)	44 (10.9)	61 (13.6)	148 (27.7)



Exception Reports (ER) over past year	
Reference period of report	1/04/24 - 1/04/25
Number relating to immediate patient safety issues	13
Number relating to hours of working	533
Number relating to pattern of work	12
Number relating to educational opportunities	29
Number relating to service support available to the doctor	13

The year saw a significant rise in exceptions coming from AMU with an increase in hours worked overtime largely accounted for by this.

Issues for Resident Doctor Forum

The Guardian of Safe Working and Director of Medical Education co-chair the Resident Doctor Forum and alternate weekday meetings to help attendance.

This forum is the vehicle for trainees to raise concerns and issues and for management and medical workforce to respond. As well as doctors in training, it is attended by representatives from Medical Workforce, the Care Groups, Medical Director, Director of Medical Education and Guardian of Safe Working.

'Live' issues for the current trainee cohort are:

Medical on call workload - this is a recurring issue at the Resident Doctors Forum and has knock-on effects on patient flow through the hospital. Medical Workforce are investigating how TRFT compares to hospitals of similar size in the region.

Upcoming JCF and CT rota gaps from April 2025 - will be backfilled with agency staff.

Accommodation on A3 and B4 - Issue taken to Space Utilisation Group. Some informal solutions are being looked at in addition.

Taskboard management and rota access from home has been looked at by the EPMA team and the solution seems to be to use Microsoft Teams for now.

Immediate risks to safety and any departures from contract will be flagged up as soon as possible to the divisions by the GSW and DME.

NHSE have mandated measures to improve working lives including timely rotas, increased availability of self-rostering, improved payroll accuracy and reduced burden of Statutory Mandatory training, amongst others and the Resident Doctors Forum will discuss implementation of these.

Appendix 2 -Q4 data

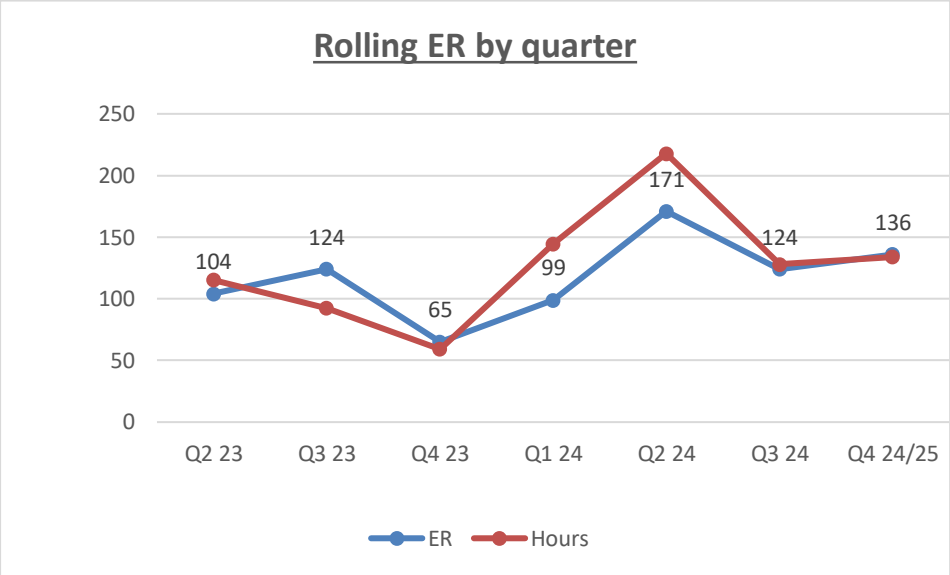
In Q4, between 29/12/24 and 29/03/25, 30 Doctors (12 FY1, 4 FY2, 5 CT1/ST1, 1 FTSTR, 1 Specialty Doctor,1 ST2, 2 ST3, 2ST4, 1 ST6, 1ST7) submitted 136 exception reports related to hours worked.

8 ER related to education and 1 related to service support were also submitted.

Q4 Working hours exceptions

(Sub) Specialty	Exceptions	Daytime Hours	Nightime hours
A1 HCOP	1	0.5	
A3 Respiratory	22	20.65	

A4 HCOP	07	4	
A5 DM	3	3	
A5 Gastro	4	3.5	
AMU	74	95	
Stroke	2	0.75	
Medical Division total	112	127.4	
Orthopaedics	5	5.416	
General Practice	2	2	
Obs and Gynae	2	2.25	1.25
Gen Surgery ASU	7	11	0.166
Gen Surg B10	1	1	
ED	1	1.25	
Paediatrics	5	4	
Total	136	154.32	1.42



Exception reports for missed educational opportunities

8 exception reports for missed educational opportunities were filed from Medicine - these are dealt with by the DME.

Immediate safety concerns

One immediate safety risk was noted due to absence of a SHO on night shift. It was dealt with by the educational supervisor of the trainee in question and discussed at Resident Doctors Forum.

Triangulation with Datix system

Search of the Datix system, however, revealed no record of incidents in this quarter where lack of trainee staff was mentioned.

Data from BDGH

Although not directly comparable, shows quarterly exceptions and hours significantly higher in July-Sept 24

	TRFT	BDGH
Hours	103	36

Guardian fines

1 fine will be levied this quarter for > 25% missed breaks excessive shift lengths, or in this case, persistent hours in excess of 48/week. Doctors on the medical FY2/CT rotas whose work schedules average 47.25 hours per week have little margin for overstays

Qualitative examples from Exception reports

“Finished late due to…
- Addition of two patients previously unallocated needing ward round
- High volume of tasks, most inappropriate to handover to night team
- Needing to refer to multiple specialties which were unreachable”

“One SHO down for on call night shift which is immediate safety concern due to not adequate staffing…”

“45 minutes later than should have finished”

Board of Directors' Meeting
2nd May 2025

The Rotherham NHS Foundation Trust

Agenda item	P77/25
Report	**Learning From Deaths & Mortality: Quarterly Report 2024/25 Q3**
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 Nov 2024) is **104.8**. TRFT remain in the 'As Expected' Band. Being in the 'As Expected' band, means that 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. Thematic Analysis Report 2024/25 Q3 2. SHMI Report – Latest Month's Data Nov 2024 3. Medical Examiner Report 2024/25 Q4

John Taylor
Learning from Deaths & Mortality Manager
April 2025

1.0 Learning from Deaths Quarterly Report: 2024/25 Q3

	Due Date	SJR Data	SHMI Latest Month
This Report	-	2024/25 Q3	Nov 2024
Next Report	06/06/2025	2024/25 Q4	Dec 2024

*SJR data is grouped & reported by the date of death

2.0 SJR Requests

				Source of SJR Request		
Discharge Date	**Adult Inpatient & UECC Deaths**	**SJR Requested**	**SJR Requested %**	**Medical Examiner**	**Trust Data**	**Other**
2024/25 YTD	720	152	21%	81	63	8
2024/25 Q1	243	60	25%	36	18	6
2024/25 Q2	210	45	21%	26	17	2
2024/25 Q3	267	47	18%	19	28	0
2023/24	1070	224	21%	111	105	8

3.0 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	Preventa-bility Score < 4
2024/25 YTD	147	5	97%	63%	17	0
2024/25 Q1	60	0	100%	45%	6	0
2024/25 Q2	45	0	100%	64%	4	0
2024/25 Q3	42	5	89%	83%	7	0
2023/24	224	0	100%	56%	40	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

3.1 Update

Timeliness figures are monitored by the Trust Mortality Group.

For deaths in 2024/25 Q1, 2 & 3, 97% of SJRs have been completed. 63% have been completed within 60 days of death, which is below the 75% target.

There are 57 breaches, which have either been completed >60 days after death, or are yet to be completed. For 28 of these breaches the Reviewers were given at least 28 days to complete.

3.2 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.

Some of the breaches resulted from having to reallocate a number of SJRs (deaths in Apr 24 – July 24) within the team due to a SJR Reviewer leaving this role.

The timeliness rate for deaths in 2024/25 Q3 was **83%.** If this % is repeated for Q4. The yearend figure will be around 70%, which would represent a significant improvement on the 57% figure for 2023/24.

4.0 Summary & Distribution 2024/25 Q3 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 Moves
End of Life/Palliative Care/DNACPR
Communication

Group
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
CG1 Mortality Meeting - Medicine
CG1 Mortality Meeting - UECC
CG2 Mortality Meeting - Surgery
Trust Mortality Group

4.1 Update:

The Thematic Analysis report for 2024/25 Q3 has been produced and distributed. The report should be read and themes relating to objectives of Trust meetings be put on the agenda and discussed.

5.0 SJR Themes to QI Project (Quality Improvement)

A twice yearly discussion group is commencing in March 2025. At this meeting SJRs themes will be reviewed for 3 quarters. The purpose of the meeting is to select themes suitable for QI projects, and to decide which team/person will lead the project. Membership will include the Deputy Medical Director, the Learning from Deaths Manager and there will be representation from the QI Team, Care Groups and the SJR Reviewer Team.

6.0 Next Report:

The next Thematic Analysis Report will be completed in June 2025 for 2024/25 Q4 SJRs.

7.0 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.

8.0 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 YTD	23	22	1	4	0
2024/25 Q1	8	8	0	1	0
2024/25 Q2	7	7	0	0	0
2024/25 Q3	8	7	1	3	0
2023/24	33	33	0	7	0

	Requested SJRs	Learning Disability or Autism	Serious Mental Illness
2024/25 YTD	23	8	15

8.1 Update

All 2024/25 Q1, 2 & 3 deaths for those with an identified Learning Disability, Autism or a Serious Mental illness have has an SJR requested. There is one SJR outstanding.

All completed SJRs 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.

9.0 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.

9.1 Update

The 17 reportable SJRs for deaths in 2024/25 Q1, 2 & 3 have all been logged as incidents for review and possible investigation on Datix. 15 of these have been concluded in Datix.

All resulting outcomes (Lessons Learnt & Actions) are reported for discussion at the Trust Mortality Group.

10.0 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/trust wide.

Due to the small volume, all UECC deaths are discussed at the bi-monthly held CG1-UECC Mortality Meetings.

10.1 Update

The Learning from Deaths & Mortality Manager completed a review of Care Group 1 Mortality Review discussions in their CG Mortality meeting and in their CSU Clinical Governance or separate Mortality meetings. This was completed for meetings held between April and Sept 2024. The purpose of this review was to determine if TRFT are continuing to meet the requirement for the final 360 Assurance Action Point, which it passed in April 2024.

We did not find evidence that suitable arrangements are in place within Medicines CSUs for discussion on the outcomes of mortality reviews/SJRs – Governance finding from 360 Assurance Audit June 2023 (passed in April 2024)

There were 24 minuted Mortality Review Discussions. This number is likely to be larger because some CSUs are unable to produce or provide minutes for their meetings. This is an issue that has been discussed at CG1 Mortality meeting.

The CG and Divisions have been asked to follow a format where the issues raised in the SJRs are discussed prior to the local clinical review. It is evident that this is now starting to happen.

A similar review of meetings held between October 2024 & March 2025 will be untaken in May 2025. The aim to give the Trust assurance that TRFT would pass the 360 Action Point, if the Trust is audited again.

11.0 SHMI Alert Investigations

The SHMI has two 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.

12.0 Last Alerts & Investigations:

SHMI Alerts are presented and discussed at the Trust Mortality Group meeting. Responses are decided and requested at these group meetings.

There have been **zero alerts** since the previous report.

13.0 Coding Changes Affecting the SHMI:

Clinical Coding and Data Quality continue to work with the MediTech team and Clinician Teams to maximise the capture of co-morbidities.

Where Have SJRs Gone in 2024/25 Q3?

Number of SJRs	Destination	Purpose
10	Resuscitation Team	Requested to assist work stream to reduce unnecessary resuscitations
34	CG1 Mortality Lead & CG1 SJR Review Group	To be reviewed to select SJRs for discussion within the CG/CSU
7	CG2 Mortality Lead	To be reviewed to select SJRs for discussion within the CG/CSU
1	UECC Mortality Lead	To be reviewed to select SJRs for discussion within the CG/CSU
42*	UECC Mortality Lead	To be reviewed to select SJRs for discussion within the CG/CSU
7	Patient Safety team (Logged Incidents on Datix)	For further review and if necessary investigation
2	SJRs to the Medication Safety Officer	To be reviewed & discussed at the Medicines Safety Committee
10	Deteriorating Patient Group & Sepsis QI	To be reviewed & discussed at the Deteriorating Patient Group or QI Sepsis Group
1	Trauma Group	To be reviewed & discussed at the Trauma Group
7	Safeguarding & Learning Disability Teams	To be reviewed for discussion at Team meetings
1	ICB LeDer Team	To assist with ICB led LeDer Reviews
1	Legal Team	To assist with reviews/inquest
17	Medical Examiner Service	To give feedback on their escalations
42	Thematic Analysis Reports	To group comments together to be reviewed by various Groups/Teams

* 1st 24 hrs Phase of Care sections

Board of Directors' Meeting
2nd May 2025

Agenda item	P/79/25
Report	**Terms of Reference – Board Committees Annual Review**
Executive Lead	Peter Walsh, Interim Director of Corporate Affairs
Link with the BAF	The paper links with all BAF risks
How does this paper support Trust Values	The documents support all Trust values.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	The Board Committees carried out a review of their respective Terms of Reference during January and February 2025. The following approved Terms of Reference are presented to Board for final ratification: • Quality Committee • People and Culture Committee • Finance and Performance Committee
Due Diligence	The Terms of Reference have been discussed and approved at the respective Committees.
Board powers to make this decision	The power to make the decision is held within the Scheme of Delegation.
Who, What and When	Following final ratification the Terms of Reference will be published on the Trust website.
Recommendations	It is recommended that the Board confirm final ratification of the attached Terms of Reference.
Appendices	• Quality Committee Terms of Reference • People and Culture Committee Terms of Reference • Finance and Performance Committee Terms of Reference

The Rotherham NHS Foundation Trust

People and Culture Committee
Terms of Reference

Name and Designation of Author	Director of Corporate Affairs
Approved by	People and Culture Committee Trust Board
Approving evidence	People and Culture Committee Minutes – 28th February 2025
Date approved	People and Culture Committee – 28th February 2025
Review date	February 2026
Review frequency	Annual Review
Target audience	People and Culture Committee Members and Attendees
Links to other Procedural Documents	Trust Board Terms of Reference
Protective Marking Classification	

Date	Version	Author Name & Designation	Summary of amendments
November 2022	2	Director of Corporate Affairs	
February 2024	3	Director of People	Significant changes presentationally given expiry of current People strategy and BELL framework.
February 2025	4	Deputy Director of Corporate Affairs	Updated authority as delegated by the Board of Directors. Additional duties in Section 3.4 in relation to Risk Management and the Board Assurance Framework

Version Control

Title	**People and Culture Committee Terms of Reference**
Constitution	1.1 The People and Culture Committee ("the Committee") is constituted as a standing committee of the Board of Directors ("the Board") of The Rotherham NHS Foundation Trust ("the Trust").
Authority	2.1 The Committee is authorised by the Board to consider any matter within its Terms of Reference and be provided with the Trust resources to do so. 2.2 The Committee has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion. 2.3 The Committee is authorised to instruct external professional advice and to invite external consultants with relevant experience and expertise to attend if it considers this necessary or expedient to exercise its functions. 2.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. This may include establishing task and finish groups as required to assist in discharging its responsibilities. 2.5 The Committee has no executive powers other than those set out in these Terms of Reference.

	2.6 The Committee is authorised to meet via a virtual/remote meeting. 2.7 The Committee is authorised, in exceptional circumstances to conduct discrete business outside of its scheduled meetings where is it not practicable to convene a full meeting. The process to be followed is set out in Section 10.7. 2.8 The Committee has the authority to approve specific policies and procedures relevant to the Committee's remit. 2.9 The Committee has the authority to approve the Integrated Equality and Diversity Plan.
Purpose & Duties	3.1 The **Purpose** of the Committee is to: a) Provide assurance to the Board that the Trust has appropriate and effective strategies and plans in place relating to TRFT's people. To include workforce planning, retention and recruitment, engagement, health and wellbeing, organisation development, culture, equality diversity and inclusion, leadership and management, talent, training, education and learning so as to enable the Trust to meet its Vision and Strategic ambitions based on its values . b) Provide assurance to the Board on the timely delivery of the agreed Operational Plan; c) Act as link to staff, stakeholders and strategic partners providing a forum for discussion and consideration of best practice reports, guidance and initiatives relating to TRFT's people and culture to enable the Trust to progress towards being the best Trust for staff and providing exceptional healthcare to the people of Rotherham. 3.2 The **Duties** of the Committee will centre around the; • People and Culture Strategy • Annual Operational Plan • Any associated People Plans e.g. Equality Diversity and Inclusion plan • Staff survey • The effective authorisation of reports requiring Board or People and Culture Committee approval including for example; o Workforce Race Equality Standard (WRES) o Workforce Disability Equality Standard (WDES) o Equality Delivery System (EDS) o Gender Pay gap report

	3.3 The Committee will receive presentations from senior Care Group and Corporate Services leaders on a rotational basis 3.4 In addition to the above, the Committee will: • Review the Board Assurance Framework risks delegated to the Committee, and to make recommendations to the Board for any required changes of risk score or content; • Review risk management information of risks rated 8 and above from the Risk Register relating specifically to the remit of the Committee, as determined by the Risk Management Committee; • Review the Issues Log as identified by the Risk Management Committee; • Review and consider emerging risks.
Reporting To	4.1 The Committee is accountable to the Board. 4.2 The Committee shall report to the Board on how it discharges its responsibilities 4.3 The Chair of the Committee will bring to the attention of the Board any items that the People and Culture Committee considers the Board should be aware of through the Chair's report to the Board in addition to any issues that require disclosure to any regulatory body. 4.4 The minutes of the Committee's meetings shall be formally recorded and submitted to the Board, once approved by the Chair of the Committee. 4.5 The Committee will consider matters referred to it for action by the Audit and Risk Committee, Finance and Performance Committee and or the Quality Committee and will report back in writing, as appropriate. The Committee will consider matters it wishes to refer to the above named committees who will report back in writing, as appropriate. 4.6 The Committee, will, on an exception basis, report into the Audit and Risk Committee any identified unresolved risks arising within these Terms of Reference. 4.7 The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed. 4.8 In addition the Chair of the Committee will provide a quarterly report on the Committee's activities to the Council of Governors.
Membership	5.1 The Committee members shall be appointed by the Board and shall comprise:

	• Three Non-Executive Directors • Executive Director of People who will be the Lead Executive; and • The Managing Director 5.2 Members who are unable to attend the meeting can send a Deputy with the prior approval of the Chair; such Deputy must have the ability and authority to make decisions and contribute fully to the business of the Committee. 5.3 The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors.
Attendees	6.1 Attendees to include: • Chief Nurse • Medical Director • Chief Operating Officer • Director of Corporate Affairs • Deputy Director of Corporate Affairs • Deputy Director of People • Head of OD and Inclusion • Chief AHP • Senior leaders from each Care Group (rotational) 6.2 Other Executive Directors or colleagues may be invited to attend for specific agenda items.
Quorum	7.1 A quorum shall be made up of three members comprising at least two Non-Executive Directors and one Executive Director. 7.2 No business shall be transacted by the Committee unless a quorum is present. 7.3 Those in attendance or observing do not count towards the quorum.
Observers	8.1 Meetings are not open to the public. 8.2 Observers may only attend with the prior approval of the Chair of the Committee.
Frequency of Meetings	9.1 Meetings shall be held bimonthly. 9.2 Additional meetings may be held after consultation with the Chair.
Meeting administration	10.1 Notice of meetings will be provided in the form of an annual calendar prepared by the end of March each year.

	10.2 The Chair of the Committee, Lead Executive and the Deputy Director of Corporate Affairs will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan. 10.3 The Lead Executive Director for the Committee will be the Executive Director of People. The Director of Corporate Affairs will support the Chair of the Committee and Lead Executive Director in the management of the Committee's business and for drawing the Committee's attention to best practice, national guidance and other relevant documents, as appropriate. 10.4 Administrative support to the Committee will be provided by the Corporate Governance Department. Agendas can only be amended by agreement of the Committee Chair and Lead Executive Director. 10.5 The agenda and papers will normally be circulated five working days prior to the meeting to Committee members and regular attendees. In exceptional circumstances (for example, timing of data) and with the agreement of the Chair and Executive lead, provision is made for an agenda item or items to be added to the binder within the 5 day period prior to the meeting. 10.6 Draft minutes and action log will be produced by the Corporate Governance Department within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting. 10.7 For business to be conducted outside of the scheduled meetings the following must apply: • The business to be conducted must be set out in formal papers accompanied by the usual cover sheets clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Governance function; • The Committee will be expected to respond, subject to availability, by e-mail to the full distribution list with their views within 3 working days of receipt of the paper; • For a decision to be valid, responses must be received from a quorum. In the event there is no unanimous agreement, the proposal shall be considered not to be approved; • The Director of Corporate Affairs will summarise the conclusions reached and these will be presented to the next scheduled meeting.
Operational Groups which report into the Committee/Group	11.1 The operational group reporting into the Committee is: • Operational Workforce Group The Director responsible shall provide a quarterly report to the Committee.

Monitoring and review	12.1 The Committee's Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board. 12.2 The Committee will undertake an annual review of its performance via a self-assessment by its members and some attendees; any agreed actions will be reported to the Audit and Risk Committee and Trust Board.

The Rotherham NHS Foundation Trust

Quality Committee
Terms of Reference

Name and Designation of Author	Angela Wendzicha, Director of Corporate Affairs
Approved by	Quality Committee Trust Board
Approving evidence	Minutes of the Quality Committee meeting held on 29th January 2025 Minutes of the Board meeting held on
Date approved	Quality Committee – 29th January 2025
Review date	January 2026
Review frequency	Annual
Target audience	Quality Committee Members and Attendees
Links to other Procedural Documents	Standing Orders of the Trust Board
Protective Marking Classification	Subject to Freedom of Information Act

Date	Version	Author Name & Designation	Summary of amendments
June 2021	1.0		
July 2022	2.0	Angela Wendzicha, Director of Corporate Affairs	Full review
January 2024	3.0	Angela Wendzicha, Director of Corporate Affairs	Full review
January 2025	4.0	Alan Wolfe, Deputy Director of Corporate Affairs	Updated authority as delegated by the Board of Directors. Additional duties in Section 3.2 in relation to Risk Management and the Board Assurance Framework

Version Control

Title	Quality Committee Terms of Reference
Constitution	1.1 The Quality Committee ("the Committee") is constituted as a standing Committee of the Board of Directors ("the Board") of The Rotherham NHS Foundation Trust ("the Trust").
Authority	2.1 The Committee is authorised by the Board to consider any matter within its Terms of Reference and be provided with the Trust resources to do so. 2.2 The Committee has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information of answer questions on a matter under discussion. 2.3 The Committee is authorised to instruct external professional advice and to invite external consultants with relevant experience and expertise to attend if it considers this necessary or expedient to exercise its functions. 2.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. This may include establishing task and finish groups as required to assist in discharging its' responsibilities. 2.5 The Committee is authorised, in exceptional circumstances to conduct discrete business outside of its scheduled meetings where it is not practicable to convene a full meeting. The process to be followed is set out in Section 10.7.

	2.6 The Committee is authorised to meet via a virtual/remote meeting. 2.7 The Committee has no executive powers other than those set out in these Terms of Reference. 2.8 The Committee has the authority to approve specific policies and procedures relevant to the Committee's purpose, responsibilities and duties as delegated from the Trust Board. 2.9 Engage with the Trust auditors in cooperation with the Audit and Risk Committee. 2.10 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. 2.11 The Quality Committee has delegated authority from the Board of Directors for oversight and scrutiny of: • Performance against the following domains of quality, safety, effectiveness and patient experience. • Compliance with essential regulatory and professional standards, established good practice and mandatory guidance.
Purpose & Duties	3.1 The Board has approved the establishment of the Committee for the purpose of ensuring the highest standard of care is provided to patients consistently across the organisation, that the Trust continually improves the standard of care delivered whilst achieving good outcomes for our patients. 3.2 The Committee will support the timely delivery of the Trust's Strategic Ambitions and relevant section of the Operational Plan giving detailed consideration to the Trust's Quality and safety issues whilst being assured as to compliance with appropriate regulatory and statutory requirements. The Committee will discharge its purpose through the following duties: • Seek assurance on the implementation of the Trust's Quality Priorities against agreed milestones; • Seek assurance of the Operational Objectives delegated from the Board; • Seek assurance of the Trust Safeguarding arrangements; • Oversight of the Risk Register and Board Assurance Framework aligned to the Quality Committee, making any recommendations to the Trust Board; • Seek assurance on the implementation of Quality Improvement, in delivery of improvement work and Qi training.; • Seek assurance on the completion of actions required following Regulatory Inspections and the appropriate reporting of evidence to Regulatory Bodies;

	• Oversee the production of and make recommendations to the Board for the approval of the Annual Quality Report; • Seek assurance that the registration criteria of the Care Quality Commission continue to be met; • Seek assurance that compliance with the NHS Provider Licence continue to be met; • Seek assurance by way of deep dives on any matters the Committee considers it has not received sufficient information or assurance; • Seek assurance that robust arrangements are in place for the review of patient safety incidents (including near misses), complaints/concerns, claims and reports from HM Coroner and that they remain fit for purpose; • Seek assurance that progress in being made against reviews relating to NICE Guidance; • Seek assurance in relation to management of Health & Safety; • Seek assurance through quarterly reports to the Committee by its sub-committees listed in Section 11.1. In addition to the above, the Committee will: • Consider matters referred to the Committee by the Board or other Board Assurance Committees; • Consider matters escalated to the Committee by its own sub-committees; • Support the Board in promoting within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's Freedom to Speak Up Policy. • Review the Board Assurance Framework risks delegated to the Committee, and to make recommendations to the Board for any required changes of risk score or content; • Review risk management information of risks rated 8 and above from the Risk Register relating specifically to the remit of the Committee, as determined by the Risk Management Committee; • Review the Issues Log as identified by the Risk Management Committee; and • Review and consider emerging risks.
Reporting to	4.1 The Committee is accountable to the Board. 4.2 The Committee shall report to the Board on how it discharges its responsibilities. 4.3 The Chair of the Committee will bring to the attention of the Board any items that the Quality Committee considers the Board should be aware of through the Chair's report to the Board. 4.4 The minutes of the Committee's meetings shall be formally recorded and submitted to the Board, once approved by the Chair.

	4.5 The Committee will consider matters referred to it for action by the Audit and Risk Committee, People Committee or Finance and Performance Committee. 4.6 The Committee will, on an exception basis, report into the Audit and Risk Committee any identified unresolved risks arising within these Terms of Reference. 4.7 The Committee will report to the Board annually on its work in support of the Annual Governance Statement. The annual report should also describe how the Committee has fulfilled its terms of reference and provide details of any significant issues that the Committee has considered and how these were addressed. 4.8 The Chair of the Committee will provide a quarterly report on the Committee's activities to the Council of Governors.
Membership	5.1 The Committee members shall be appointed by the Board and shall consist of: • Three Non-Executive Directors (one of whom must have a relevant clinical background) • Chief Nurse, who will act as Lead Executive; and • Medical Director 5.2 Members who are unable to attend the meeting can send a Deputy with the prior approval of the Chair; such Deputy must have the ability and authority to make decisions and contribute fully to the business of the Committee. 5.3 The Board shall appoint the Chair and the Vice Chair of the Committee from its Non-Executive Directors.
Attendees	6.1 Attendees to the Committee to include: • Director of Corporate Affairs • Deputy Director of Corporate Affairs • Director of Operations/Deputy Chief Operating Officer • Deputy Medical Director • Deputy Chief Nurse • Deputy Chief Nurse • Head of Quality Improvement • Clinical Effectiveness Manager • Chief AHP 6.2 Other members of staff will be invited to attend to present for specific agenda items. 6.3 The Chief Executive Officer or other Executive Directors may be invited to attend for specific agenda items.

Quorum	7.1 A quorum shall be made up of three members comprising at least two Non-Executive Directors and one Executive Director. 7.2 No business shall be transacted by the Committee unless a quorum is present. 7.3 Those in attendance or observing so not count towards the quorum.
Observers	8.1 Meetings are not open to the public. 8.2 Observers may only attend with the prior approval of the Chair of the Committee.
Frequency of Meetings	9.1 Meetings shall be held monthly. 9.2 Additional meetings may be held after consultation with the Chair
Meeting administration	10.1 Notice of meetings will be given at least seven working days in advance, unless members agree otherwise. 10.2 The Chair of the Committee, Lead Executive and the Deputy Director of Corporate Affairs will meet to agree the agenda for each meeting. 10.3 The Lead Executive Director for the Committee will be supported by the Director of Corporate Affairs in the management of the Committee's business in addition to drawing the Committee's attention to best practice, national guidance and other relevant documents. 10.4 Administrative support to the Committee will be provided by the Corporate Governance Department. 10.5 The agenda and papers will normally be circulated four working days prior to the meeting to all Committee members and those in attendance. Those individuals presenting papers will be provided with a copy of the final paper. 10.6 Draft minutes and action log will be produced by the Corporate Governance Department and provided to the Executive Lead and Chair within 5 working days of the Committee. Draft minutes will be approved by the Chair within 10 working days of the meeting. Action logs will be circulated to all those who have an action to complete. 10.7 For business conducted outside of the scheduled meetings, the following must apply: • The business to be conducted must be set out in formal papers accompanied by the usual cover sheets clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Governance Department;

	• The Committee will be expected to respond, subject to availability, by e-mail to the full distribution list with their views within 3 working days of receipt of the paper; • For a decision to be valid, responses must be received from a quorum. • The Director of Corporate Affairs will summarise the conclusion reached and these will be presented to the next scheduled meeting.
Operational Groups which report into the Committee/Group	11.1 The operational groups which report into the Committee are: • Patient Experience Committee • Patient Safety Committee • Safeguarding Committee • Infection Prevention & Control Committee • Medication Safety Committee • Clinical Effectiveness Committee • Health and Safety Committee The Director responsible for each area shall provide a quarterly report to the Committee.
Monitoring and review	12.1 The Committees Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board. 12.2 The Committee will undertake and annual review of its performance, via self-assessment by its members and attendees. Any agreed actions will be reported to the Audit and Risk Committee and Trust Board.

The Rotherham NHS Foundation Trust

Finance and Performance Committee
Terms of Reference

Name and Designation of Author	Angela Wendzicha, Director of Corporate Affairs
Approved by	Finance and Performance Committee
Approving evidence	Minutes of the meeting held 29th January 2025 Minutes of Board meeting
Date approved	Finance & Performance Committee – 29th January 2025
Review date	
Review frequency	Annual
Target audience	Finance and Performance Committee Members and Attendees
Links to other Procedural Documents	Trust Board Terms of Reference
Protective Marking Classification	Subject to FOI Act

Version Control

Date	Version	Author Name & Designation	Summary of amendments
February 2021	1		
April 2022	2	Angela Wendzicha, Director of Corporate Affairs	Full review
January 2024	3	Angela Wendzicha, Director of Corporate Affairs	Full review
January 2025	4	Deputy Director of Corporate Affairs	Updated authority as delegated by the Board of Directors. Additional duties in Section 3.1 in relation to Risk Management and the Board Assurance Framework

Title	Finance and Performance Committee Terms of Reference
Constitution	1.1 The Finance and Performance Committee ("the Committee") is constituted as a standing committee of the Board of Directors (the Board) of The Rotherham NHS Foundation Trust (the Trust).
Authority	2.1 The Committee is authorised by the Board to consider any matter within its terms of reference and be provided with the Trust resources to do so. 2.2 The Committee has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion. 2.3 The Committee is authorised to instruct external professional advice and to invite external consultants with relevant experience and expertise to attend if it considers this necessary or expedient to exercise its functions. 2.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. This may include establishing task and finish groups as required to assist in discharging its' responsibilities. 2.5 The Committee has no executive powers other than those set out in these Terms of Reference. 2.6 The Committee is authorised to meet via a virtual/remote meeting.

	2.7 The Committee is authorised, in exceptional circumstances to conduct discrete business outside of its scheduled meetings where it is not practicable to convene a full meeting. The process to be followed is set out in the Section 10.7. 2.8 The Committee has the authority to approve Policy documents delegated from the Trust Board. 2.9 Approve specific policies and procedures relevant to the Committee's remit. 2.10 Approve the recommendations from the Accountable Emergency Officer for Emergency Preparedness, Resilience and Response via the annual self-assessment submission. 2.11 Recommend to Board the submission of the Trust's annual plan to the regulator. 2.12 Review the finance report on a monthly basis and approve any submissions of monitoring reports to the Regulator. 2.13 Seek any information it requires from within the Trust and to commission independent reviews and studies should these be considered necessary. 2.14 Make any recommendations to the Board of Directors in relation to capital and other investments, cost improvement plans and business development opportunities. 2.15 Approve business cases in accordance with delegated authority limits as described with the Standing Financial Instructions. 2.16 Operate within the remit of its approved Terms of Reference.
Purpose & Duties	3.1 The Board has approved the establishment of the Committee for the purpose of supporting the timely delivery of the Trust's Strategic Ambitions and the Operational Plan giving detailed consideration to the Trust's financial and operational issues whilst being assured as to compliance with appropriate regulatory and statutory requirements. It will discharge this purpose through the following duties: • Oversee implementation of the Trust's priority in year operational and financial objectives/enablers against agreed milestones; • Review in year actual operational and financial performance against plan; • Review in year forecast operational and financial performance against plan; • Review the Trust's efficiency and productivity plans (including cost improvement performance) and processes; • Oversee all aspects of cash management to ensure the Trust discharges its responsibilities in respect of payroll and non-pay costs

	• Oversee the management of cash in respect of payments, receipts borrowing and temporary overdraft facilities and treasury management, as detailed in the Trust's Scheme of Delegation; • Oversee embedding and audit of the Financial Governance Action Plan; • Review key operational and financial plans/ policies to ensure they are up to date and fit for purpose (including Finance, Procurement, IT and Estates); • Oversee and seek assurance on delivery relating to Winter Planning; • Oversee and seek assurance that the Trust is delivering against key performance indicators as set out in the Integrated Performance Report; • Oversee and seek assurance in relation to the programme of Recovery; • Confirm that the Trust manages its' asset base effectively and efficiently and confirm capital projects of significant value whether related to property or other assets, are properly identified, managed and controlled. This relates to both acquisition of assets and their disposal. • Seek assurance that the Trust has appropriate strategies relating to environment and sustainability and policies are effectively implemented and monitored; and • In accordance with the Trust's Scheme of Delegation: • Review business cases, tenders and contracts for approval by the Board, ensuring that they have been developed within the terms of the business case protocol; and • Review post implementation reviews of the above to agree key action points to inform future decision making. • Review procedural documents as delegated by the Board of Directors. The Committee will also: • Review the Board Assurance Framework risks delegated to the Committee for review, and to make recommendations to the Board for any required changes of risk score or content; • Review the 12+ scored risks from the Risk Register and risk management information of risks rated 8 and above, relating specifically to the remit of the Committee, as determined by the Risk Management Committee; • Review the Issues Log as identified by the Risk Management Committee; • Review and consider emerging risks; and • Review EPRR Core Standards.
Reporting to	4.1 The Committee is accountable to the Board. 4.2 The Committee shall report to the Board on how it discharges its responsibilities 4.3 The Chair of the Committee will bring to the attention of the Board any items that the Performance Committee considers the

	Board should be aware of through the Chair's report to the Board in addition to any issues that require disclosure to any regulatory body. 4.4 The minutes of the Committee's meetings shall be formally recorded and submitted to the Board, once approved by the Chair of the Committee. 4.5 The Committee will consider matters referred to it for action by the Audit & Risk Committee, People Committee and or the Quality Committee and will report back in writing. 4.6 The Committee, will, on an exception basis, report into the Audit & Risk Committee any identified unresolved risks arising within these Terms of Reference. 4.7 The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed. 4.8 In addition the Chair of the Committee will provide a quarterly report on the Committee's activities to the Council of Governors.

Committee Membership	5.1 The Committee members shall be appointed by the Board and shall consist of: • Three Non-Executive Directors (one of whom must have relevant and current financial experience); • Executive Director of Finance, who will act as Lead Executive; and • Chief Operating Officer. 5.2 Members who are unable to attend the meeting can send a Deputy with the prior approval of the Chair; such Deputy must have the ability and authority to make decisions and contribute fully to the business of the Committee. 5.3 The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors. 5.4 Membership of the Committee will include at least one common Non-Executive Director member of the Audit Committee. This member will act as a conduit of information and assurances across the two Committees in support of the Trust's integrated governance approach.
Attendees	6.1 Attendees to include: • Managing Director; • Deputy Director of Finance; • Deputy Chief Operating Officer/Director of Operations ; • Care Group General Managers; • Director of Health Informatics; • Director of Estates and Facilities; • Director of Corporate Affairs / Company Secretary; • Deputy Director of Corporate Affairs; • Deputy Chief Nurse; • Corporate Governance Administrative support. 6.2 The Medical Director and the Chief Nurse may be called to attend any meeting as the Chair deems relevant. 6.3 Other members of staff will be invited to attend to present for specific agenda items as agreed with the Chair 6.4 The Chief Executive Officer, other Executive Directors or their colleagues may be invited to attend for specific agenda items so to assist in deliberations.
Quorum	7.1 A quorum shall be made up of three members comprising at least two Non-Executive Directors and one Executive Director. 7.2 No business shall be transacted by the Committee unless a quorum is present.

	7.3 Those in attendance or observing do not count towards the quorum.
Observers	8.1 Meetings are not open to members of the public. 8.2 Observers may only attend with the prior approval of the Chair of the Committee.
Frequency of Meetings	9.1 Meetings shall be held monthly. Additional meetings may be held after consultation with the Chair of the Board. 9.2 Additional meetings may be held after consultation with the Chair
Meeting administration	10.1 Notice of meetings will be given at least seven working days in advance unless members agree otherwise. 10.2 The Chair of the Committee, Lead Executive and the Director of Corporate Affairs will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan. 10.3 The Lead Executive Director for the Committee will be the Executive Director of Finance. The Director of Corporate Affairs / Company Secretary will support the Chair of the Committee and Lead Executive Director in the management of the Committee's business and for drawing the Committee's attention to best practice, national guidance and other relevant documents, as appropriate. 10.4 Administrative support to the Committee will be provided by the Corporate Affairs Department. Agendas can only be amended by agreement of the Committee Chair and Lead Executive Director. 10.5 The agenda and papers will normally be circulated four working days prior to the meeting to Committee members and regular attendees. 10.6 Draft minutes and action log will be produced by the secretary within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting. 10.7 For business to be conducted outside of the scheduled meetings the following must apply: • The business to be conducted must be set out in formal papers accompanied by the usual cover sheets clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Governance function; • The Committee will be expected to respond, subject to availability, by e-mail to the full distribution list with their views within 3 working days of receipt of the paper;

	• For a decision to be valid, responses must be received from a quorum. In the event there is no unanimous agreement, the proposal shall be considered not to be approved; • The Director of Corporate Affairs will summarise the conclusions reached and these will be presented to the next scheduled meeting.
Operational Groups which report into the Committee	11.1 The operational groups which report into the committee are: • Cost Improvement Programme (CIP) Efficiency Board; • Digital Transformation Committee; • Care Group Performance Meeting; and • Capital Monitoring Group. 11.2 The Chair from each of the operational groups will provide: • a report to the next meeting of the Committee; and • the minutes from the group's meeting to the Committee following approval of the minutes at the next group meeting.
Monitoring and review	12.1 The Committee's Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board. 12.2 The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Audit Committee and Trust Board.

Board Planner

Event/Issue

Action	TRUST BOARD MEETINGS		2025								2026	
			Jan	March		May	June	July	Sept	Nov	Jan	March
			9	7		2		4	5	7	9	6
			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						●		●		
	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		●		● Annual report		●		●		●
	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						•				
	Safeguarding Annual Report	CN							•			
	Infected Blood Inquiry	MD							•			
	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						•				
	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				•					•	
	Mortality & Learning from Deaths Quarterly Report	MD		•		•		•		•		•
	Mortality & 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)		SC			RS		KM		JB	HW	
	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							•				