Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 4 July 2025, 9:00 AM — 1:00 PM BST
Venue	Boardroom, Level D
Organiser	Alan Wolfe

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P94/25.	Chairman's welcome and apologies for absence For Information - Presented by Dr Mike Richmond
	P95/25.	Quoracy Check For Assurance - Presented by Dr Mike Richmond
	P96/25.	Declaration of interest For Assurance - Presented by Dr Mike Richmond
	P97/25.	Minutes of the previous meeting held on 02 May 2025 and 06 June 2025 For Approval - Presented by Dr Mike Richmond
	P98/25.	Matters arising from the previous minutes (not covered elsewhere in the agenda) For Assurance - Presented by Dr Mike Richmond
	P99/25.	Action Log For Decision - Presented by Dr Mike Richmond
9:10 AM	OVERVIEW AND CONTEXT	

	P100/25.	Board Committee Chair's Reports i. Quality Committee - Julia Burrows ii. People and Culture Committee - Hannah Watson iii. Finance and Performance Committee - Martin Temple For Assurance
	P101/25.	Board Assurance Framework For Decision - Presented by Alan Wolfe
	P102/25.	Corporate Risk Register For Assurance - Presented by Alan Wolfe
	P103/25.	Report from the Chairman (verbal) For Information - Presented by Dr Mike Richmond
	P104/25.	Report from the Chief Executive For Information - Presented by Bob Kirton
	P105/25.	Endoscopic Retrograde Cholangiopancreatography (ERCP) Update For Information - Presented by Jo Beahan
9:40 AM	CULTURE	
	P106/25.	Patient Story For Information - Presented by Helen Dobson
	P107/25.	Patient Experience Annual Report For Noting - Presented by Helen Dobson
	P108/25.	End of Life Annual Report For Noting - Presented by Helen Dobson
10:20 AM	STRATEGY AND PLANNING	

	P109/25.	Quality Strategy For Approval - Presented by Helen Dobson
	P110/25.	The Workforce Plan 2025 - 2028 For Approval - Presented by Daniel Hartley
	P111/25.	Teaching Hospital Status For Decision - Presented by Jo Beahan
11:20 AM	SYSTEM WORKING	
	P112/25.	South Yorkshire Bassetlaw Integrated Care System and Integrated Care Partnership Report For Information - Presented by Bob Kirton
11:25 AM	BREAK	
11:35 AM	PERFORMANCE	
	P113/25.	Integrated Performance Report For Assurance - Presented by Bob Kirton
	P114/25.	Finance Report For Assurance - Presented by Chris Thickett
	P115/25.	Safe Staffing and Establishment For Decision - Presented by Helen Dobson
12:05 PM	REGULATORY AND STATUTORY REPORTING	
	P116/25.	Maternity and Neonatal Safety Report Presented by Sarah Petty For Assurance

	P117/25.	Annual Data Security and Protection Toolkit/CAF 360 Audit Report For Assurance - Presented by Bob Kirton and James Rawlinson
	P118/25.	Mortality and Learning from Deaths Quarterly Report For Assurance - Presented by Jo Beahan
12:30 PM	ASSURANCE FRAMEWORK	
	P119/25.	Well Led Developmental Review For Assurance - Presented by Bob Kirton
12:40 PM	BOARD GOVERNANCE	
	P120/25.	Annual Planner For Information - Presented by Dr Mike Richmond
	P121/25.	Any Other Business For Discussion - Presented by Dr Mike Richmond
	P122/25.	Questions from Members of the Public on the Business of the Meeting For Discussion - Presented by Dr Mike Richmond
	P123/25.	Date of next meeting - Friday 05 September 2025 For Noting - Presented by Dr Mike Richmond
	CLOSE OF MEETING	

Draft until approved at the 4th July 2025 meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING
Friday 2nd May2025, 09:00 – 12:00 pm
Boardroom, Level D

Present:
Dr M Richmond, Chairman
Dr R Jenkins, Chief Executive
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 J Rawlinson, Director of Health Informatics
Mr S Dickinson, Director of Estates and Facilities
Mr A Wolfe, Deputy Director of Corporate Affairs
Ms C Rimmer, Corporate Governance and Risk Manager (minutes)
Mr H Dim, Head of OD and Inclusion (for item P69/25)
Ms G Baxter-Smith, Education and Development Matron (for item P69/25)
Ms E Bellis, Industry Skills Coach (for item P69/25)
Mr F Rahman, T-Level student (for item P69/25)
Ms H Khaira, Freedom to Speak Up Lead (for item P71/25)
Mr G Lynch, Guardian of Safe Working Hours (for item P76/25)
Mrs S Petty, Director of Midwifery (for item P75/25)

Observers:
Mr A Wilkins, member of the public

Apologies:
Mrs H Craven, Non-Executive Director
Ms H Watson, Non-Executive Director
Mr P Walsh, Interim Director of Corporate Affairs

Item	Procedural Items	Action
P56/25	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE** Dr Richmond welcomed all those present to the meeting.	
P57/25	**QUORACY CHECK**	

	The meeting was confirmed to be quorate.	
P58/25	**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. Mr Malik's interest in terms of his Non-Executive Director role at Birmingham Hospital was noted.	
P59/25	**MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 7TH MARCH 2025** The minutes were approved as a correct record.	
P60/25	**MATTERS ARISING** There were no matters arising which were not covered by either the action log or agenda items.	
P61/25	**ACTION LOG** The Action Log was received and the following discussed: - Log no. 5 was agreed to remain open as there were some comments received to review - Log no. 4 – In reference to Virtual Ward, Mrs Kilgariff linked this to log no. 7 for consideration on specific items that need board attention and proposed there could be a specific piece on virtual ward if required. The action was agreed to be closed.	
	OVERVIEW AND CONTEXT	
P62/25	**Board Committees Chairs Reports** i. Quality Committee (QC) Ms Burrows presented the chairs log and highlighted the key details in the report for the attention of the Board following the meetings in March and April. On the Care Group 1 presentation, Mr Temple queried the stark range in the staff survey results on the advocacy questions with the lowest at circa 7%. Mrs Dobson explained that the lowest scoring area had a very small team and various challenges, but that there was lots of support ongoing and involvement from Freedom to Speak Up (FTSU) as well to improve the culture. Reflecting on the IPR and the pass or static reporting, Mr Mondon posed that the 65 week waiting lists should report as 'good' as it is a positive position opposed to 'static: investigate and understand'. Dr Beahan highlighted a similar position for Medication incidents for community which has remained at zero. Mrs Dobson	

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detailed that the IPR would be refreshed in line with the new financial year and these issues addressed. Dr Jenkins added that it was a consequence of the methodological approach to SPC data and there was need for further interpretation.

Dr Shah raised that the medical bed reconfiguration plays a part in various areas, impacting on staff and pressures on services and queried how this is being addressed. Mrs Kilgariff responded that it has been in discussion for a period of time as had been interrupted by the winter bed base surges. The plan is to exit winter into a new bed base and meetings are ongoing with the care groups with a paper to Executive team. It also linked in with a wider project for the Trust on bed bases and flow. Dr Shah added that, looking at the pressures coming through, March continues with high attendance and posed whether the sustained demands will create a barrier to change of the bed base. Mrs Kilgariff concurred that March numbers were high however not all were admissions and there had been a drop in attendance in April.

Dr Richmond queried whether there was further data on the impact of inquest demands on clinicians. Dr Beahan explained that there had been verbal feedback from clinicians on the increased demands for this aspect and that the Coroner had been invited to the Joint Clinical Lead meeting with Barnsley, and these issues would be raised.

ii. People & Culture Committee (P&CC)

Prof. Congdon presented the chairs report on behalf of Ms Watson and updated that it had been a productive and interesting meeting. Prof. Congdon focused on the HWB and attendance, noting the discussions around the objectives and framing targets around culture, pride and a whole system approach and raised that there was significant variation on sickness and attendance by services and care groups. The committee was highly assured by the HWB programme and offerings, and suggested more specific focus on areas of most benefit to get the engagement needed. Sickness is a priority for the committee with the impact triangulated through other areas and committees.

iii Finance & Performance Committee (FPC)

Mr Temple presented the report and highlighted key aspects for the attention of the Board. Mr Temple commented on the areas of improvement in Care Group 1 and in theatres and feedback that a key challenge from care groups this year had been sickness absence, impacting on costs, quality and morale.

In terms of the deep dive reports, Dr Richmond suggested the committee uses their discretion for reporting to Board and it was put forward that an annual report would be useful.

iv. Audit and Risk Committee (ARC)

Mr Malik introduced the chairs log from the meeting in April and drew attention to the key points, particularly the Patient Flow audit and difficulties in Standard of Business Conduct (SoBC) Declaration compliance.

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	Dr Richmond noted the challenges for SoBC and Dr Jenkins explained that this was a common issue across other organisations of the medical workforce not making the declarations and would pick up outside the meeting. As some issues were referenced as simple to rectify, Prof. Congdon raised that, if simple, these should not be happening and whether there is something at a basic level happening which is similar across areas. Mr Malik detailed that at a macro level there are governance processes but these can be impacted by capacity and it is a benefit of internal audit to highlight these areas and give more focus to identify opportunities as well. Mrs Kilgariff explained that there were some practical steps to take such as maintaining pace with frequent national policy changes, and accuracy and coding at ward level. The audit was requested as it was known to be an area with challenges and has provided tangible actions to work through. Mr Kirton added that, through ETM, there is clear momentum from Executives to get things right and looking at opportunities, such as patient flow, to move forward.	
P63/25	**Board Assurance Framework (BAF)** Mr Wolfe presented the BAF and updated that O3 and R2 would be presented at FPC for monitoring, moving forward. Mr Wolfe drew attention to the query on BAF risk D8 and the likelihood score now the year end has been reached. It was agreed that, subject to audit, the BAF should reflect the 2024/25 year end position and be reduced. For 2025/26, the risk score should be lower, based on the achievements gained to be continued from the previous year.	
P64/25	**Corporate Risk Register Report** Mr Wolfe introduced the report and drew attention to the further details on the strengthening of the risks management process and the outcomes from the work. The Board discussed the inherent risks in healthcare, looking at the number of risks reported, and the live nature and relevance of the risk register. There is need to scrutinise the mitigations, monitor fluctuations and increases in likelihood, as well as identifying themes and trends to focus work and see a collective pull down. Mr Kirton concurred that the suggestion of theme analysis would be powerful and an area for the Risk Management Committee to look into. Mr Malik shared that the ARC discussed the themes around static risks and the consideration to the risk appetite and the 'so what' to ensure focus is in the right areas.	
P65/25	**Risk Management Policy** Mr Wolfe presented the updated policy which included updates recommended by 360 Assurance, updates to Care Groups and the Risk Appetite. The Board approved the Risk Management Policy.	

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P66/25	**Report form the Chairman - Verbal** Dr Richmond shared that there was clearly a lot to be proud of on how the organisation had performed in the last year and congratulated everyone, ward to board. Despite the challenges faced by Care Groups, they have often tackled these issues against a backdrop of high pressure and Dr Richmond commended the delivery and leadership from Dr Jenkins. Looking ahead, Dr Richmond expressed excitement about the future, highlighting the abundance of talent within the organisation. There is a culture of open-mindedness and a willingness to adapt to find what works best, which will serve the organisation well; the ambition to improve is evident. Dr Richmond stressed the importance of not losing sight of the primary goal: providing healthcare to the population of Rotherham. Quality and safety of care must remain paramount, even as the organisation strives to meet constitutional standards. Part of the executive thinking includes addressing the high levels of sickness absence, which affect every aspect of the delivery trajectory. Foundational objectives must be established as everyone's business, with a focus on risks and the collateral benefits of addressing them, as well as operational efficiency to improve flow. Dr Richmond thanked everyone for their efforts over the past year and looked forward to the year ahead.	
P67/25	**Report from the Chief Executive** Dr Jenkins updated that he had joined the new 'Work and Health Board' which is leading the South Yorkshire delivery of the Pathways to Work programme. Dr Jenkins also called out the Proud Awards which will be taking place in June. Expanding on national events, Dr Jenkins feedback on the recent national Chief Executives meeting, where Jim Mackey discussed various changes. The overarching theme was the new national team's efforts to organise, lead, and deliver effectively. While some announcements have caused anxiety in certain areas, there is a lot of positive information, including greater clarity on organisational roles, clearer expectations, and stronger performance management. The primacy of boards was emphasised, along with the distinction between Integrated Care Boards (ICBs) and regional teams. A model ICB document will be released soon. Dr Jenkins also discussed the new accountability framework, the Urgent and Emergency Care (UEC) plan with a stronger tone, and the national performance assessment framework. A ten-year plan is set to be published in June, and some slides will be shared with Non-Executive Directors (NEDs) as part of a comprehensive framework review. Mr Temple reflected on the challenges and gaps in commissioning for front line services and Dr Shah queried the validation and cap on activity.	

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	In terms of Corporate costs, Mr Hackett clarified that the ask was to reduce growth by 50%. Dr Jenkins concurred that there was an emphasis to have corporate services as lean as possible. On validation, Mrs Kilgariff updated on the validation sprint in quarter 1 and that the updates were in line with work already in train. Mr Kilgariff raised that a challenge will be the validation of a large waiting list when the resource has not fluctuated alongside this. Mr Malik queried the themes from the updates, posing whether there was a move towards more autonomy. Dr Jenkins concurred and summarised the expectations set nationally will get more scrutiny from the region. Mrs Kilgariff highlighted that the 4hour report to FPC was already an aspect of this change and scrutiny.	
	STRATEGY AND PLANNING	
P68/25	**TRFT Five Year Strategy – 6 month review** Mr Kirton presented the report noting all achievements and risk areas. Dr Richmond queried the barriers to the work on frailty and Dr Beahan outlined that there had been achievements but there were further improvements to be made and would link in with a wider piece of work in the bed reconfiguration plans. Dr Beahan drew parallels to the work on Diabetes Management; getting the basics and foundations right to move forward. Prof. Congdon posed that some of the plans on frailty were uncertain and whether the dashboard will be continued and a live environment to be used. Dr Beahan confirmed that the work will continue and be reported through QC. Dr Shah put forward that there is a wider debate here, linking with the emphasis on neighbourhood working and community; the 'prevent' space, looking to wider partners, rather than frailty assessments. Dr Beahan shared the exciting developments led by the Community Consultant on a model of proactive care. Initial work showed an hour intervention had reduced hospital admissions, mortality and ambulance conveyance. Dr Richmond queried whether the work was targeted or business as usual and if targeted, what are the goals and aims for clarification. Dr Beahan detailed that it was assessing the front door aspect and systematic approach. Mr Kirton added that there are wider discussions ongoing at Place and would bring back further information as it had been made one of their priorities.	
	CULTURE	
P69/25	**Staff Story – T Levels & Apprenticeships** Mr Hartley welcomed Mr Dim, Ms Baxter-Smith, Ms Bellis and Mr Rahman, to the meeting. Mr Dim updated the board on the apprenticeship provisions to develop leaders both clinical and non-clinical, as well as the data academy, and the outcomes of efficiencies and real opportunities.	

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	Ms Bellis provided an overview of the T-Level course, merging traditional course aspects with academic rigour. Ms Bellis noted the growth in the course attendance with six this year, and thirty enrolled for next year and the new clinical suite which had been very well received and gave a realistic learning environment. Ms Baxter-Smith expanded on the work of the team to facilitate the T-Levels; thinking differently and building up the governance framework. The success is demonstrated in the growth and AHP colleagues were now on board which will further broaden the programme. Mr Rahman feedback that it had provided good insights into what aspects and job roles were most appealing and shared that he had successfully gained a paid position in the organisation. Mr Mondon queried the consideration of offering unspent levies to partner organisations and whether apprenticeships and T-Levels are built into workforce planning. Mr Dim detailed that plans were in train in regards to the levy and that the new apprenticeships were being built into the planning process, however, this would be dependent on government announcements.	
P70/25	**<u>NHS Staff Survey 24/25 and next steps 25/26</u>** Mr Hartley formally presented the staff survey results to Public Board and reinforced the commitment to our people, continuous improvements and specific changes this year including linkage to the People and Culture Strategy. The report set out the improvement journey, challenges and vehicles to drive change. Dr Shah queried how the gaps between excellent and poor care perspectives will be closed and Mr Hartley put forward that there were a number of key factors driving variations, such as bad experiences, leadership, and approaches would include data learning sets enabling appreciative enquiry and upskilling of people. Mr Malik drew attention to the People Promise slide and commended the organisation for achieving above average on all. Mr Temple reflected on the most declined scorings and with FTSU work, people feel they are not able to raise concerns. Mrs Dobson detailed that there has been targeted work around patient safety and culture and the scores did not reflect the reporting of FTSU. Dr Jenkins raised the difficulties in sharing the news on concerns raised and how they are acted upon, due to confidentiality and the sometimes sensitive nature.	
P71/25	**<u>Freedom to Speak Up (FTSU) Quarter 4 Report and Annual Report 2024/25</u>** Mrs Dobson introduced the report and welcomed Ms Khaira to the meeting. Ms Khaira highlighted the key aspects from the reports including the number of concerns raised which is reported nationally, good representation across the care groups and all professional worker capacities and the closure data for	

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	concerns. Ms Khaira detailed the difficulties in engaging service users with feedback, but from the feedback given, 100% would raise a concern again. Moving forward, there will be more triangulation of data and looking at the processes in areas, such as sickness and accreditation. Mrs Dobson raised that triangulation was already happening anecdotally but will be formalised. Dr Jenkins shared that there was a recent national report expressing that internationally educated healthcare professionals were not having their voices heard. Ms Khaira was aware of this and although no concerns or issues had been raised, was actively seeking a FTSU champion in that area. Dr Richmond pressed the need to be proactive rather than reactive and posed whether there was anything in the board's remit to contribute to FTSU being well understood. Ms Khaira outlined that raising the profile was beneficial, as well as Dr Jenkins being a champion. Mrs Dobson commented that the profile of how to raise a concern has increased significantly, however, the next steps are not as understood. This would be raised with senior leaders and Mrs Dobson suggested support from the board for these leaders.	
	SYSTEM WORKING	
P72/25	**National, Integrated Care Board and Rotherham Place Update** Mr Kirton introduced the report and drew attention to the strategy in the pack which had been discussed at FPC and the priorities to be determined; there is opportunity to influence. Dr Jenkins commented that the timing of the strategy was not optimum with the 10 year health plan on the horizon and the lack of Public Health Directors; the themes were broad and needed to be more specific. Dr Shah concurred that there is need to help shift and move on the priorities, to be brought to joint strategic meetings. Ms Burrows concurred that there needed to be specific priorities to get engagement and drive. Prof. Congdon shared that there were similar themes emerging in Bradford and when thinking about the trusts contribution, it may not lie in business but in the employment of people and supporting economic growth.	
	PERFORMANCE	
P73/25	**Finance Report** The Finance report was presented by Mr Hackett who provided the financial headlines for Month 12 and reminded the board of the initial annual financial plan and commitment to an improved plan over the course of the year which had been delivered favourably. Mr Hackett thanked colleagues for their work on the capital expenditure, benefiting staff and patients in utilising the allocations. Dr Shah declared a conflict of interest as a registered GP and asked, referring the recent guidance published, what mechanism will be used for job plans and PAs to respond to changes. Mr Hackett detailed that the change will be on capturing data and looking at the process against the guidance. Mrs Kilgariff commented that the metrics need to be reviewed and is an area of focus, particularly for services that offer both in person and virtual.	

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	Dr Richmond queried whether the invoice to Western Park had been settled and Mr Hackett updated that the full invoice had been issued but would seek an update. Looking at pay costs overspend, Dr Shah questioned whether there was merit increasing the substantive staff to improve on costs and Mr Hackett explained that it can be specific to specialty and is discussed and actions taken on a regular basis. Mr Temple asked regarding extra capital for new projects and Mr Hackett detailed several in the pipeline. Mrs Kilgariff reflected that conversations around UECC capital bid were held well in advance and it is key to have conversations with leaders nationally to secure resources.	
P74/25	**Integrated Performance Report** Mr Kirton presented the IPR as a story of improvement with some real positives and some stand out concerns, particularly staff sickness and Mr Kirton reiterated the team effort to understand, address and deliver. Dr Richmond and Dr Beahan discussed the SHMI data and whether good coding practice of comorbidities would impact SHMI and it was concluded that it is dependent on reporting and something to be mindful of in future. It was suggested to have some board training around this area of reporting. Dr Richmond posed that the IPR needs to ensure clarity and trust in reporting.	
	REGULATORY AND STATUTORY REPORTING	
P75/25	**Maternity and Neonatal Safety Report** The Board welcomed Mrs Petty to the meeting who presented the new format of the report. Key highlights from the report included the perinatal mortality data, key areas of improvement in triage, workforce review, and LMNS referrals. Dr Richmond drew attention to the high C-section rates and the impact in terms of Length of Stay, nursing support and costs, and asked whether it is understood and whether any actions can be taken. Mrs Petty answered that it is very complex and driven by maternal choice. There are issues with theatre capacity and the other challenges described and the team is looking at how to increase theatre capacity to create a seamless theatre pathway. The increase had also been discussed at Quality Committee who debated the level of risk aversion seen and the national news influencing here; there is a real period of change. Dr Shah raised that there is an increase in trend across the board and there is need to be careful to make sure actions are the most appropriate for the individual. For the staffing paper, Dr Shah suggested to reflect on medical staff as well. In relation to the previously reported spike in still births, Dr Richmond queried whether there was any further information to be shared with the Board. Mrs Petty detailed the work on triage, the improvement plan and looking at the estate to enhance the triage offering.	
P76/25	**Guardian of Safe Working Hours**	

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	Dr Beahan welcomed Dr Lynch, Guardian of Safe Working Hours, to the meeting. Dr Lynch summarised the BMA changes to exception reporting and the porting of Statutory and Mandatory training as part of the work to improve the conditions for residence doctors. Dr Lynch highlighted that the exception reports demonstrate significant pressures in Medicine and there is benchmarking work ongoing. In particular, Dr Beahan raised the concerns from exception reports around AMU, which is an area that has struggled to recruit a consultant, and Out of Hours staffing.	
P77/25	**Mortality and Learning From Deaths Quarterly Report** Dr Beahan reported that SHMI remained static and 'as expected'. There had been no alerts and no diagnosis flagging as higher than expected. SJR completion rates were good and the review panel continues. The mortality group meets bi-annually and monitor themes and trends and identify areas for improvement. Dr Beahan also highlighted the medical examiner activity both in the acute and community setting. In terms of governance, Dr Shah queried the assurance that care groups are considering the themes and trends and sharing the learning gained. Dr Beahan detailed that an action from 360 assurance was specifically around this aspect and the mortality manager conducts regular audits of activity through care group governance meetings and reports into the Mortality Group, to ensure this is ongoing. Dr Jenkins recognised the progress here under Dr Beahan's leadership.	
	BOARD GOVERNANCE	
P78/25	**Board Committee Terms of Reference** Mr Wolfe presented the Terms of Reference for ratification. The Board approved the terms of reference, subject to a review of the exclusion of the reference to external auditors in the P&CC Terms of reference, compared to FPC and QC.	
P79/25	**Escalations from Governors - No Escalations** There were no escalations from the Council of Governors.	
P80/25	**Board Annual plan** The Board noted the annual planner. Mrs Kilgariff raised that the winter plan would need to be brought forward to September. Dr Beahan updated that a Research and Development paper had been agreed at QC and could be brought to Board in July. Mr Hartley requested to add the workforce plan for July. Mrs Dobson requested to add the Quality Strategy for	**Cmte. Sec.**

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	July. Dr Richmond suggested that due to these requests, the board visits may have to be postponed in July to allow time for a full agenda.	
P81/25	**Any other business** There were no other items of business.	
P82/25	**Questions from Members of the Public** No questions were received.	
P83/25	**Date of next meeting** Friday 4th July 2025	
	CLOSE OF MEETING	

Chair:

Date:

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Draft until approved at the 04 July 2025 meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING
Friday 06 June 2025, 9:00 - 10:45am
Boardroom

Present:
Mr K Malik, (KM) Non-Executive Director - Chair
Mrs H Craven, (HC) Non-Executive Director
Mrs H Dobson, (HD) Chief Nurse
Dr J Beahan, (JBe) Medical Director
Mr S Hackett, (SH) Director of Finance
Dr R Jenkins, (RJ) Chief Executive
Mrs S Kilgariff, (SK) Chief Operating Officer
Mr M Temple, (MT) Non-Executive Director
Mr D Hartley, (DH) Director of People
Mr B Kirton, (BK) Deputy Chief Executive
Dr R Shah, (RS) Non-Executive Director
Ms J Burrows, (JB) Non-Executive Director
Ms H Watson, (HW) Non-Executive Director
Professor S Congdon, (SC) Non-Executive Director
Mr A Mondon, (AM) Associate Non-Executive Director

In attendance:
Mr S Dickinson, (SD) Director of Estates and Facilities
Mr P Walsh, (PW) Interim Joint Director of Corporate Affairs
Mrs J Roberts, (JRo) Director of Operations/Deputy COO
Ms E Parkes, (EP) Joint Director of Communications
Mr A Wolfe, (AMW) Deputy Director of Corporate Affairs (minutes)
Mr A Cresswell, (AC) Consultant Surgeon, observer
Mrs R Bell, (RB) Professional Lead for Medical Imaging, Physics and Illustration and Staff governor, observer

Apologies:
Mr J Rawlinson, (JR) Director of Health Informatics
Mr M Richmond, (MR) Chairman
Ms A Wendzicha, (AW) Director of Corporate Affairs

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Item	Procedural Items	Action
P84/25	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE**	
P85/25	**QUORACY CHECK** The meeting was confirmed to be quorate.	
P86/25	**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.	

	Ms 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. Mr Walsh's interest in terms of his role as Interim Joint Director of Corporate Affairs of the Trust and Barnsley Hospital NHS Foundation Trust was noted. Mr Malik's interest in terms of his Non-Executive Director role at Birmingham Hospital was noted. Mrs Dobson confirmed that she had a previous line management role as the line manager for the single consultant nurse operator involved. Dr Beahan confirmed that her husband is an equity partner at Irwin Mitchell Solicitors, specialising in commercial litigation. Irwin Mitchell are representing two of the families involved, although he does not have any direct links with these cases. Mr Cresswell, observer, confirmed that he had been interviewed as part of investigation process.	
P87/25	**MINUTES OF PREVIOUS MEETING** The minutes from the 2nd May Board to be taken at the 4th July Public Board of Directors.	
P88/25	**MATTERS ARISING** There were no matters arising which were not covered by either the action log or agenda items.	
P89/25	**ACTION LOG** The action log from the 2nd May Board to be taken at the 4th July Public Board of Directors	
	OVERVIEW AND CONTEXT	
P90/25.	**Endoscopic Retrograde Cholangio Pancreatography (ERCP) Update Presented by Jo Beahan** RJ opened the session by offering an apology to those patients who may have experienced deficiencies in care. He set out that the investigations are highly complex and technical in nature, and the three independent reviews were critical of the care which had been delivered. He noted that the conclusions drawn by these reviews are not universally accepted by all parties involved and that it is sometimes difficult to link deficiencies in care to specific harm. However, it is important that the Board acknowledges the issues raised, takes responsibility for any shortcomings in care, and apologies to the patients involved.	

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KM noted that JB would provide a detailed walkthrough of the findings and recommendations.

JBe explained that ERCP is a complicated type of endoscopy process that involves passing a thin, flexible tube through the duodenum to look at the pancreas and inject dye to observe it. The procedure is also used to remove stones and stents. ERCP is an alternative to surgery and is often performed on frail patients with underlying conditions who are at high risk and often unwell. ERCP is recognised as a high risk procedure with risks of complications between 10-14% and risk of 30 day mortality an average of 4.2% in recent data, with a reported mortality rate of up to 8.5%.

She highlighted that complications were relatively common and include pancreatitis, inflammation of the pancreas which is potentially fatal. The risk being 5-10% (up to 30% in high risk patients). This risk can be reduced by 50% with prophylaxis. Other risk include bleeding, a 1-2% risk. This risk increases with a sphincterotomy (a small incision that is sometimes necessary to help remove a gallstone). Should a bleed occur, the mortality is high at around 40%. There is also perforation (a hole in the digestive tract) with a 2% risk, and a risk of mortality of between 16-18%. Lesser known risks include Cholangitis (inflammation or infection of the bile ducts) 1% risk, the risks from sedation, and that complication rates are significantly higher than many surgical procedures such as cholecystectomy (removal of the gall bladder).

JBe outlined that from 2016 to 2021, the ERCP service was delivered by a single consultant nurse operator, with some temporary staff when the nurse was unavailable. This situation arose because all gastroenterology consultants had left, and the Trust was unable to recruit or train new staff. Audits carried out in 2020 and 2021 showed results within the national reporting rate for mortality. However, in 2021, a cluster of incidents led to two serious incident investigations and two inquests. Five deaths within 30 days of the procedure suggested the need for a review, and the service was suspended. Since then, no ERCP procedures have been performed at The Rotherham NHS Foundation Trust, and all procedures have been referred to Sheffield Teaching Hospitals NHS Foundation Trust.

JBe explained that in February 2022, the Trust commissioned a Royal College of Physicians Invited Service Review (RCP ISR) into the ERCP service, in order to understand the pathways and protocols in place and ensure they were within national guidance. The terms of reference and scope took time to establish, and verbal reports were provided in July 2022, with the final report issued in January 2023. Following verbal feedback, an internal action group, the ERCP Control Group, was established. Peer reviews of case notes and internal and regional meetings have been held since then. The recommendations of the report were extremely detailed and have been implemented.

	In line with RCP recommendations, the Trust identified all ERCP procedures undertaken between 2016 and 2021. The RCP reviewed 25 case records of patients who had an ERCP between July 2019 and July 2021. The review also looked at the staffing, governance, quality, safety and oversight of the ERCP service. 13 cases reviewed were 'index' patients who had died or had significant complications and 12 cases were selected at random. The overriding conclusion of the review team was that the isolated practice by a Consultant Nurse had not provided high standards of performance and safety and resulted in a higher than expected complication rate for ERCP. Issues identified included inadequate consent, poor radiological documentation, concerns regarding choice of stents, sedation type and level, discharge processes, and lack of multidisciplinary team involvement. JBe noted that the practitioner involved disputes the findings of the report. The initial RCP review raised concerns about the management of the ERCP service from 2016 to 2021, following which the nurse consultant was reported to the Nursing and Midwifery Council. The nurse consultant has subsequently been dismissed by the trust. The endoscopy service has been moved to Care Group 1, and a new JAG-accredited consultant has been appointed. The Trust then commissioned two independent reviews of cases. The first by Dr Painter, concluded that the reviews highlighted significant concerns regarding the delivery of the ERCP service including consent process, case selection, consideration of alternative approaches and senior decision making. These findings are consistent with the RCP report. Dr Painter also stated 'The case reviews showed no prolific questionable practice, most practice was within expected clinical variation.' Three deaths directly related to ERCP were all recognised complications and individually did not raise significant concerns. The second review commissioned was by Dr Woodward, who identified examples of unsafe practice and concerns about consent, selection of patients, sedation, use of stents and their follow up, consideration of prophylaxis, documentation of the procedure and technical performance. He also identified seven individuals who experienced complications directly arising from the ERCP, and raised concerns about the follow up of patients with long term stents and recommended a review of patients with stents. The review of 44 patients with stents found no harm. Four of the cases reviewed by the RCP have had coronial inquests. Two of these were prior to the receipt of the RCP report. The conclusions of the inquests was that the care did not contribute to death, although for one patient the Coroner concluded that there had been a missed opportunity for specialist input and management but this had not changed the outcome. Two of the families have initiated litigation processes. The Trust has a formal Duty of Candour to patients who have suffered Moderate or higher degrees of harm. This requires NHS Trusts to be open	

	and transparent with patients and their families when something goes wrong. The Trust decided to go beyond the required Duty of Candour process and had committed to inform all 68 patients involved, assess the degree of harm and apologize for any deficiencies in care. The Trust has undertaken Duty of Candour phone calls and offered further meetings to patients and families. Contact details for one of the Trust senior nurses has also been provided to those families in order to support ongoing communication. Out of the 68 families involved, 49 have been contacted. Multiple attempts have been made to contact the remaining families, including calls to GPs and next of kin. JBe reported that patients and families had so far appreciated the Trust's communication and efforts to address their concerns. The Trust is also providing support for staff involved, and the Freedom to Speak Up policy has been promoted. HD confirmed that a review of single operator services within the Trust had identified eight practitioners, including five nurses and three allied health professionals (AHPs). All services are managed within the Care Group structures with appropriate lines of management. Board members raised questions about decision-making around the service, and whether the suspension of the service happened in a timely fashion. KM emphasized the need for the Board to fully understand the sequence of events and decision-making around the service. RJ confirmed that the external governance review will review decision-making around the service ahead of its suspension in 2021. He also explained the complexity of the review process to date, including the involvement of external experts. JBe confirmed that the Trust had already implemented changes as a result of learning from the cases, including changes to mortality reviews, clinical effectiveness, consent processes, patient information leaflets, and shared decision-making. The Trust is also one of the first in the country to implement Martha’s Law. The Board was updated about litigation related to this service, and noted the potential for additional cases to be brought. RJ emphasized the importance of being open and honest with patients and addressing any deficiencies identified in the review process. The next focus will be on providing answers to patients' questions and improving governance going forward. Board members highlighted the need for clear communications to local partners. EP confirmed that the Trust anticipates some media coverage as a result of publishing the reports, and will provide a statement in response. This will include information about how patients can contact TRFT if they are worried about their care. The Trust will also provide information to our	

	staff, and executive directors are briefing staff in endoscopy later in the day. The Board noted the long-term ambition to safely resume the ERCP service at TRFT, so that local patients do not have to travel unnecessarily. JBe confirmed that this would only be done when the Trust can recruit the staff to allow a safe service. More broadly, RJ emphasised the importance of seeking JAG accreditation for endoscopy services. AC noted that some Trusts are continuing to operate an ERCP service with higher levels of mortality. RJ explained the complexity involved in making comparisons around mortality. He stressed that the Trust has kept NHS England informed throughout the process. With regards to next steps it was confirmed by the Board that the three external reports are being published in the Trust Board papers, alongside the Trust's response to the recommendations made by the RCP report. The Trust will continue to support the affected patients and families, and will arrange further meetings with them where requested. The Board will be updated about this at the next meeting in public. The Trust expects to receive the external governance review in the next couple of months, and will present it to the Board. The Trust Internal ERCP control group meetings and the external NHSE control group meetings will continue for the foreseeable future. In conclusion, KM acknowledged the importance of the discussion, and learning the lessons. It was right that the Trust is acting openly and honestly, and apologising to patients. He noted that this is one stage in the process, and the Board will return to this when it receives the governance report. This will help the Trust ensuring safe and effective services for all our patients.	
	BOARD CLOSING MATTERS	
C91/25	**Any other business** There were no other items of business.	
C92/25	**Questions from Members of the Public on the Business of the Meeting.** There were no questions raised.	
C93/25	**Date of next meeting** Friday 04 July 2025.	

Chair

Date:

DRAFT

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	27.06.25 - Research and Development Report scheduled to be presented at July Quality Committee and be presented at Board in September.	Recommend to Close
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 27.06.25 - BAFs have been reviewed and updated.	Recommend to Close
5	07.03.25	Board Committees Chairs Reports - Audit and Risk Committee	P33/25	Circulate the Risk Management Strategy to Board Members for virtual approval.	AMW	May-25	Strategy on agenda for approval 02.05.25 - Further comments received for review. 27.06.25 - Action completed and strategy approved.	Recommend to Close
6	02.05.25	Annual Plan	P80/25	Several additions for July board agenda. Consideration to be given to the timings of public board and Board Visits.	AMW	Jul-25	27.06.25 - Board visits postponed for July.	Recommend 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: 19th May 2025**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Care Group 3 (Children and Young People's Services, Obstetrics & Gynaecology and Integrated Sexual Health) Presentation	RTT and Gynaecology was raised as an area of concern and it was reported that there was confidence in the solutions, including opportunities in outpatients and utilisation in theatres to enhance delivery. The work of the GIRFT team was also noted. The Committee were also updated on the increase in HIV workload and the risks associated, following a substantial increase in interactions with the service, many of which are life-long. The Committee also noted the positive news including the CQC in-patient survey results for Children's services, the HSJ award shortlist for Pharmacy and their work on digitisation, and the implementation of Call For Concern across Children's and Maternity services.	Board of Directors
2	Chief Nurse and Medical Director Monthly Highlight Report	In the Medical space, the Committee were updated that the team have been shortlisted for a Royal College of Physicians workforce award, and noted the Pharmacy shortlisting for a HSJ award. Various awards in the Nursing and AHP space were also noted and celebrated.	Board of Directors
3	Patient Safety Committee Report	The Committee highlighted the overall increase in moderate harms, which triangulated with the increase in demands. As noted previously, the improvements in flow and ease in pressures will take time to feed into the data to demonstrate the impact on patient outcomes, but this	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		will be continuously monitored by the committee via the IPR, alongside this report. The Committee also acknowledged the work to embed Martha's Rule and Call for Concern, noting that although calls made were not of the appropriate criteria, all were redirected accordingly.	
4	Patient Experience Annual Report	The Committee received the Patient Experience annual report and discussed how the trust is encouraging all ethnicities to advocate for themselves, and the ownership of good customer service across the whole organisation and every stage of interaction.	Board of Directors
5	End of Life Care (EOLC) Annual Report	The Committee received the EOLC annual report and highlighted the positive journey and improvement, whilst acknowledging there is still more work to do, with next year focusing on education and engagement.	Board of Directors
6	Board Assurance Framework	The BAF was reviewed and updated in line with the Trust priorities and operational plan for 2025/26. The committee agreed for the score of BAF Risk P1 to remain at 12.	Board of Directors
7	Quality Account 2024/25	The Committee approved the Quality Account and authorised the Chief Nurse to make the final amendments once the remaining data is available.	Audit & Risk Committee
8	Quality Committee Annual Report	The Committee received the annual report and the annual effectiveness survey. The Committee has fulfilled its duties under the Terms of Reference and from the survey feedback, it is considered a good meeting platform that is well-chaired and effectively run. There	Audit & Risk Committee

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		has been demonstrable progress since the previous effectiveness review, reflective of the conscious efforts and changes made.	

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: 25th June 2025**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Action Log / Chief Nurse and Medical Director Monthly Highlight Report	The committee were updated on the continued improvements in patient flow and patient journey metrics including waiting times and length of stay. Triangulation in the quality space will continue to be monitored with positive impact noted in other areas, such as staff sickness rates. The committee were notified of a Regulation 28 notice that had been served which related to a patient fall. A detailed action plan was in development and a Falls Prevention lead had been recently appointed.	Board of Directors
2	Care Group 4 (Community, Therapies, Dietetics and Radiology, Medical Physics and Medical Illustration) Presentation	The Committee noted the Care Group and Virtual Ward's strong reputation across South Yorkshire, noting that peers and partners recognised the Trust's agility and innovation. The new leadership team structure had laid strong foundations, with collaborative efforts in radiology and urgent and emergency care (UEC) already making a significant impact. The mobile X-ray service was highlighted as a successful example of productivity, quality, and attendance intervention aligning with Finance & Performance priorities. The committee raised concerns around pressure damage, particularly moisture related, and were updated on the thematic review of incidents underway, supported by recent audits and a QI project aimed at identifying root causes and enhancing preventative	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		measures. There were also close links with the Continence Team and Tissue Viability Team.	
3	Integrated Performance Report (IPR)	The Committee received the report and, continuing the focus on pressure damage, noted the recurring sub-theme through reports of pressure ulcers. It was reported that this remains a key area of focus and part of the Trust's commitment to delivering the fundamentals of care. On C.Difficile rates, it was reported that the Trust has the lowest rate in South Yorkshire with improvements attributed to strengthening antimicrobial stewardship through the Quality Priority, targeted campaigns, staff training and bed configurations. The Committee noted the changes in reporting structure, including the separation of positivity scores within patient experience metrics to provide greater clarity, and changes to Care Hours Per Patient Day (CHPPD) data to show fill rates, which was considered a more meaningful and accurate metric for assurance.	Board of Directors
4	Pharmacy Focus	The committee received a presentation from the Chief Pharmacy which detailed current performance against key performance indicators, benchmarking against good practice in other areas, and work to increase engagement with patients through their patient journey. It was reported that there is strong engagement from the executive team and that the pharmacy service was increasingly involved in strategic discussions. Links with the wider Chief Pharmacists' Network were also being strengthened to support innovation and influence.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
5	Quality Strategy 2025-2027	The committee approved the Quality Strategy to recommend to Board, following a couple of minor amendments and additional information on launch and implementation.	
6	Clinical Effectiveness Committee Report	The Committee wished to reiterate the need for better engagement and accountability across the Care Groups in this space. The Committee noted the report and requested a re-structure of the reporting format to ensure clarity on key concerns and as well as achievements.	Board of Directors
7	Organ and Tissue Donation Committee (OTDC) Report	The Committee received a positive update on organ and tissue donation, noting increased activity—particularly in corneal donations—and referrals made by the palliative care team. Progress was supported by team commitment and leadership, community engagement events, and the formal opening of the Memorial Wall. The OTDC chairs log is available in the Review Room for further information.	Board of Directors
8	Board Assurance Framework	The committee agreed for the BAF Risk P1 to remain at a score of 12, whilst keeping under close review triangulating with performance metrics as well as quality data.	Board of Directors
9	Mortality and Learning From Deaths Quarterly Report	SHMI remains ‘as expected’ and the Committee highlighted the importance of remaining curious and vigilant in this space, particularly in light of data changes and acknowledged the need for continued scrutiny and responsiveness to emerging trends.	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: 20th June 2025	Chair: Dr Rumit Shah

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Director of People Report: Key Issues	The Committee were informed that Skills Street has opened for school visits ahead of the official opening this summer. TRFT have collaborated with Rotherham Metropolitan Borough Council and Rotherham and Doncaster and South Humber NHS FT to create the Health and Care skills sector experience. It was noted the importance of proactively engaging with young people in the local area to boost the workforce pipeline, particularly in the context of national changes to international recruitment, and as an anchor institution. On sickness absence, the Committee were pleased to note that there are encouraging signs in relation to long term sickness absence rates; these have improved for 5 months running and are now at the lowest rates for 2 years. The Committee were updated that, with the support of the Trust's Charitable Funds Committee, the People Team submitted a bid for £170K for the establishment of a Staff psychological support service; the outcome of the bid will be in August. Lastly, the Committee suggested the Board remains alert to potential industrial action, as the employee relations climate is considered to be increasingly challenged given national activity and a range of Trade Union expectations not being met.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
2	Corporate Services (Health Informatics) People Presentation	The Committee recognised the team's ambitions for the future in transformational technologies and artificial intelligence. Digital was described as a key strength for TRFT and Rotherham more broadly, with examples such as NHS app usage, and the digital interfaces used by community and social care which links to the national agenda and focus on integrated neighbourhood working. The team discussed the staff survey results and initiatives to ensure individuals feel supported and valued in a service intensive environment.	Board of Directors
3	Care Group 1 (Medicine and UECC) People Presentation	The Committee received updates from the Care Group on sickness absence rates, talent management, appraisal rates, training and development, and team resilience. It was noted that the Care Group's short term sickness rates were incredibly low; the longer term absence rates remain a key issue. The Committee reflected on the Care Group's previous attendance in February and remarked on the shift in morale and positive presentation, showcasing a refreshed and re-energised team.	Board of Directors
4	Board Assurance Framework	The Committee agreed for the BAF Risk score to remain at 8.	Board of Directors
5	Safe Staffing and Establishment	The Committee welcomed the transparency of the report, citing visibility of both increases and reductions in staffing which supports a fair and balanced approach. The Committee approved the report, to recommend to Board for approval.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
6	Matters Delegated from Board or other Committees	The Committee received a referral from FPC on emerging risks, particularly in reference to the Supreme Court ruling on biological sex. It was acknowledged that the risk is relatively low in terms of immediate operational impact, however, it is a highly sensitive issue and there are examples in the media of cases escalating rapidly. The Committee agreed to keep abreast of the updates and emerging risks to the organisation through the Director of People report.	Finance and Performance Committee (FPC) / 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:** 25th May 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 advise the Board in respect of the multiyear planning and the changing emphasis on finance and funding if a trust fails to hit targets linked to CIP. There is potential funding withdrawal which could lead to a £30m deficit becoming a £38m deficit. This would also be linked to potential impact on upcoming projects such as the new EPR.	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:** 25th June 2025	**Chair: Mrs Heather Craven**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Board Assurance Framework (BAF)	The Committee agreed to advise the Board that the recommended rating for BAF risk D9 is currently at 16 and following discussion about the financial position at the end of month 2 and progress to date on CIP further discussion and approval by the Board of the score was considered to be appropriate.	Board of Directors
2	Operational Priorities - Cancer Update	The Committee agreed to assure the Board of the progress made relating to the Cancer quality priority, although it agreed to advise the Board that the 62 days target would not be met, and that the progress was being monitored and triangulated via this committee and also the Quality Committee.	Board of Directors
3	Integrated Performance Report (IPR)	The committee was assured on the progress made and agreed to advise the Board on the role and impact the virtual ward was having. A review of the scope and structure of virtual ward is underway and a report will come back to the committee in quarter 3.	Board of Directors
4	Operational Report	With regards to the new urgent and emergency care plan 2025/26 the committee queried the recommendation for separation of urgent and emergency care and was an urgent treatment centre required on the new capital scheme. The committee agreed to advise the Board that while it was not a UTC the new build will provide extra capacity, is adaptable and fits the model required at the Trust.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
5	Care Group Performance Escalation Summary	The Committee assure the Board regarding the positive work being undertaken by the Care Groups.	Board of Directors
6	Winter Evaluation	It was agreed that the committee should advise the Board that in relation to the Winter Plan the People & Culture Committee should be monitoring the staff planning for the plan as an identified improvement from the last winter plan review was better full team planning in addition to the focus on nursing, and as such this has been cross referenced to that committee. It was also noted that the Plan needs to be approved and signed off by the summer so will require the People & Culture Committee to meet virtually.	Board of Directors
7	Integrated Financial Performance Report	The risk score of 16 for financial delivery (Risk 7341) was discussed, the proposal was to further debate at Board but the Director of Finance advised that his position would be to keep the score at 16 given the early point in the financial year and early indications that ERF income was ahead of plan which was not reflected in the M2 position. This triangulates with item 1.	Board of Directors
8	Six Monthly Procurement Report	The committee welcomed the six month report and agreed that the Board should be assured on the introduction of the new procurement dashboard that is joint with Barnsley allowing both teams access.	Board of Directors
9	Care Group 3 Presentation	It was noted that the Gynaecology service has fallen from 2nd to 3rd quartile, referrals have risen by 6%, the committee agreed to advise the Board that improvements have been made but are not keeping pace with service demand. This has been a challenge for a long time and an in depth review including GIRFT is to be undertaken and brought back in September.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
10	Endoscopy Business Case	The Endoscopy business case was approved.	Board of Directors
11	CIP Performance Update	The committee agreed to advise the Board that progress on CIP was considered and whilst progress has been made it is £1.5 million behind plan. Reports do not yet show multiyear plans or progress against back to balance plans and this reporting change was again requested.	Board of Directors

The Rotherham NHS Foundation Trust

Agenda item	P/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 1 2025/26. The development of the Board Assurance Framework has continued on a monthly basis. The People & Culture 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 April and June 2025 Committees. **Finance and Performance Committee:** Discussed and approved the position in relation Strategic Risk D5 and D9 relating to future financial risk at the May and June 2025 meetings. Recommended changes to the risk ratings are detailed below in sections 5, 6 and 7. The Finance & Performance Committee now also reviews the Strategic Risks R2 and O3, and there had been no change to the previously recommended ratings of **8** for each risk. **Quality Committee:** Discussed and approved the position in relation to Strategic Risk P1 at the May and June 2025 meetings.

Due Diligence	The relevant sections of the Board Assurance Framework have been discussed at the relevant Board Committees during May and June 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 reduce to 12; ➢ The rating for BAF Risk D8 was closed, and ➢ The rating for BAF Risk D9 to reduce to 16
Appendices	Appendix 1: Overall Board Assurance Framework for Quarter 1 2025/26

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 May and June.

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 Control C6 relating to the three 2025/26 Quality Priorities, 360 Audit are looking at Effectiveness of Quality Priorities in Q1 2025/26- revisiting one historic and one current priority - reporting Q2 2025/26..

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 1 2025/26**.**

3 Risk aligned to the Finance & Performance Committee

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 June 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 1 2025/26 that the score remained at **8** which the Committee will note was at target score, the risk was reviewed in June and will be further reviewed in July 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 June 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 July 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 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 1 to review the risk, the last review being in June 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 in June 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 1 2025/26.

Update to the Controls and Mitigations

5.1 The wording of D5 was amended to refer the 2025/26 Organisational Priorities.

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.

5.4 The risk continues to be reviewed on a monthly basis and following review in May 2025 the Finance & Performance Committee recommended that the rating be reduced to **12** as the operational priorities this year had been set in line with national expectations and trajectories set to deliver this.

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 was closed following sign off of the year-end accounts.

7 D9: 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.

7.1 The new BAF Risk D9 covers the financial situation for the Trust, 2025/26. The outstanding controls and gaps from D8 have been carried forward on advice of the Risk Owner.

Update to the Controls and Mitigations

7.2 There were no changes to the Controls, apart from the updates of Committees where assurance was provided.

Updates to Gaps in Assurances

7.3 There were no changes to the gaps.

Review of the Risk Score relating to D8

7.4 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.

7.5 The risk was discussed at the May 2025 Board of Directors where it was agreed that the financial plan is in place and as such the rating should be reduced to 16, following review in June 2025 this is still the recommendation.

Recommendations

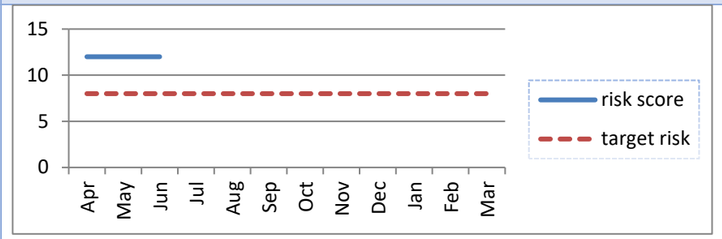
The Board of Directors is asked to:

- Discuss and note the outcomes of the 2025/26 BAF following review of the BAF Risks with the individual Executive Leads.

Alan Wolfe

Deputy Director of Corporate Affairs

June 2025

Strategic Theme: Patients	Risk Scores											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**	**Board Assurance 2025-26**					
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)**	**CAUTIOUS**		**Previous Score Q4 2025-26**	**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**				
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	Established meeting structure reporting directly to Quality Committee on a quarterly basis to provide assurance with regards to Patient Safety, Patient Experience, Clinical Effectiveness, Infection Control, Safeguarding, Medication Safety and Health & Safety	May 2025	QC	L1				Chief Nurse	
		Quarterly report on Quality Assurance to Quality Committee and Board of Directors to provide update on all aspects of Quality Strategy. QC sub-committees Chair's Logs added to reading room for each Board.	November 2024 Board July 2025	QC	L1				Chief Nurse	
		Range of tools utilised to measure quality achievements including Tendable Audit programme and	March 2025	QC	L1				Chief Nurse	

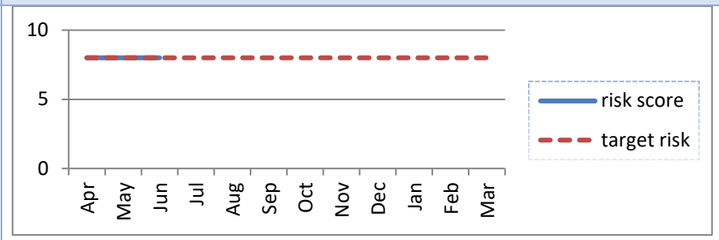
		Power Bi Quality Dashboards with outcomes reviewed at monthly Care group Performance meetings.	Monthly						
		Exemplar Accreditation Programme continues for adult inpatient areas, paediatrics and maternity. On boarding of new areas in 2025. Added into Quality Report for QC, first presentation due July 2025	January 2025	QC	L1				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 regular basis providing assurance around key areas. Discharge presentation to CQC	May 2025 June 25	QGAG PSC	L1 L3				Chief Nurse
C2	Ongoing monitoring of Patient Safety and PSIRF implementation through a variety of sources to ensure we keep patients safe and optimise patient outcomes	Ongoing use of Datix incident reporting system to report all adverse incidents or near misses. All incidents rated as moderate or above reviewed at Incident Review panel by CN / MD three times a week. Incidents identified as requiring a PSII or AAR and associated themes and actions reported to Patient Safety Committee and Quality Committee quarterly. Harm Free Panel reviews TVN and IPC incidents monthly. Summary of key findings included in report to Patient Safety Committee and Quality Committee quarterly. Completed PSIIs reviewed in Executive led monthly sign off panel with representation from ICB. Summary of key findings included in report to Patient Safety Committee and Quality Committee quarterly. Actions from PSIIs and AARs monitored to ensure completion within agreed timescales. Monthly report sent to Care Groups and summary included in report to Patient Safety Committee and Quality Committee quarterly. All National Patient Safety Alerts and information received by the Central Alerting System Liaison Officer are shared quarterly through the Patient Safety Committee with completion of action plans monitored by the	May 2025	PSC QC ETM	L1				Chief Nurse

		Quality Governance and Assurance Team. Operation plan PSIRP next due for update Qtr3. PSIRF Plan and Policy completed. PSIRF plan now available on external Trust website and fully embedded with ongoing monitoring continuing and reported through Patient Safety Committee.	November 2024						
C3	Mortality and Learning from Deaths	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 added to Datix 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. Quarterly distribution to Care Groups. The SHMI continues to be monitored through the Trust Mortality Group. 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.	March 2025 November2024 March 2025 QC - May 2025 May 2025	CEC QC Board	L1				Medical Director
C4	Ongoing monitoring of the effectiveness of the 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) to the Clinical Effectiveness Committee. There is a Clinical Effectiveness Committee Report at the Quality Committee on a quarterly basis	November 2024 March 2025	CEC QC	L1				Medical Director

C5	Ongoing monitoring of Patient Experience through a variety of sources to ensure we are providing the best possible care and experience for our patients.	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	November 2024 QC April 2024	QC	L1				Chief Nurse
		Friends and Family Test offered to all patients. Results shared with Care Groups on a monthly basis and reported at Patient Experience Committee and Quality Committee quarterly	May 2025	QC	L1				Chief Nurse
		Report on Complaints including volume, themes and learning reported at Patient Experience Committee and Quality Committee quarterly	May 2025	PSC QC	L1				Chief Nurse
		Monitoring of PALs 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	May 2025 November 2024 - public - Inpatients Q1 25/26 - currently under embargo, UECC Nov24, Maternity Nov24. CYPS Published May 2025	In 2025	L1				Chief Nurse
C6	Three Quality Priorities have been agreed for 2025/26	Rolling monthly update report to Quality Committee resulting in an update being received for each priority quarterly. Template provides data in SPC format, supported by Qi, Effectiveness and Data Analysis teams. 360 Audit looking at Effectiveness of Quality Priorities in Q1 2025/26- revisiting one historic and one current priority - reporting Q2 2025/26.	June 2025 Q1 - Q2 2025/26	QC QC	L1 L3				Chief Nurse
C7	Seek External Assurance to triangulate with internal assurance data	Quarterly reports on progress against self-assessment by Care Groups to Quality Governance & Assurance Group reported through Patient Safety Committee, Medication Safety Committee and Quality Committee quarterly	QC - May 2025	QGAG PSC QC	L2				Chief Nurse
		External body reports such as from NHSE or inspections	May 2025	SC QC	L3				Chief Nurse

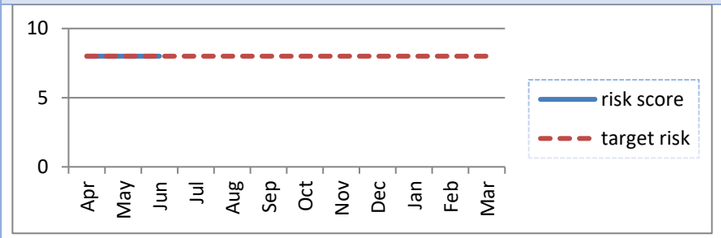
		reported to Quality Committee via the appropriate sub group on quarterly basis								
		Quarterly Safety, Experience or Effectiveness reports to Quality Committee to provide updates on any partnership working with BDGH and details of associated actions	February 2025	QC	L2					Chief Nurse
		Annual audit 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 April 2025	QC	L3					Chief Nurse
Gaps in Controls or Assurance Quarter 1 2025-26		**Actions Required**	**Action Owner**		**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Need for Quality Strategy to be approved and implemented	Quality Strategy due at QC June 2025 and Board of Directors July 2025.	Chief Nurse	January 2025						
G2	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 - interviewed and offered post. Exec Team to Exec Team meeting TRFT and Rotherham Hospice held in January 2025.	

								Commenced work with Barnsley to implement a peer review process. First domain to be reviewed is end of life care in Qtr2. Reporting to QC in October 2025.	
G3	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.	
		Commenced work with Barnsley to implement a peer review process. First domain to be reviewed is end of life care in Qtr2. Reporting to QC in October 2025.	Chief Nurse	**May 2025**					
G4	Qi work themed from Mortality		Medical Director/Head of Quality Improvement	**April 2024**	April 2025			To include as agenda item at QC February 25 and April 2025 Board	
G5	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	**May 2025**				Plan has been developed and is now being monitored through the MSC. New Chief Pharmacist started 20 January 2025 - Actions in progress and nearing completion.	
G6	CDiff rates	Development and completion of an antimicrobial action plan. Action plan reported on a quarterly basis through the Quality Priorities	Chief Nurse	**April 2025**	July 2025			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.	
G7	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**				To be agreed at ARC April 2025	
G8	Need to recruit Patient Safety Partners	Scoping works to be undertaken in Qtr 1	Chief Nurse	**May 2025**					
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 2025-26**				
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**	**SEEK**		**Previous score Q4 2024-25**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: R2: Ensure equal access to services								**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	TRFT is a member of a number of partnership meetings including: Place, Health and Wellbeing Board and Rotherham Together Partnership.	Trust Board receives reports from these key meetings, and there are weekly updates into Executive Team on Place.		**May 25**	Board minutes		Level 1				**Control remains ongoing**	
C2	TRFT is developing its approach to reducing HI's including appointment of Public Health Consultant and production of a plan.	There are a number of examples of projects focused on reducing health inequalities. A presentation on progress is planned for October Board. For discussion on progress of objectives. Weekly updates to Executive Team		**May 25**			Level 1				**Control remains ongoing**	
C3	Improved Board insight into Place through Board development session	Presentation delivered ib February 25, further paper with recommendations to following May 25 from Managing Director		**February 25**			Level 1				**Control remains ongoing**	
C4	**Archived - see version BAF R2 - Rotherham Version 4.1 Quarter 4**											
C5	**Archived - see version BAF R2 - Rotherham Version 4.1 Quarter 4**											
C6	**Archived - see version BAF R2 - Rotherham Version 4.1 Quarter 4**											

Gaps in Controls or Assurance Quarter 1 2025/26	**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**	**Progress Update**

G1	Ethnicity details not on all electronic systems	Public Health Consultant identifying and working on solution. A working group has been established including the Public Health Consultant and the Director of Health Informatics	Managing Director	Ongoing	~~End of Quarter 1~~ End Quarter 4			Reporting improved so performance can be broken down by ethnicity as well as other protected characteristics	
G2	Non-elective activity continues to increase with a disproportionate number of people from higher deprivation areas attending UECC and more likely to be admitted	Working with Place colleagues on Place priorities including: Community Services review and the UECC plan (Rotherham and National)	Managing Director	Ongoing	End of Quarter 4			Ongoing with regular updates to the Board	
G3	Lack of a definitive Trust plan to support the reduction of HI's	A plan is in development linked to other key strategies including quality, performance and delivery. Being presented at October 25 Strategic Board forum.	Managing Director	End of Q1					
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

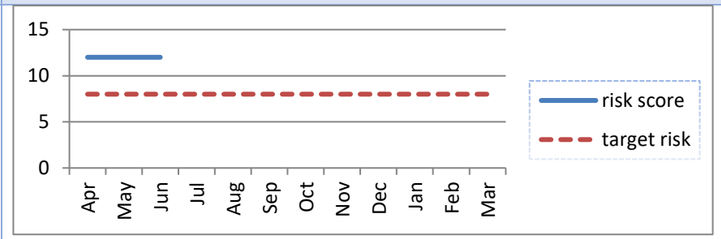
Strategic Theme: Patients	Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2025-26				
Strategic Ambition: **Our Partners: *We will be PROUD to collaborate with local organisations to build strong and resilient partnerships* that deliver exceptional, seamless patient care.**	**O3**	**2(L)x4(C) = 8**	**8**	**2(L)x4(C) =8**	**SEEK**		**Previous score Q4 2024-25**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***O3: Our Partners: Work together to succeed for our communities.***							**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 and executives contribute to all meetings	Reports received by the Trust Board every two months from Chief Executive Report. Weekly updates to Executive Team.	**April 2025**		Level 1				
C2	Existing collaboration with Barnsley on some clinical services. Board to Board, Joint Strategic Partnership and Joint Executive	Gastro service up and running, Haematology service in progress MEOC now embedded. Meetings of the Strategic Partnership every quarter, Monthly for Delivery Group.	**April 2025**	**Reports to Boards on progress**	Level 1				

	Delivery Group established for oversight and delivery of partnership plan											
Gaps in Controls or Assurance Quarter 1 2025/26		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**				
G1	Archived - Refer to BAF O3 - Our Partners - Version 4.1 Quarter 4											
G3	Mexborough Elective Orthopaedic Centre (MEOC) - lack of signed partnership agreements	The partnership agreement needs to be completed and signed off by all parties.	Managing Director / DoF	April 2024	Q1 2025/26			Partnership agreement is still under review and requires agreement				
G4	Pathology Partnership model	Formal reporting structure is in place, the outstanding actions are the need to have a signed off partnership agreement and further clarity on the FBC benefits case delivery.	Managing Director / DoF	June 2025				Up-date to be brought to FPC in July 2025 regarding the FBC benefits progress and partnership agreement This specific control was previously part of G1, now separated out for better clarity				
Archived Controls within month – Completed												
Archived Gaps within month – Completed												

Board Assurance Framework People Committee: 2025/26 Quarter 1: Version 1.3

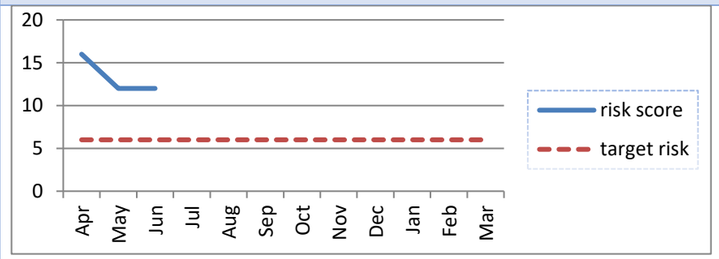
BAF Risk U4

Strategic Theme: Us		Risk Scores										
		BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2025-26				
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	Seek		Previous score Q4 2024-25	Q1	Q2	Q3	Q4
Link to Operational Plan: ***P3: Supporting our People*** ***P2: Improve engagement with our medical colleagues***								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	People & Culture Strategy 2024-2027	There will be a Year 2 review presented to the P&CC.		April 2026	P&CC Oct24	Level 1						
C2	Integrated EDI (Equality Diversity Inclusion) Plan	Current Board approved plan published and on website, was refreshed for November Public Board 2024. EDI plan 2024/27 underpins WRES and WDES signed off at Board EDI plan update to be presented with WRES and WDES TO Board November 2025.		EDI Plan to P&CC in October 2025 and Board November 2025	Board Nov24	Level 1						
C3	Delivery of the People Promise – staff experience	Review progress against the Trust 'We said we did' plan 2025/26 in October 2025. Care Groups to present progress on their 'We said we did plans' at their P&CC presentations. Regular Corporate Bulletins sent via Communications.		October 2025 and April 2026 At Care Group P&CC presentations	P&CC Oct 24 Ongoing confirmation from Care Groups	Level 1						

		June 2025 launched trust wide 'we said, we did' 2025/26. NHS Staff survey outcomes and 2025/26 People and Culture objectives will go to People and Culture Committee and then the March 2026 Board of Directors.	P&CC February 2026 Board Mar26		Level 3				
C4	Health wellbeing and attendance work	Deep dive presented to ETM and P&CC in April 2025 and provided assurance on overall approach. 360 audit gave limited assurance on how managers manage long term sickness, audit currently being rerun Qtr 1 2025/26 Health and Wellbeing Programme established with 5 working groups supporting work. Update in Qtr 2 to September 2025 P&CC Contract awarded and go live September 2025 for Occupational Health contract. Monthly sickness absence performance provided to P&CC at every meeting.	April 2025 Quarter 2 2025/26 Quarter 2 2025/26 April 2025	P&CC Feb25 and Apr25 updates	Level 1 Level 2				
C5	Development of the Trust Workforce Plan	Existing Workforce Plan in place. New Trust Workforce Plan under development and to be presented to Board Qtr 2. Board strategy discussion Qtr 1 2025/26. Monthly turnover performance data provided to PAA at every meeting	June 2025 P&CC and July 2025 Board April 2025		Level 1				
C6	Joint Leadership Programme	Programme complete Value Circle completed programme of work, formal evaluation and feedback awaited.	October 2024 P&CC		Level 1				

Gaps in Controls or Assurance Quarter 1 2024-25		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Challenges around sufficient workforce to support the recovery plan and mitigate industrial action.	High level risks from Care Groups regarding exceptional workforce challenges monitored via P&CC. Care Group 1 Care Group 2	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 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						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 **All Care Groups and Corporate Team - Risk7338 - New National Job Profiles for B4-9** **Paper to be taken to June 2025 P&CC.**	
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 approval in Quarter 2 2025/26.	Director of People					Completed	
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 2025-26					
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)X3(C)=15** **4(L)X3(C)=12** ~~**Recommend to reduce in line with performance against trajectories**~~	**2x3=6**	**MINIMAL**		**Previous Score Q4 2024-25**	**Q1**	**Q2**	Q3	Q4
Link to Operational Plan: ***D5: To deliver 4 hour performance in line with the Trust's trajectory and 78% by March 2026, to deliver the national standard for reducing long-waiting patients and increasing RTT performance by 5% and consistently deliver the Cancer Faster Diagnosis Standard.***								**15**	**12**				

BAF Risk Description	Linked Risks on the Risk Register & BAF Risks				Assurance Committee & Lead Executive Director
D5: There is a risk we will not deliver our performance priorities (*Urgent Care, Elective Recovery and Cancer*) because of insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.	**~~Risk 5761,~~ ~~Risk 6569~~, RISK6800, RISK6627, RISK6762 ~~RISK6414~~, RISK6755, RISK6638, RISK6718, RISK6723, RISK6958, RISK6888, RISK6598 , and RISK6801**				**Finance and Performance Committee** **Director of Finance & Chief Operating Officer**

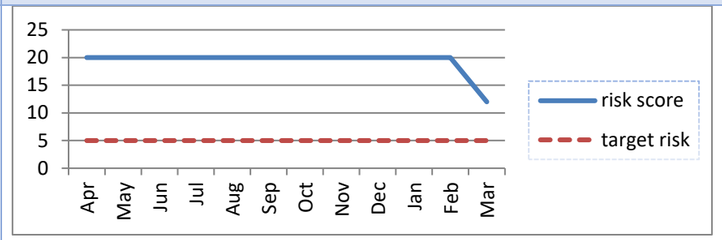
Controls and Mitigations *(what have we in place to assist in securing delivery of our ambition)*		Assurance Received *(what evidence have we received to support the control)*	Date Assurance Received	Confirmed By:	Assurance Level *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*				
C1	**PERFORMANCE:** Care Group Performance meetings chaired by the Deputy CEO.	Performance Meeting minutes and chairs logs Monthly reports within IPR to Finance and Performance Committee and Board Care Group Performance meetings with each CSU	**May25** **May25 IPR**	**Minutes** **Chair's Log**	Level 1				Managing Director
	PERFORMANCE: Executive Team oversight via IPR	Weekly receipt of Performance IPR	**May25**	**ETM minutes Weekly** **ETM minutes Weekly**	Level 1				Weekly Executive Team Meeting Managing Director
C2	**URGENT CARE:** Monitoring waiting	Monthly TRFT Urgent Care Meeting	**May25**		Level 1				COO

	times of patients in UECC	Metric included in the Integrated Performance Report Weekly report to ETM Daily review of position and weekly through the acute care performance meeting and ETM Weekly 4 hour performance emergency care target meeting chaired by COO. Waiting times have improved in UECC and monitored against trajectory		**Minutes of F&P** **ETM minutes** **ETM minutes** **ETM minutes** **Action log** **Daily performance report**					
	URGENT CARE: Monitoring Criteria 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 Escalation meetings with external partners. Action plan in place in relation to recommendations in patient flow audit	**May25 IPR** **May25 IPR** **May25 IPR**	**Minutes of Urgent Care Meeting** **Weekly ETM minutes** **Weekly ETM minutes**	Level 1 Level 3 - 360 Assurance audit report Patient Flow – Limited assurance – action plan in place				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 chaired by the Deputy Place Director and deputy chair COO.	**May25**	**Minutes of Urgent Care meeting**	Level 1				ACT Steering Group – emergency pathway workstream Medical Director Rotherham Urgent and Emergency Care Group COO
C3	**ELECTIVE:** Weekly access meetings with tracker for elective recovery schemes	Elective Delivery Group Weekly Access Meetings Care Group PTL Meetings Outpatient, Theatre & Endoscopy Transformation Programmes External review of Trust PH processes via FF20 Programme - feedback report received	**May25**	**Monthly** **Weekly** **Weekly** **Weekly** **Monthly Highlight Report**	**Level 1** **Level 3 - 360 Assurance audit report - July24**				COO Ass Director of Operations Ass Director of Operations
C4	**CANCER:** Cancer PTL	Rotherham Cancer Strategy & Performance Meeting Cancer Services Quality, Governance & Business Meeting	**May25**	**6 weekly** **Monthly**					COO Ass Director of Operations

		Cancer PTL Meetings. Cancer Improvement Programme		**Weekly Monthly Highlight Report FPC 1/4ly**					Cancer Manager
C5	**WINTER: Winter planning**	Evaluation of 2024/25 Winter Plan Development of Winter plan for 2025/26 to commence earlier Evaluation and initial draft recommendations to June ETM and FPC Draft Plan to July ETM and FPC	**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 2025-26		**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 Admission avoidance work with partners including ICB and YAS to reduce demand	DoF COO					No growth funding in 25/26 contract Project Chronos focus on reducing ambulance conveyances New SDEC to open July 2025 aims to reduce UECC attendances via direct to SDEC pathways	
G2	Lack of consistent SDEC model and trolley capacity across medical and surgical SDECs	ACT programme developing consistent models of care New purpose built medical SDEC to create ringfenced capacity Bed reconfiguration to create capacity to ring-fence trolleys in surgical and gynae SDEC	COO	Q1	Q3			Pathways and protocols being developed New SDEC to open July 2025 Trust-wide review of bed base to support SDEC trolley capacity being developed by Dir of Ops	
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	Associate Director of Operations, Planning and Performance	Q1	Q2			Review of capacity completed and draft business case developed.	

		maintain requirement to meet 90% validation Standardise validation processes and embed consistent ways of working Training of existing staff to support validation of waiting list Ensure oversight through regular audits and performance monitoring						Business case approved at ETM to increase validation resource. Interim increase in validation resource, including external support Text validation and admin validation in place, training of staff has been undertaken Awareness sessions with clinical leads and clinicians at CSY level taking place in relation to Access Policy and RTT rules	
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. Risk of further Industrial action - where this does take place this will be subject to regular industrial action meetings to mitigate impact.	Care Group Leads & FPC					No IA planned currently but doctors balloting and is risk this may result in IA	
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 workforce has taken place, with support from national Clinical leads via GIRFT, with workforce plan in development Recruitment to additional Anaesthetic Consultant and new Specialist posts Insourced support in place as interim measure/mitigation	
G6	Financial investment/resources to support recovery of waiting lists	Financial allocation identified in plan for 2025/26 – 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 2025/26 plan	
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~~ 3 (L) X 4 (C) = 12***	***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**	**12**

BAF Risk Description	**Linked Risks on the Risk Register & BAF Risks**					**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 7130, RISK6755 and RISK6801** **Risk**					**Finance and Performance Committee** **Director of Finance**

	Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***	**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*				
C1	Improvement of clinical productivity to levels experienced in 2019/20 without central funding for outsourcing clinical activities	Monthly Elective Programme Meeting chaired by Chief Operating Officer	**May25 Board**		Level 1				
C2	CIP Track and Challenge in place		**May25 Board**		Level 1				
C3	Contingency of £3m in place.		**May25 Board**		Level 1				
C4	Winter funding allocated in reserves of £1.2m.		**May25 Board**		Level 1				
C5	Elective recovery fund £6.0m		**May25 Board**		Level 1				
C6	Financial plan submitted to NHSE by 08/05/2024	Submitted on time, still awaiting sign off by NHSE	**May25 Board**						
C7	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee	**May25 Board**		Level 1				
C8	System wide delivery of Recovery	Director of Finance attends South Yorkshire DoF Group	**May25 Board**		Level 1				

	On plan with mitigations in place to manage winter pressures.	Monthly Finance Report to CEO Delivery Group	**May25 Board**		Level 1					
		South Yorkshire Financial Plan Delivery Group			Level 1					
C9	Suitably qualified Finance Team in place	Team in place			Level 1					
C10	Established Capital Monitoring Group	Capital and Revenue Plan signed off by Board	June 2024							
C11	Current Standing Financial Instructions in place	Reviewed and approved by Board			Level 1					
C12	Internal Audit Reports	Internal Audit Financial Reports			Level 3					
		Review of HFMA Improving NHS Financial Sustainability checklist			Level 3					
		360 Assure Head of Audit opinion presented to Risk and Audit Committee initial indications show Significant Assurance overall			Level 3					
C13	Monthly challenge on performance	Monthly Divisional Assurance meetings	June 2024							
C14	Clarity on Financial Forecast	Financial forecast will commence based on June financial position. Director of Finance in process of agreeing financial recovery plans with each accountable officer – these will be fed into monthly assurance meetings.			Level 1					
C15	Deloittes review of South Yorkshire system including investigation and intervention work.	I&I report will be finalised and presented to Senior Leadership Executive for South Yorkshire highlighting areas for improvement	August 24							

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Adherence to expenditure Run Rate as per financial plan	Monthly budget reports. Expenditure profile produced monthly throughout year. Reserves Policy in place. F&PC oversight. Internal audit systems budgetary control audit. External audit annual accounts.	Director of Finance	Q1	Ongoing				
G2	Potential reduction of cash balances due to expenditure higher than income which would result in late payments to suppliers. Impact to invest in capital projects.	Situation acceptable currently, future risk	Director of Finance					For Gaps G4-G7 awaiting further national guidance to fully assess the position. The Trust will run out of cash at some point during the second half of the financial year 2024/25.	

								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					Year-end financial plan is £299K surplus	
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									

Strategic Theme: Us	Risk Scores										
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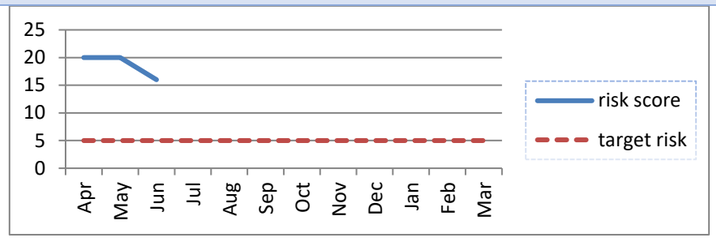
Strategic Ambition: Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation.	**D8**	**5(L) X 4(C)=*20***	***~~5(L) X 4(C)=20~~*** ***4(L) X 4(C)=16***	***1(L)x4(C) =4***	***CAUTIOUS***		**Previous Score Q4 2024-25, as D8**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: D9: To deliver the financial plan for 2025/26 reducing our cost base and delivering a balanced financial position. Embed a multi-year approach to financial sustainability, delivering year one of this requirement in support of a recurrent balanced position.							**20**	**16**			
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks** **RISK 7130, RISK6755 and RISK6801**				**Assurance Committee**	
D9: 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 2025/26 leading to further financial instability.						**Risk**				**Finance and Performance Committee** **Director of Finance**	

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Archived Controls within month – Completed									
Archived Gaps within month – Completed									

Board of Directors
4th July 2025

The Rotherham NHS Foundation Trust

Agenda item	P/102/25
Report	**Risk Management Report (including Corporate Risk Register)**
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 'Together'
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Summary (including reason for the report, background, key issues and risks)	This report provides an update to the Board 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. Key highlights include: **Risk Review Compliance**: Trust-wide compliance with risk review dates has improved to 88% in June, up from 83% in May. **High-Rated Risks**: There are 21 high-rated risks (15–25) approved by the Risk Management Committee (RMC). Risks recently approved for escalation in risk score are brought to the attention of the Board (see Section 2). **Action Plan Monitoring**: The Corporate Affairs team and Risk Management Committee (RMC) continues to scrutinise action plans, with a focus on those lacking updates or marked as complete without reassessment. **Issues and Emerging Risks**: The report introduces an updated Issues Register and outlines emerging risks such as the potential impact of the UK Covid-19 inquiry and the Assisted Dying Bill. **Ongoing Improvements**: Development of a Power BI dashboard is underway to enhance data analysis and reporting efficiency. Risk management training and support continues across Care Groups to strengthen governance and early risk identification.

	The report affirms that the Trust continues to embed a culture of proactive risk management, with ongoing efforts to ensure timely reviews, effective mitigation, and strategic oversight of emerging and high-impact risks.
Due Diligence	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 Committees, Executive Team Meeting and finally the Board of Directors.
Board powers to make this decision	The Trust Board of Directors are required to have oversight of the Trust's risk management processes.
Who, What and When (What action is required, who is the lead and when should it be	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 Risk Management Committee: • Note the content of the report; • Note the ongoing work carried out to further strengthen the risk register
Appendices	1. Corporate Risk Register 2. Issues Register

1. Introduction

1.1 This report to the Board of Directors is to provide assurance that the Care Groups are considering their risks, issues and emerging risks. The information provides an update to the Board for the review of all Approved risks rated at 8 or above as at the 25th June 2025, with additional scrutiny on risks rated 15 and above. Appendix 1 details all Risk Management Committee (RMC) approved risks rated at 15 and above and includes full risk details, progress updates and action plans. For 'All Trust' data and graphs, these include risks rated 12 or below which are discussed and approved at Care Group Governance meetings and not RMC.

1.2 In June 2025 the Trust had a total of 239 Approved risks recorded on Datix, these are risks rated between 8 and 25, as follows:

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

This report does not contain any details to risks rated at 12 or below, apart from the graphs indicating review date and action plan compliance. These are as follows:

Moderate Risks rated 8 - 12 and Care Group Approved = 218

Low Risks: Controlled/Managed Risks: rated 1 - 6 = 392

1.3 The following report illustrates the overview and analysis of the risks by review dates, action plans, as well as emerging risks.

2. High Level Risks for the attention of the Board of Directors

2.1 There are 21 risks rated 15 and above (Appendix 1). At RMC, all RMC approved risks rated 15 above are presented by Care Group Senior Leadership Teams (SLT) and scrutinised by the committee which includes Executive input. New risks or risks for escalation/de-escalation in risk rating are presented and the following risks are highlighted for the attention of the Board:

Risk 7338 (Corporate Services), relates to the new National Nursing and Midwifery job profiles for Bands 4-9 and was approved at June RMC at a score of 15. These updated profiles will require all NHS providers to review existing job descriptions for all staff band 4-9 and amend accordingly to ensure compliance with the updated National profiles and associated pay bands. There are currently 1600 nursing and midwifery staff that are likely to be included in the review, ranging from Band 4-9. The People and Culture Committee received a detailed presentation on the review and remain abreast of the work in train.

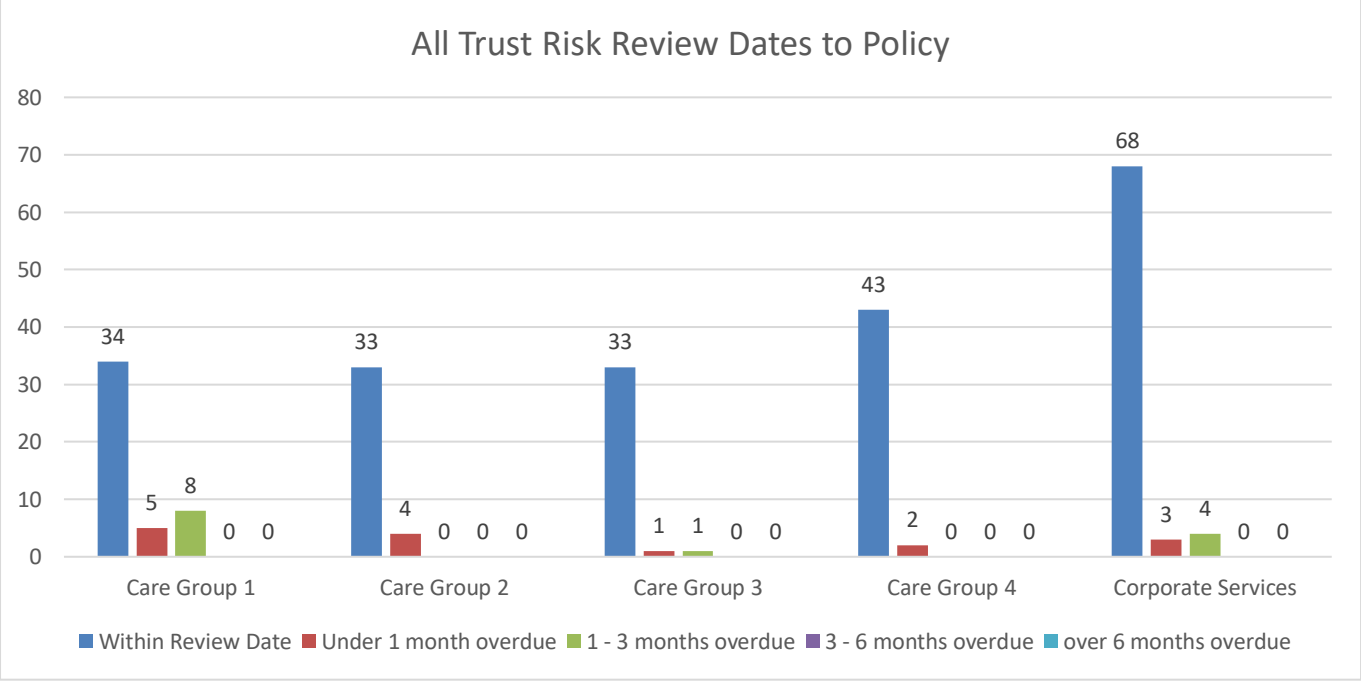
Risk 7289 (Care Group 4), relates to the non-conformances in radiopharmacy during an MHRA inspection and was approved at June RMC at a score of 15 recognising the ongoing financial, and potential clinical and reputational, impact. It was reported by Care Group 4 to Quality Committee in June that the action plan had been completed and the service is expected to go live in July. The Care Group recognised the substantial investment made and the support received from the Executive team, and highlighted it will mark the establishment of the first new radiopharmacy in the region for several years. It is expected that the risk will significantly reduce on the next review due to the actions taken.

Risk 6692 (Care Group 1), relates to inadequate nursing establishment in the UECC, and was approved at May RMC at a score of 16. Increasing attendances to Urgent and Emergency Care Centre has been seen both locally and nationally as well as increased acuity of patients resulting in increased nursing time/support to manage patients safely and effectively on the service. This risk will be reviewed and reflected on in establishment review meetings to examine the risk further and mitigations to be put in place. This high risk triangulates with the Safe Staffing and Establishment report to the Board of Directors and the recommendations for this area of the Trust.

3. Risk Review dates

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 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:

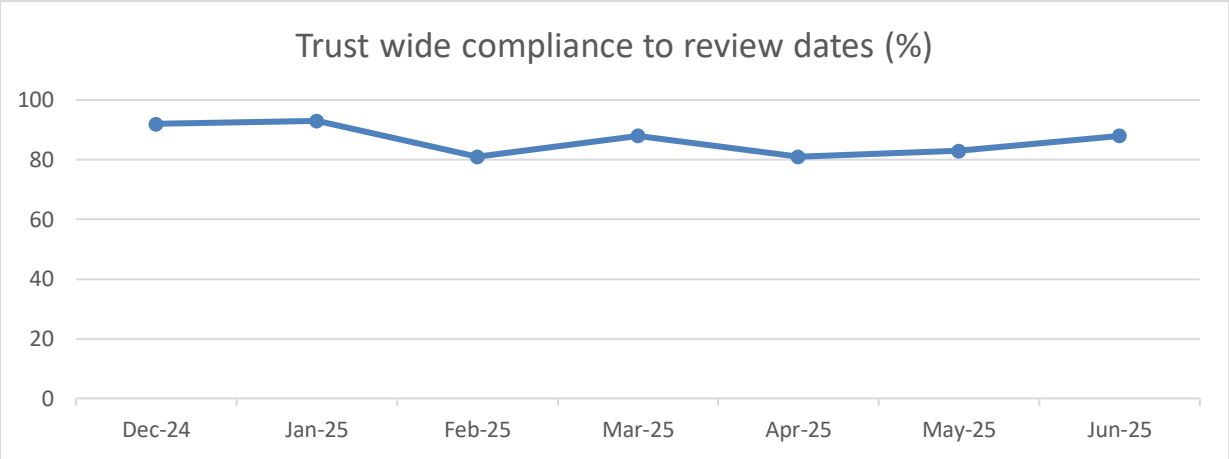
- High Risks - Monthly review
- Moderate Risks - Three Month review
- Low Risks - Annual review



3.2 Trust-wide compliance with risk review dates is reported at 88%, reflecting an improvement from the 83% reported from May data to RMC. Care Group 1 has the lowest compliance at 72%, but marks a positive shift from last month, improving from 62%. Care Group 3 leads with the highest compliance rate at 94%.

3.3 There were no risks out of date for review over three months, 13 risks that were out of date for review for between one and three months, and 15 risks overdue by less than one month. At the time of writing, there were no high rated risks overdue for review.

3.4 Trust-wide review date compliance has maintained over 80% for the past 6 months (see graph below). Compliance has ranged from 81% to 93%, fluctuating depending on risk owner and Care Group circumstances, evidenced by the alternating highest achieving care group and the lowest compliance rate care group detailed in risk management reports.



3.5 All Care Group management and governance teams are provided with monthly information on risks that require further review. There is the expectation that these risks are addressed and discussed at the Care Group Governance meetings. Corporate Services risks owners are contacted by the Corporate Affairs Team directly.

4. Board Committee & Performance Reporting of Risks

4.1 A version of this Risk Management report is shared with Board Committees to support triangulation and highlight relevant risks, including those under the threshold of Board reporting, such as risks rated between 8 and 12.

4.2 In addition, specific high level risks are brought to the attention of appropriate committees and performance meetings following deliberations at the Risk Management Committee (RMC) and feedback from the Executive team. This process ensures that critical risks receive the necessary scrutiny and oversight, facilitating more in-depth discussion within the committees and meetings.

5. Risk Action Plans

5.1 The scrutiny of action plans continues to 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. This is presented monthly to RMC, and quarterly to Audit and Risk Committee.

5.2 The Corporate Affairs team has been working with the Director of Health Informatics to develop a Power BI dashboard aimed at enhancing the efficiency of the risk management function, specifically action plan monitoring. This initiative focuses initially on reducing the time required for data formatting and analysis in reporting processes, with a longer-term goal of establishing a centralised platform for integrated reporting.

5.3 High risk action plans that have been highlighted as non-compliant, are as follows:

Risk 6888 (Corporate Services), has no active action plan in place and is rated 15. It is the risk in relation to the lack of clinical psychology support for all services for which it is required. It has been raised that there is no appetite for a business case and the funding control for these services sits with commissioners. There are limited actions that the Trust can put in place to mitigate, beyond what has already been actioned and the controls in place.

Risk 5967 (Care Group 1), is a risk relating to insufficient provision of medical cover within the UECC and is rated at 15. There is an overdue action in relation to the ACT programme and reviewing the streaming to SDEC to reduce footprint in UECC. The SDEC is due to open at the beginning of July, so it is likely this action will align and be completed on the next review.

Risk 6692 (Care Group 1), the risk relates to inadequate Nursing Establishment in the UECC and is rated 16. There is an overdue action mirrors the action detailed above in Risk 5967 in regards to the ACT programme and SDEC.

Risk 6630 (Care Group 2), is the risk in relation to the lack of critical care follow up clinic, and is rated 15. The overdue action is around the business case

for the service and was due in May 2025. It was reported that meetings have been held with key stakeholders and the business case will be refreshed and presented to SLT. It has been suggested that the datix action is aligned with this update.

5.4 Work will continue to highlight the importance good risk management in regard to action plans and consideration to the impact on the risk level when actions are completed.

6. Issues Register

6.1 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.

6.2 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/

6.3 The list below details the issues identified. All of these risks have been registered on the risk management database as at 25th June 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 there are advancing discussions with the Bed Remodeling team to look at alternative arrangements for a trolley space for Surgical SDEC and ASU and be part of a wider series of moves expected in 25/26. The CG2 leadership team have discussed options and these are being worked up with Executive oversight to rehome the service.

6.4 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.

7. Emerging Risks

7.1 The emerging risks have been identified by the Care Groups at the Risk Management Committee and also during Board Committees. As of June 2025, none of these risks have been registered on the risk management database due to insufficient detail. Those identified were as follows:

- UK Covid-19 public inquiry and the likelihood of claims against the NHS. The inquiry is expected to conclude its public hearings in 2026, with final reports published as each module is completed. Module 1 Report – The resilience and preparedness of the United Kingdom, has been published and found that the UK's approach to preparing for a pandemic had several serious weaknesses, which affected the ability to respond effectively (UK Covid-19 Inquiry, 2024). Whilst the Inquiry does not assign legal blame, its finding could have implications for claims.
- The Assisted Dying Bill could significantly impact the NHS by potentially causing resource strain, complex ethical decision-making processes, and potential staff concerns, whilst also raising questions about whether it would lead to improved or diminished access to quality palliative care. The Bill

passed its third reading in the House of Commons on 20 June 2025 and it is now undergoing scrutiny in the House of Lords, where it must pass through several stages.

- The Supreme Court Ruling on biological sex and the emerging risk of legal, operational, and reputational exposure arising from the need to align policies and services, while balancing the rights and dignity of trans and non-binary individuals. There have been referrals made between Finance and Performance Committee and People and Culture Committee on this issue, with the risk considered low in terms of immediate operational impact, but it was also acknowledged that it is a highly sensitive issue that attracts significant public and media attention. It was emphasised the importance of recognising its relevance to staff and patients. Further information has been requested from the F&PC to the P&CC.

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

8. Moving Forward

8.1 Risk Management training and support continues with the Care Groups, led by the Corporate Affairs Team. This month included ad-hoc support meetings and discussions with risk owners and specific deep dives through sub-committee risk reports.

8.2 The RMC continues 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 includes scrutiny on fully completed 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 the risk management process can be seen in other meetings such as the Board Committees and the monthly Care Group Performance Committee.

8.3 Corporate Affairs are working with the Director Health Informatics to develop a Power BI dashboard for risk management, to streamline efficiency in exporting Datix data and identification of risks that require further management and scrutiny.

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

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

Alan Wolfe
Deputy Director of Corporate Affairs
27th June 2025

Appendix 1: Corporate Risk Register (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	23/06/2025	23/07/2025	[Broadhurst, Lucy Miss 23/06/25 16:11:11] Updated 23/06/25 - Unable to reduce the risk because established staffing levels have not changed. Disparity between establishment and increasing workload. Current issues: * Device team remain under pressure due to maternity leave and backlog of overdue remote follow-ups (>120 pts). 0.75 WTE locum support finishes this week (end June). Approval to continue with some OT. One staff member works an extra day per week on a long-term basis and another has offered to work extra days throughout July (short-term). * No change in funded Echo staffing & disparity between capacity and demand. Approval to continue with 'enhanced levels' of insourcing until Jan 2026 (mat leave cover). Business case proposal (Echo) submitted to Deputy Professional Lead 23/06/25. * Unable to secure suitable locum/bank cover for vacancies * Ongoing project to recoup tariff income for services but no income received yet. Current vacancies: * 1.0 WTE B6 (filled with a student who does not qualify until Sept 25) * 1.0 WTE Band 6 Fixed term (cover for clinical practice educator) -out to advert for fifth time * 1.0 WTE B6 post filled with B5 (training ongoing) * Vacant B5 hours filed at B3 level (turned into L6 apprenticeship training post) role to acknowledge challenges recruiting to these posts * Awaiting approval to upgrade one B6 to B7 to retain Clinical Practice Educator (using vacant B4 hrs) * 2.0 WTE Vacant B3 Cardiographers Current absences: * 0.75 WTE B7 Mat leave (Echo) due to return Jan 2026 * 0.75 WTE B7 Mat leave (devices) due to return Jan 2026 LB	Approved Risk	Business case to increase staffing	01/07/2022	23/09/2025		Broadhurst, Miss Lucy
													Source Locum Support for Non-Invasive Team	28/11/2024	04/08/2025		Barsby, Melvina
													Support Admin/ Reception Team	02/12/2024	29/08/2025		Barsby, Melvina
7076	04/03/2024	Orr, Gemma	Care Group 4 (Community, Therapies, Dietetics & Medical Imaging)	Pelvic Health Waiting List and Capacity to treat patients	1. Delayed patient care 2. Patients condition detoriating as a result of the delay 3. Delay to Gynaecology consultants and urine incontinence pathway	High 15	High 15	Moderate 9	24/03/2025	10/07/2025	[Orr, Gemma 09/06/25 08:13:05] Waiting times remain static at 6 months, but unfortunately have 2 Band 5 staff leaving in the summer, so anticipate a deterioration. The recruitment for the Band 6 is underway, interviews taking place in the next 2 weeks.	Approved Risk	Staffing	01/11/2024	29/08/2025		Fletcher, Mrs Becky
													Templates	01/11/2024	30/04/2025	06/05/2025	Fletcher, Mrs Becky
													Pathway	01/11/2024	31/12/2025		Fletcher, Mrs Becky
													MSK Funding	11/11/2024	31/12/2025		Fletcher, Mrs Becky
													Capacity & Demand modelling	03/12/2024	29/08/2025		Orr, Gemma
													Use of Technology	03/12/2024	29/08/2025		Fletcher, Mrs Becky
7289	24/02/2025	White, Mr Duncan	Care Group 4 (Community, Therapies, Dietetics & Medical Imaging)	Non-conformances in radiopharmacy during MHRA inspection	The refurbished radiopharmacy may not be re-licenced by the MHRA	High 15	High 15	Low 3	30/05/2025	01/07/2025	[Rimmer, Claire 04/06/25 09:59:49] June RMC - The committee agreed to accept this risk at a score of 15, recognising the ongoing financial, and potential clinical and reputational, impact.	Approved Risk	Major non-conformances	03/03/2025	30/06/2025		White, Mr Duncan
													Other non-conformances	03/03/2025	30/06/2025		White, Mr Duncan
													Go / no-go document	03/03/2025	30/06/2025		White, Mr Duncan
7290	26/02/2025	Hutchinson, Mrs. Michelle	Care Group 4 (Community, Therapies, Dietetics & Medical Imaging)	Lack of Speech and language provision within the care homes team	Patients who reside in a care home not receiving timely interventions from speech and language therapy	High 15	High 15	Low 6	21/05/2025	25/06/2025	[Bell, Beky Miss 28/05/25 11:11:29] Risk reviewed at CSU Nursing Governance Meeting, no change to current staffing	Approved Risk	To recruit new Speech and Language Therapist to existing funded vacancy	03/04/2025	31/10/2025		Hutchinson, Mrs. Michelle
													To employ a Speech and Language Therapist Locum until permanent position filled	03/04/2025	30/06/2025		Hutchinson, Mrs. Michelle
7338	29/05/2025	Storer, Cindy	Corporate Services	New National Job Profiles for B4-9	The below risks are linked to risk 7069 on the Trust risk register and were presented in the initial business care. Overall current risk score is 20. Due to likelihood (Certain) and Impact (Major) 1a - There is a risk that the consultation process is not managed affectively and in line with Trust policy. 2a - There is a risk that agreements with staff side on backpay are not accepted resulting in increased and unpredictable costs. 3a – There is a risk, new job descriptions and associated clinical skills frameworks are not followed and implemented in line with Trust policy. 4a – There is a risk that the organisation consultation is delayed resulting in increased backpay. 5a – There is a risk of trade union disputes and action. 6a – There is a risk of local and National media attention if the process is not managed effectively. 7a – There is a risk of organisational unrest and indirect impact on clinical care due to ongoing consultation process affecting workforce and morale. 8a – There is a risk large sections of the workforce do not meet the minimum requirements of the national job descriptions	High 20	High 16	Low 4	29/05/2025	27/06/2025	[Rimmer, Claire 04/06/25 09:57:45] June RMC - The risk was approved at a score of 15 with the score to be reviewed in line with project developments.	Approved Risk	Create project team to support the review	29/05/2025	27/06/2025		Dobson, Helen

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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')
7341	03/06/2025	Wolfe, Alan	Corporate Services	Ability to deliver 2025/26 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 20	High 16	Low 4	03/06/2025	02/07/2025	[Wolfe, Alan 03/06/25 12:28:44] Risk approved at June 2025 Risk Management Committee.	Approved Risk	Development of Winter plan.	03/06/2025	01/10/2025		Kilgariff, Mrs. Sally
													Cost improvement Efficiency Board.	03/06/2025	01/10/2025		Kilgariff, Mrs. Sally
													Development of robust capacity plans.	03/06/2025	01/10/2025		Kilgariff, Mrs. Sally
													Outpatient utilisation programme.	03/06/2025	03/11/2025		Kilgariff, Mrs. Sally
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	03/06/2025	03/07/2025	[Rimmer, Claire 10/06/25 14:05:59] Discussed at RMC 03.06.25 - VH reported that the situation had worsened due to another psychologist leaving, leading to longer patient stays and a negative impact on recovery. The committee acknowledged the ongoing funding and service delivery challenges.	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
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	24/06/2025	28/07/2025	[Rimmer, Claire 24/06/25 13:29:09] Reviewed by GC: Escalated to COO/DCOO - awaiting feedback, as is for the trust to agree escalation time frames with RDASH. Risk went to MHSG last week - awaiting feedback. Continues to be a risk. Individual patients still continue to have long waits.	Approved Risk	Arrange task and finish group with stakeholders, including RDASH, to discuss and work through pathways and escalations for patients - awaiting outcome and decision	02/11/2023	31/10/2025		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	03/06/2025	01/07/2025	[Rimmer, Claire 17/06/25 11:24:14] Risk reviewed at June RMC: As previous update -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. A new 2025/26 financial risks has been opened.	Approved Risk	Development of robust capacity plans.	01/06/2024	31/03/2025	20/03/2025	Kilgariff, Mrs. Sally
													Theatre improvement programme.	03/03/2023	30/06/2025		Kilgariff, Mrs. Sally
													Outpatient utilisation programme.	23/03/2023	30/06/2025		Kilgariff, Mrs. Sally
7164	15/07/2024	Grainger, Mrs. Jane	Care Group 1 (UECC and Medicine)	Provision of NIV (Respiratory) in an appropriate setting by suitably trained staff	Respiratory patients receiving suboptimal NIV care and treatment - led by Respiratory Physician. No suitable location of care for level 2 patients requiring NIV. All patients currently receive care in HDU due to no Respiratory Support Unit (RSU) leading to delay in treatment and positive patient outcome.	High 16	High 16	Low 6	03/06/2025	03/07/2025	[Rimmer, Claire 10/06/25 14:01:18] 03.06.25 RMC - PS reported that the risk was being addressed by a working group, with recommendations to be submitted to ETM. The risk score would be reviewed once further progress was made.	Approved Risk	Advanced Care Planning for NIV patients	14/11/2024	14/11/2025		Reynard, Jeremy
													QI working group to be established to address NIV on medical area	01/05/2025	09/07/2025		Benton, Jennifer
6969	18/08/2023	Staunton, Eamon	Care Group 1 (UECC and Medicine)	Lack of IT integration services, EPR not working consistently. (investigations going to wrong clinician)	Key Issue 1: Imaging, not being seen or delay to be seen by correct speciality /consultant. Significant increased work to sort imaging and redirect Imaging to correct Consultant and speciality. With subsequent SI and incidents arising from specialities not seeing own imaging. 2 PAs of EM Consultant time a week sorting this, and 2 hrs a day of secretarial time used. Key Cause 2: lack of electronic speciality referrals	High 15	High 15	Low 6	24/06/2025	22/07/2025	McAuley, Heather 26/06/2025 15:31:28 Discussed at CSU 1 governance. updated title to better explain issues with IT, particularly with investigations and results not moving to the correct medical teams.	Approved Risk	Consultant Awareness of Issue	02/02/2024	29/11/2024	02/01/2025	Reynard, Jeremy
													progression of electronic referrals across care groups and specialities.	01/07/2024	30/06/2025		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	24/06/2025	22/07/2025	McAuley, Heather 26/06/2025 15:33:07 Reviewed in CSU 1 governance. felt actions all in place, this involves a change of policy.	Approved Risk	QI Project	16/11/2023	28/02/2025	04/03/2025	Staunton, Eamon
													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
													Safer care nursing tool	01/01/2023	31/12/2024	06/01/2025	Maton, Lynsey
													Review appropriateness of scans requested in the UECC	02/09/2024	23/12/2024	02/01/2025	Reynard, Jeremy
													Review CT Trauma guidelines with Radiology	07/03/2025	30/06/2025		McAuley, Heather

Appendix 1: Corporate Risk Register (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')
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	24/06/2025	22/07/2025	McAuley, Heather 26/06/2025 14:45:56 discussed in CSU 1 governance. should show an improvement from August when the middle and junior grades rota will be full. to review at this, with a view to potentially closing the risk.	Approved Risk	ACT programme	04/04/2022	16/06/2025		Hammond, Lesley
													Senior clinical fellows	04/12/2023	30/08/2024	02/01/2025	Reynard, Jeremy
													Workforce Programme	07/03/2025	30/09/2025		Stafford, Dr Matthew
													Deanery Trainees	07/03/2025	01/07/2025		Reynard, Jeremy
													Consultant Recruitment	07/03/2025	30/04/2025	25/04/2025	Reynard, Jeremy
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 16	Moderate 9	03/06/2025	01/07/2025	Rimmer, Claire 27/06/2025 10:24:07 RMC 03.06.25 - PS highlighted that the risk had reduced down to 16 as ward B6 had been closed. The risk remains high, pending the outcome of bed reconfiguration work.	Approved Risk	SHOP Ward round principles	13/03/2024	30/06/2025		Reynard, Jeremy
													Bed Reconfiguration Work	12/07/2024	30/06/2025		Stewart, Paul
													Utilise Perfect Week to enact de-escalation	18/07/2024	24/07/2024	22/08/2024	Stewart, Paul
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 16	Moderate 12	24/06/2025	22/07/2025	McAuley, Heather 26/06/2025 15:10:44 trajectory heading in the right direction. to review next month to allow for a full month of data to review if a sustained improvement in performance. potential then to reduce harm level.	Approved Risk	Work with Executive team on embedding the standards and engagement with the Trust	01/11/2023	30/06/2025		Reynard, Jeremy
													ACT Programme	07/03/2025	30/09/2025		Beahan, Dr Jo
													Escalation SOP for Paediatrics for busy periods	13/09/2024	27/01/2025	03/02/2025	McAuley, Heather
													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 (on-going action - closed and action plan updated inline with 4hour delivery plan)	13/09/2024	30/04/2025	23/04/2025	Kilgariff, Mrs. Sally
													Bed Reconfiguration	07/03/2025	30/06/2025		Stewart, Paul
													Medical SDEC	07/03/2025	31/07/2025		Hammond, Lesley
													Reducing specialty delays - COO and MD to facilitate meetings with clinical and operational leads from UECC and each specialty, Surgery – enhancement of surgical SDEC to protect trolley capacity, Development of GAU, & Ortho direct streaming	01/04/2025	31/03/2026		Kilgariff, Mrs. Sally
6692	28/04/2022	Maton, Lynsey	Care Group 1 (UECC and Medicine)	Inadequate Nursing Establishment in the UECC	Not enough Nursing staff to safely manage the current demand in the department leading to poor patient outcomes, increasing incidents where harm has been caused, poor patient experience. The effect on nursing workforce morale, retention, recruitment and wellbeing. Based on April 2022 SEDIT data benchmarking for registered nurses is set at 82.5WTE. Current budget is 60.89WTE of which 56.17WTE are clinical. Failure to meet RCN/RCEM Nursing Workforce standards for Type 1 ED NHS Professionals only fill gaps to current WTE budgeted workforce this does not address the issue that budgeted nursing establishment is below national benchmarking as identified above Inability to undertake intentional rounding and risk assessments as per standard operating procedure	High 20	High 16	Low 4	24/06/2025	22/07/2025	McAuley, Heather 26/06/2025 15:22:21 discussed at CSU 1 governance, await feedback from ETM re staffing paper.	Approved Risk	ACT programme	04/10/2021	16/06/2025		Hammond, Lesley
													additional nurse to support winter pressures	01/11/2024	31/03/2025	31/03/2025	Maton, Lynsey
													further SNCT collection	01/07/2025	30/09/2025		Farrow, Lindsay
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	06/07/2025	[Short, Sally Mrs. 24/06/25 14:28:05] No further update at present	Approved Risk	Review bed modelling to understand bed capacity needs - Care Group 2	19/07/2024	31/10/2025		Howlett, Darren
													SDEC Working Group established - look at options to run SDEC models throughout winter	02/09/2024	31/03/2025	24/03/2025	Howlett, Darren

Appendix 1: Corporate Risk Register (15+ Risks)

ID	Opened	Handler	Care Group / Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6630	28/01/2022	Windsor, Claire	Care Group 2 (Surgery)	Lack of Critical Care Follow Up Clinic	Critical illness leaves patients at highly significant risk of long term physical, cognitive and psychological problems. This has the potential for considerable residual impact on patients morbidity and longevity. Caused by no Critical Care follow up service. Resulting in failure to provide vital support following discharge resulting in the inability to identify any complications relating to critical illness which require effective management and ongoing treatment or onward referral including significant mental health / psychological sequalae and physical disability. Failure to meet GPIC's V2 standards.	High 15	High 15	Low 6	31/07/2025	01/08/2025	[Howlett, Darren 24/06/25 14:56:35] Met to discuss the BC with key stakeholders discussed the needs and complexities of the service. TO refresh the BC and present to SLT. Discussed at CG2 performance meeting 24/06 with the execs and feedback given to the team to factor in. Request oversight of case before submission,	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
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	13/06/2025	31/07/2025	[Roper-Bowen, Beth 13/06/25 11:48:00] Reviewed at Risk Review Group - agreed to review with greater scrutiny in July 2025 and assess performance against commissioner agreed trajectory with a view to reducing risk if everything continues as current and milestones continue to be met.	Approved Risk	To introduce the new streamlined assessment pathway	01/01/2025	31/03/2025	25/03/2025	Cowie, Alison
													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
June 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	24/06/2025	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.	Howlett, Darren 06/05/2025 09:11:34 Advancing discussions with Bed remodelling team to look at alternative arrangements for a trolley space for Surgical SDEC and ASU. Part of a wider series of moves expected in 25/26. CG2 leadership team discussed options and these being worked up with Exec oversight to rehome the service. [Short, Sally Mrs. 24/06/25 14:28:05] No further update at present	Deborah Timms	3 - High	TBC: Dependant on bed remodeling and wider series of moves	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
4 July 2025

The Rotherham NHS Foundation Trust

Agenda item	P/104/25
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.South Yorkshire & Bassetlaw Acute Federation Annual Report

1.0 Operational Matters

1.1 In May 2025, the Trust sustained its focus on meeting national elective recovery standards (reducing waiting lists and RTT) and made further progress in reducing long waits. The total waiting list decreased slightly to 31,192 and the Trust continued to maintain zero patients waiting over 65 weeks and delivered a further reduction in the number of patients waiting over 52 weeks, with 703 patients reported against a trajectory target of 812. This reflects the impact of targeted recovery actions that care groups continue to take.

1.2 Referral to Treatment (RTT) performance improved to 68.2% in May, with a number of specialties achieving the 92% constitutional compliance standard. These included General Medicine (92.5%), Geriatric Medicine (100%), Ophthalmology (92.1%), Respiratory (95.2%), Clinical Haematology (96.7%), Paediatrics (96.1%) and Paediatric Cardiology (95.5%). This is a fantastic achievement and highlights the sustained efforts of clinical and operational teams.

1.3 Diagnostic performance has remained strong, with compliance against the DM01 standard reported at 0.63% in May 2025. However, the inclusion of surveillance patients on the Audiology DM01 active waiting list continues to present a compliance risk. Work remains ongoing to address this issue, with the aim of achieving full compliance by the end of July 2025.

1.4 In April 2025, the Trust achieved the Faster Diagnosis Standard (FDS) with performance at 80.2% and continued to maintain excellent performance against the 31-day first treatment standard, achieving 98.5%. However, the 62-day referral to treatment standard was not met, with performance reported at 72.2%. The Trust remains focused on recovery of cancer performance and continues to engage in system-level discussions to ensure appropriate access to diagnostic and treatment services across the South Yorkshire Cancer Alliance footprint. As we move into the summer period, restoring 62-day performance remains a key operational priority alongside maintaining the high levels of performance already achieved against the 31-day and FDS standards.

2.0 Urgent and Emergency Care Activity

2.1 The Trust achieved 68.6% in May against the 4-hour emergency care standard, which exceeded the Trust trajectory of 64%. The number of attendances at UECC are remaining high and saw 9248 attendances during May against a submitted plan of 8674. In comparison to May 2024 attendances were 8971 which is 5.74% increase

2.2 The Trust has seen a number of complex patients including out of area mental health patients who have seen an extended length of stay in the Emergency department.

2.3 Key areas the Trust needs to focus on remains non-admitted patient waiting times, streaming from the front door and criteria to reside. Positive performance should however, be noted in the following key metrics:

- 12 hours in department
- Ambulance Handover Times
- Length of Stay

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

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

3.2 The Barnsley and Rotherham partnership continues to collaborate and grow and the Trust continues to work with partners locally, regionally and at a national level to deliver a co-ordinated and consistent approach to the effective management of services.

3.3 I am pleased to share the South Yorkshire & Bassetlaw Acute Federation Annual Report for 2024/25 at appendix 1 of this paper.

4.0 People

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

- Mr A Wilkins, General Surgery, Upper GI (June 2025)
- Dr K Alkhazrji, Acute Medicine (July 2025)
- Dr M Shaban, Acute Medicine (August 2025)

4.2 I had the great pleasure of attending and presenting at The Rotherham NHS Foundation Trust annual PROUD awards event 2025. The event was an evening of celebration to recognise and thank everyone who works at the Trust who play such an important role in ensuring that the Trust provides a high quality of care for the people of Rotherham and beyond.

Congratulations to all of our very worthy winners in each of the categories below:

Excellence Award Individual:
Dr Fiona Hendry, Consultant in Palliative Care
Excellence Award Team:
Health Informatics
Excellence Award Public:
Intensive Care Unit/High Dependency Unit
Volunteer of the Year Award: Pat Wiles, Charity Volunteer

Quality Improvement Award: Infection Prevention and Control and Fitzwilliam Ward for the Gloves Off campaign
Inspiring Leader Award: Annmarie Grogan, Clinical Lead for Complex Children's Care/Paediatric Virtual Ward
Diversity and Inclusion Award: Infant Feeding Team
Clinical Team of the Year: Acute Response Team
Non-Clinical Team of the Year: Respiratory Physiology and Medical Physics administration team
Unsung Hero: Caroline Saunders, Mammographer, Breast Imaging and Danny Hallatt, Project Manager, Estates Capital Projects
Learner of the Year: Ayan Muhammad and Shannon Allonby-Wright
Public Recognition Award: Claire Christopherson, Community Midwife
Partnership Award: Trusted Assessors, Care Homes Team
Governors' Award for Living the Values: Danny Hallatt, Project Manager, Estates Capital Projects
Chief Executive's Award: Home Chemotherapy Service
Chairman's Award: Pulmonary Rehabilitation Team

We also had 11 colleagues who were awarded with long service certificates: 9 for 40 years, 1 for 50 years and 1 for 60 years!

Dr Richard Jenkins
Chief Executive
July 2025

NHS
South Yorkshire & Bassetlaw
Acute Federation

Annual Report
2024/2025

Contents

1. **A message from the South Yorkshire and Bassetlaw Acute Federation Committees in Common** 3
2. **Who we are and what we do** 5
3. **Our year at a glance** 6
4. **The five-year vision** 8
5. **Progress against our priorities** 9
   - 5.1 Elective care recovery 9
   - 5.2 Diagnostics recovery 12
   - 5.3 Clinical services sustainability 14
   - 5.4 Acute Paediatric Innovation 17
   - 5.5 Plan for people 20
   - 5.6 Digital convergence 21
   - 5.7 Pathology service 22
6. **Working collaboratively with partners** 23
   - 6.1 Cancer Alliance 23
   - 6.2 Children & Young People's Alliance 23
   - 6.3 QUIT smoking programme 24
   - 6.4 Collaborative Procurement 24
   - 6.5 Integrated Stroke Delivery Network 25
7. **The year ahead - 2025/2026** 26

A message from the South Yorkshire and Bassetlaw Acute Federation Committees in Common

The South Yorkshire & Bassetlaw Acute Federation Annual Report for 2024/25 outlines our work and progress over the past year. It showcases a range of achievements which are a testament to the coalition of five acute and community trusts in South Yorkshire & Bassetlaw and demonstrates how we continue to build on our history of working together to address some of the challenges facing the NHS.

The year saw improvements in quality, access and efficiency with the proportion of patients being treated within 18 weeks rising from 62% to 63% despite demand growing by nearly 5,000 since the previous year, 2,500 patients being seen through mutual aid, over 268,000 more diagnostic tests being delivered through Community Diagnostic Centres, 3,500 surgeries delivered through elective orthopaedic centres, 55 more endoscopists through immersive training at the Yorkshire Endoscopy Training Academy and nearly £1.2 million saved through collaborative procurement.

As one of nine national provider collaborative innovators, the secondary care Paediatric Innovator Programme successfully launched the paediatric virtual ward pilot project which will avoid unnecessary hospital admissions, and launched the Healthcare that Works for Young People plan, regarded regionally as pioneering in its ambition and reach. Thanks to investment from the South Yorkshire ICB we also implemented a paediatric dental surgical hub which will reduce waiting times for patients. Our work on paediatric services matters because South Yorkshire & Bassetlaw has significant health inequalities with 25% of children living in families experiencing relative poverty. It is our mission to do all we can to give children and young people the best start in life by giving them access to excellent healthcare.

Whilst South Yorkshire & Bassetlaw has been affected by the same resourcing and waiting list challenges faced by the rest of the NHS we believe that through collaboration we have been able to lay the foundations for stronger, more sustainable, clinical services for the benefit of patients and staff. In keeping with the Acute Federation's clinical strategy, we have identified the clinical services which will benefit most from collaboration, strengthened our ways of working to achieve a networked clinical workforce and collaborated on technological innovation. Each organisation has agreed in principle to converge on a single Electronic Patient Record in the future which is a sign of our commitment to collaboration. Convergence on digital systems is a key enabler for clinical collaboration with the purpose of delivering more joined up care for our patients who we know use multiple services across all of our organisations.

We have seen provider collaboration in South Yorkshire go from strength to strength, not only across our five trusts but also with our healthcare partners across the patch. This is evidenced in a range of projects including the primary-secondary care interface guidance, co-developed with the Primary Care Alliance to ease the flow of patients between general practice and hospital, the publication of the Healthcare that Works for Young People Statement of Intent, co-produced with the Mental Health, Learning Disability & Autism Provider Collaborative and closer working with the voluntary, community and social enterprise sector for mutual benefit. We're also working in partnership with the South Yorkshire Integrated Care Board on workforce

initiatives such as the people digital systems plan to enable a networked workforce and reduce procurement costs.

Our Imaging Network will enable us to improve quality and drive efficiency by working at scale to modernise equipment and ways of working, and deliver resilient services. We have also witnessed the development of inventive solutions to improve the precision of diagnosis using AI technology in areas such as polyp detection.

We know that collaboration can foster innovation, promote quality improvement and drive efficiency and want to thank all of the colleagues involved in making our provider collaborative a success. We look forward to continued partnership working for the benefit of patients and staff.

Dr Richard Jenkins,
Chief Executive,
Barnsley Hospital NHS
Foundation Trust

Sheena McDonnell,
Chair,
Barnsley Hospital NHS
Foundation Trust

Richard Parker OBE,
Chief Executive,
Doncaster and Bassetlaw
Teaching Hospitals NHS
Foundation Trust

Suzy Brain England OBE,
Chair,
Doncaster and Bassetlaw
Teaching Hospitals NHS
Foundation Trust

Dr Richard Jenkins,
Chief Executive,
The Rotherham NHS
Foundation Trust

Dr Mike Richmond,
Chair,
The Rotherham NHS
Foundation Trust

Ruth Brown,
Chief Executive,
Sheffield Children's NHS
Foundation Trust

Prof. Laura Serrant CBE,
Chair,
Sheffield Children's NHS
Foundation Trust

Kirsten Major,
Chief Executive,
Sheffield Teaching Hospitals
NHS Foundation Trust

Annette Laban,
Chair,
Sheffield Teaching Hospitals
NHS Foundation Trust

Who we are and what we do

The South Yorkshire & Bassetlaw Acute Federation is a provider collaborative of five acute and community hospital trusts serving a population of 1.6 million people. It is made up of:

- Barnsley Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust

Our aim is to use our collective expertise and resources to ensure the people of South Yorkshire and Bassetlaw have prompt access to excellent healthcare through:

Quality care	Health equality	Happy staff	Great partner	Waiting times	Effective spending
Working together to drive the quality of care to be amongst the best in the country	Taking a proactive approach to reduce health inequalities for the populations we serve	Collaboratively developing our colleagues and teams so that there are happy staff across all partners	Being a great partner to the rest of the health and care system in South Yorkshire and Bassetlaw	Supporting each other to achieve all the NHS waiting time standards for local people	Seeking innovative ways to more effectively use the NHS pound so there is enough resource for the whole system

We do this by benchmarking performance data to stimulate quality improvement and reduce unwarranted variation, collaborative service redesign to transform care for patients, and delivering initiatives to improve care pathways and pool resources, where appropriate, to be as efficient and effective as possible.

Our work is underpinned by these principles:

1. We will continue to work together in partnership to best serve our 1.6 million population and over 30,000 colleagues
2. We will proactively look for opportunities to do things once on behalf of all where it makes sense to do so
3. We will standardise clinical care procedures to reduce unwarranted variation
4. We will build a collaborative workforce that ensures the resilience of our services
5. We will prevent long term conditions to support the shift from sickness to prevention
6. Through collaboration our work should reduce health inequalities

The Acute Federation is supported by our professional partnership groups, clinical networks and a central coordination team:

Our year at a glance

- Increased the proportion of people receiving elective treatment within 18 weeks from 62.31% to 63.25%.
- Over 1,500 people have received surgery at the new Montagu Elective Orthopaedic Centre, a collaboration between Barnsley NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and The Rotherham NHS Foundation Trust.
- Over 3,000 patients have had surgery at the Sheffield Elective Orthopaedic Centre.
- Screened over 400 orthopaedic surgery patients through an early screening programme designed to identify patients who are ready for surgery much earlier.

  Over 560 patients have been given the option to receive quicker elective treatment through mutual aid.
- Reduced the rate of missed appointments from 6.6% to 6.1%.
- Increased the rate of patient initiated follow up appointments from 3.5% to 4%.
- Delivered 268,419 more diagnostic tests through our Community Diagnostic Centres.

- Trained 55 endoscopists at the Yorkshire Endoscopy Training Academy in Sheffield reducing oesophagogastro-duodenoscopy training time from 2 years to 10 months and colonoscopy training time from 4 years to 15 months.

- Over 2,000 patients received their diagnostic test earlier through mutual aid.

- Developed a system level integrated strategy to provide standardised imaging across the network.
- Established a South Yorkshire & Bassetlaw-wide footprint for the viewing of imaging across the network with the introduction of integrated technology.

- Introduced AI-assisted Olympus technology to improve polyp detection and enhance training opportunities.

- Treated 40 patients through a South Yorkshire & Bassetlaw urology pathway giving patients access to more targeted treatments for benign prostatic hyperplasia.

- Launched a paediatric high-volume dental hub which will enable around 700 more children to receive oral surgery a year.

- Paediatric virtual ward pilots went live at The Rotherham NHS Foundation Trust and Sheffield Children's NHS Foundation Trust and will enable patients to be cared for at home and reduce unnecessary hospital admissions.

- Launched the Healthcare that Works for Young People plan which equips staff with the tools to provide more personalised care for young people with complex conditions.

- Co-developed with the Primary Care Alliance the primary-secondary care interface guidance to improve patient care, flow and experience and reduce inappropriate administrative work.

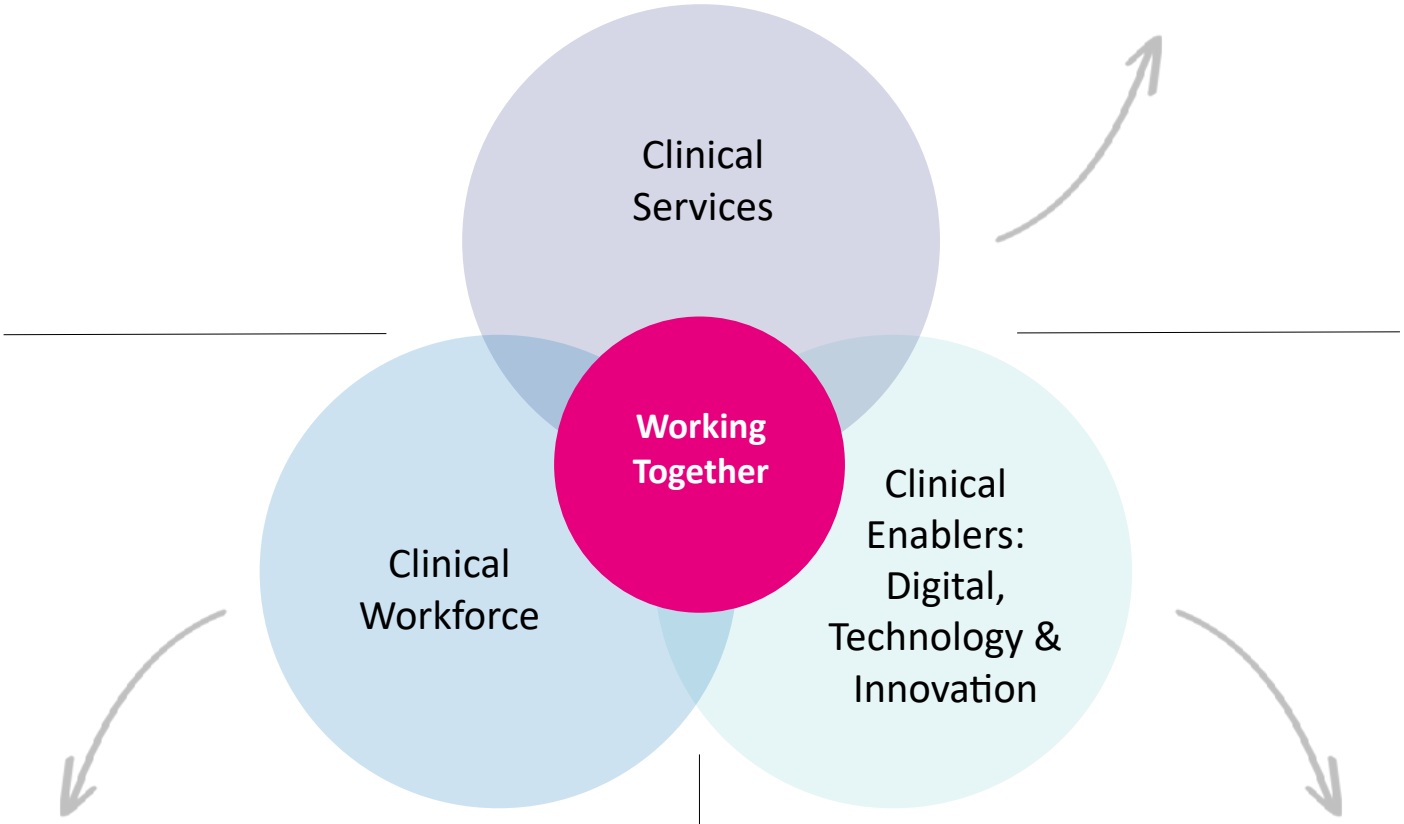
- Identified opportunities to strengthen the sustainability of six clinical services – audiology, community paediatrics, dermatology, ophthalmology, oral surgery and urology - through collaboration.

- A single unified South Yorkshire & Bassetlaw Pathology Service was formed in April 2024.

- Saved £1,167,000 through collaborative procurement.

The Five-Year Vision

Services at different hospitals across South Yorkshire play complementary roles as part of an acute federation **collaborative model**	**Shared care** to be developed further across primary and secondary care including Mental Health services. Everyone is clear on the contribution secondary care can make to prevention of ill-health	**Life stages** recognised as an important framework for end to end pathways, to support more proactive planning and working
Patients experience **high standards of care**, no matter which hospital they attend; with constant energy on driving down unwarranted variation across the system	Standardisation for **better outcomes and patient experience**, and taking action on health inequalities	Patients can **move seamlessly** from one hospital to another in order to access specialist care or faster treatment



A networked workforce
build the system for developing opportunities for clinicians to gain experience/support patient services across South Yorkshire

Resilience and sustainability
priority criteria for the system, future models of care incorporating new ways of working

Greater **interoperability** across the organisations so that our staff can seamlessly access and share electronic patient information and records

Best use of our **collective estate** to offer choice, access and state of the art facilities

Models of care that optimise new technologies, innovative ways of working and environmental sustainability, learn from new research evidence and change how, where and when we deliver services

Progress against our priorities

2.1 Elective Care Recovery

The programme aims to improve elective performance and recovery across South Yorkshire & Bassetlaw through collaboration to reduce waiting times, development of sustainable patient pathways, optimisation of capacity and expansion of digital solutions.

Reduce waiting times for patients

Aim	Progress summary
Reduce waiting times for patients, ensuring all in South Yorkshire & Bassetlaw have access to timely, and effective care to optimise health outcomes.	In February 2025, 63.25% of people in South Yorkshire & Bassetlaw were treated within 18 weeks and 2.26% of people were waiting longer than 52 weeks for treatment. This is an improvement from 62.31% treated within 18 weeks. Between February 2024 and February 2025, South Yorkshire & Bassetlaw has made the following waiting time improvements: • 43 fewer people are waiting longer than 78 weeks for treatment • 591 fewer people are waiting longer than 65 weeks for treatment • 946 fewer people are waiting longer than 52 weeks for treatment • 264 fewer people are waiting longer than 18 weeks for treatment These improvements have been achieved despite the total number of people waiting for treatment growing by 4665.

Anaesthetic and Peri-Operative Medicine

Aim	Progress summary
Increase early screening, risk assessment and health optimisation in elective surgical pathways.	Long waiting times can result in worsening health, and late identification of health risks can further extend the wait time for surgery and require additional resources. A pilot early-screening programme for the Montagu Elective Orthopaedic Centre commenced in December 2024 and has screened over 100 patients, identifying people who are ready for surgery much sooner than if the pilot was not in place. Another orthopaedic early-screening pilot is taking place within SYB, and has screened over 320 patients to date. Early findings from this pilot are: • The surgical postponement rate halved • More patients were declared fit to proceed within the 16-week pre-operative period • Median listing to surgery time reduced by 12 weeks • Ferinject use reduced. We also delivered an active wait pre-habilitation programme to help patients to wait well and be fit for surgery.

Outpatients

Aim	Progress summary
Improve outpatient productivity and efficiency through better utilisation of capacity and reducing unnecessary demand.	In February 2024, the rate of missed appointments in South Yorkshire & Bassetlaw was 6.6%, but due to a range of initiatives including improved scheduling, improved patient communications and waiting list validation this has reduced to 6.1% in February 2025. This equates to 1,522 fewer missed appointments. In February 2025, the rate of Patient Initiated Follow Ups (PIFU) in South Yorkshire was 4%, which is an increase from 3.5% in February 2024. PIFU allows patients to contact their healthcare team to request follow up appointments when they feel it is necessary. It reduces unnecessary appointments and can save patients time.

Surgical hubs

Aim	Progress summary
Increase elective capacity to reduce waiting times for patients.	The Montagu Elective Orthopaedic Centre (MEOC) opened on 14th January 2024 and by February 2025 over 1,500 people have been operated on at the centre. The Sheffield Elective Orthopaedic Centre opened in the winter of 2023, January 2024 and February 2025 over 3,000 patients had surgery at the centre. The South Yorkshire & Bassetlaw Children and Young Person's Dental Hub launched on 11th March 2025. The hub will provide an extra full day a week of dental assessments and an extra full day a week of exodontia.

Primary-Secondary Care Interface

Aim	Progress summary
To enable health and care professionals across secondary and primary care to work collaboratively and efficiently to improve patient care, flow and experience and reduce inappropriate administrative work.	Co-developed with the Primary Care Alliance and launched the South Yorkshire Primary-Secondary Care Interface Guidance. Launched a standardised referral process for rheumatology to support primary care to reduce unnecessary referrals to secondary care. It will be embedded in GP IT systems.

Elective Mutual aid

Aim	Progress summary
Reduce waiting times for patients by offering them choice to move to an alternative provider where they can be seen sooner.	Across ophthalmology, paediatric urology, audiology and neurology a coordinated approach to sharing capacity has reduced patient waiting times. Although more is still to be achieved, over 560 patients have been given the option to receive their treatment sooner through collaborative working.

Digital elective care

Aim	Progress summary
Support adoption of digital tools e.g. patient engagement portal functionality to optimise use of available resources, reduce waiting times and improve patient experience.	Throughout 2024-25, all acute providers in South Yorkshire & Bassetlaw have implemented and further developed digital communication and booking tools. Some examples are provided below. • Doncaster and Bassetlaw Teaching Hospitals has begun implementation of digital patient-initiated-follow-up, whereby patients can use a digital tool to request a follow up appointment. DBTH has also launched notifications and messaging to patients via the NHS App. • The Rotherham NHS Foundation Trust has begun implementation of the Federated Data Platform outpatient module, which offers the benefits of enhancing clinic operations with waiting list validation, data quality tools and cohorting features. • Barnsley Hospital NHS Foundation Trust has now implemented Robotic Process Automation (RPA) to offer appointments via 2-way text messaging.

2.2 Diagnostic Recovery

The programme aims to improve diagnostic performance, capacity and efficiency across South Yorkshire & Bassetlaw through the development of sustainable patient pathways, standardisation of referral processes, expansion of digital solutions, and a focus on workforce development.

Workforce development

Aim	Progress summary
Equip our people with the skills and tools to deliver excellent care and enable a networked workforce.	The Yorkshire Endoscopy Training Academy enabled earlier qualification of endoscopists through immersive training. The Academy trained 55 immersion trainees, reducing oesophagogastro-duodenoscopy training time from 2 years to 10 months and colonoscopy training time from 4 years to 15 months. The UK's first-ever GI Bleed Nursing Course was successfully delivered to 30 nurses by the Acute Federation clinical lead on behalf of the British Society of Gastroenterology at Northern General Hospital, Sheffield.

Imaging Network

Aim	Progress summary
Accelerate the benefits of the South Yorkshire & Bassetlaw radiology services to deliver high quality, accessible patient services and improve efficiency.	• We have developed a system level integrated strategy to provide standardised imaging across the network. • Established a South Yorkshire & Bassetlaw-wide footprint for the viewing of imaging across the network with the introduction of the AGFA Xero network. • We are currently in the process of enabling cross site (staged) reporting with funding from NHS England. • We have conducted an evaluation of an AI solution for chest x-ray and CT head to reduce waiting times for patients with chest and intracranial imaging. • Worked alongside the Cancer Alliance to standardise cancer imaging across the network to improve performance against the 28-day faster diagnosis standard • The mechanical thrombectomy service for stroke has been extended from a 5-day service to a 7-day 8am-8pm service with plans in place to move to a 24/7 service. • Supported procurement of a Picture Archiving Communication System (PACS) and Radiology Information System (RIS) to enable more joined up delivery of diagnostic services across the Imaging Network. • Image sharing of diagnostic tests is now possible across hospitals. • Helped to secure national investment for: the iRefer clinical decision support system at Sheffield Teaching Hospitals NHS Foundation Trust, order communications integration for test result management and more standardised communication with primary care, and PACS integration across South Yorkshire & Bassetlaw. • Digital interconnectivity will be critical to the future success of the Imaging Network.

Montagu Community Diagnostic Centre (CDC)

The Montagu Community Diagnostic Centre (CDC), based at Montagu Hospital in Mexborough Endoscopy Service has delivered nearly 4,500 procedures, playing a vital role in diagnosing and treating conditions early with a dedicated state-of-the-art facility and training rooms. Patients have benefited from reduced waiting times, currently averaging just seven to 14 days for appointments, and streamlined care processes, including receiving results and treatment plans on the same day as their procedures, helping to alleviate patient anxiety and support quicker recovery.

The service's location and accessibility have greatly benefited patients, particularly those living in the Dearne Valley. Situated on a major bus route and offering ample on-site parking, the hospital is further supported by a free shuttle service between Doncaster and Montagu hospitals. These features, combined with its welcoming environment, have been widely appreciated by patients and staff in recent surveys.

Lead Nurse for Endoscopy at Montagu CDC, Debi Oxley, reflected on the service's impact:*"What we're doing here at Montagu CDC is so much more than just offering procedures. It's about providing a service that patients can trust, in a place that's easy to reach and welcoming. Knowing we're making a difference, from helping people get the answers they need quickly to supporting their ongoing care, is incredibly rewarding. Diagnostic tests are incredibly important - they allow us to identify issues early, improving health outcomes and quality of life for people in our communities. Achieving JAG accreditation is a fantastic accomplishment for our team and highlights our dedication to excellence in patient care. We're looking forward to continuing this service and expanding to meet the needs of even more patients."*

Patient feedback: *"I attended the Endoscopy Unit at Mexborough hospital today and the service was absolutely wonderful. From checking in at the reception desk on the unit, the receptionist was so warm and caring. Then to the next member of staff who took my obs and went through the procedure, she was just wonderful and so reassuring.*

"The team who then undertook the Endoscopy were amazing. I wasn't the easiest of patients either due to anxiety about the procedure but they were all just fabulous.

"I feel very blessed to have had the staff I was given today and I feel so lucky that in Doncaster we have this facility at Mexborough, as with the many facilities we have there. I feel this needs an acknowledgement as people are always quick to complain but not to compliment. Please pass on my gratitude."

Diagnostics mutual aid

Aim	Progress summary
Reduce inequalities in patient waiting times by offering patients choice of provider.	Across ultrasound, MRI, endoscopy and audiology we have co-ordinated sharing of capacity to reduce patient waiting times. Although more is still to be done to consistently meet diagnostic waiting time standards, over 2,000 patients received their diagnostic test earlier through collaborative working.

Endoscopy innovation

Aim	Progress summary
Expand use of AI assisted diagnostics.	AI-assisted Olympus technology was introduced to improve polyp detection and enhance training opportunities.

Capacity expansion

Aim	Progress summary
Expand provision to enable more patients to be treated quicker.	Three Community Diagnostic Centres delivered 268,419 additional tests for patients.

2.3 Clinical Services Sustainability

The Acute Federation partners have identified opportunities to strengthen the sustainability of six clinical services through collaboration.

Audiology

Aim	Progress summary
• To reduce waiting times, and improve access, outcomes and experience for patients as a result of standardised streamlined pathways for both routine and complex care where patients are seen in the right place for the best service. • Sustainable, resilient, safe and high-quality patient care across South Yorkshire & Bassetlaw Audiology services. • Increased efficiency and optimised use of available resources. • Greater staff retention, engagement, and professional development.	Agreed a plan to: • Explore innovative approaches, restructure models, and streamline pathways across South Yorkshire & Bassetlaw to reduce waiting times and improve care quality. • Learn from audiology centres of excellence where transforming service delivery has improved patient outcomes, efficiency, and care standards. • Develop a system-level waiting list dashboard to track and implement audiology activities and enable 'load sharing' across providers, reducing waiting times. • Adopt integrated, standardised diagnosis and treatment approaches to enhance patient pathways. • Improve integration of digital tools and innovations in patient care and consider digital tools and technologies to improve care and develop new pathways. • Enhance staff engagement, networking, and training to foster a supportive, cross-site mentorship and peer support environment.

Dermatology

Aim	Progress summary
• Standardise effective triage and teledermatology services, in line with best practice pathways, to reduce the time patients wait for diagnosis and treatment. • Spread of workforce innovation to support trusts to meet the national referral to treatment standard. • To deliver sustainable sub-specialty Dermatology services across South Yorkshire & Bassetlaw which provide equitable access to care for all patients.	Agreed a plan to: • Adopt innovative workforce approaches which maximise the use of resources across South Yorkshire & Bassetlaw, support the development of new skills and the adoption of non-medically led pathways where appropriate. • Explore benefits of South Yorkshire & Bassetlaw service model at specialty or subspecialty level. • Commission a standardised high quality teledermatology service that provides effective triage for all dermatology referrals into secondary care, ensuring that patients receive appropriate advice and treatment as soon as possible and without unnecessary travel. • Share learning to optimise the benefits from 'one stop shop services' for patients including 'see and treat' specialist nurse-led clinics. • Pool resources to improve patient access and information, and service suitability. • Maximise the potential adoption of medical technology/AI, ensuring that patients have equal access to the latest treatments and that waiting lists are reduced.

Ophthalmology

Aim	Progress summary
• To deliver sustainable sub-specialty ophthalmology services and on call services across South Yorkshire & Bassetlaw which provide equitable access to care for all patients. • To work with community-based optometrists to offer care closer to home for patients across South Yorkshire & Bassetlaw, in line with best practice pathways, reducing the time patients wait for diagnosis and treatment, so that all Trusts meet the national referral to treatment standard.	Agreed a plan to: • Explore benefits of shared service model at specialty or sub-specialty level. • Adopt innovative workforce approaches which maximise the use of resources across South Yorkshire & Bassetlaw, support the development of new skills, career frameworks and the adoption of non-medically delivered pathways • Develop a sustainable out of hours on-call service which meets the needs of the South Yorkshire & Bassetlaw population and pools the collective expertise across Trusts. • Support commissioning of a safe, standardised high-quality single point of access service that provides effective triage for all ophthalmology referrals, ensuring that patients receive timely advice and treatment, without unnecessary travel, and freeing up secondary care capacity for those that need it most. • Implement and adopt a standardised eye electronic referral system across South Yorkshire & Bassetlaw to enable direct referral from optometrists with attachment of high-quality images, and which establishes an effective feedback and learning loop. • Maximise the potential adoption of medical technology/AI, ensuring that patients have equal access to the latest treatments and that waiting lists are reduced • Share learning across South Yorkshire & Bassetlaw through a clinical forum, ensuring that all services align to Getting it Right First Time (GIRFT) best practice. • Pool resources to improve patient access and information, and service suitability.

Oral Maxillofacial Surgery (OMFS) and Oral Surgery

Aim	Progress summary
• To deliver sustainable, resilient high-quality patient care across South Yorkshire & Bassetlaw OMFS and oral surgery services. • To work closely to deliver sustainable on call service across South Yorkshire which provides equitable access to care for all patients. • To strengthen oral surgery capacity to support the delivery of exodontia services and ensure that waiting times meet the national referral to treatment standard. • To increase efficiency and optimise use of available resources.	Agreed a plan to: • Deliver a sustainable out of hours on-call service which meets the needs of the South Yorkshire & Bassetlaw population and pools the collective expertise across Trusts. • Explore benefits of a surgical hub for oral surgery work. • Share learning across South Yorkshire & Bassetlaw through a clinical forum. Clinicians from both OMFS and oral Surgery will work together to explore system-based solutions which create a sustainable model that meets the needs of all South Yorkshire & Bassetlaw patients, reduces waiting times and ensures that all services align to GIRFT best practice. • Agree and implement consistent coding of procedures and use of reliable data sources across South Yorkshire & Bassetlaw to enable benchmarking, inform service, productivity and efficiency improvement.

Urology

Aim	Progress summary
• A sustainable out of hours on-call service will be in place. • Waiting times for elective surgery will meet the national referral to treatment standard. • The Urology Area Network will be further strengthened through 2024-2026 to provide comprehensive coverage of urological services as recommended by GIRFT.	• Tested a networked approach to Benign Prostatic Hyperplasia (BPH) which has resulted in: - Improving access so that all patients across the region can access a range of different treatments best suited to their condition - 40 patients receiving a different treatment approach through joined up clinical decision making - The introduction of a regional procedure waiting list dashboard so that volumes and waiting times are visible for all Trusts which helps to inform clinical decision making - Standardised approaches to treatment decision making and patient counselling • Lower Urinary Tract Symptom (LUTS) clinics, with three out of four units now offering these and the fifth planned for 2025. • Implemented straight to test MRI for prostate cancer. • Non-medically led local anaesthetic trans perineal biopsy is now available in four acute trusts, with the fifth planned for 2025. • Revised standards of care specifying local vs. network protocols for prostate, bladder, kidney, penile, and testicular cancer.

Community Paediatrics

Aim	Progress summary
To map community paediatric services across South Yorkshire & Bassetlaw, identify opportunities to standardise where it benefits patients and staff and improve efficiency and effectiveness of services.	Agreed a plan with the commissioner to: • Map and review the services provided in each place. • Agree a core set of deliverables to improve quality, outcomes and experience for children, young people and their families. • Share learning from new models that have been adopted to tackle challenges e.g. flexible workforce models, screening and hub and spoke models of care.

2.4 Acute Trust Paediatric Innovation

Around 25% of children in South Yorkshire live in poverty which is higher than the national average of 22% and this is linked to poorer health outcomes.

Approximately 14% of young people have a long-term condition or disability. 29% of children and young people in South Yorkshire have tooth decay with the highest levels of tooth extraction in England.

The Paediatric Innovator Programme aims to work collaboratively, as one of nine innovators, to transform care, reduce health inequalities and improve outcomes for the children and young people living in South Yorkshire & Bassetlaw.

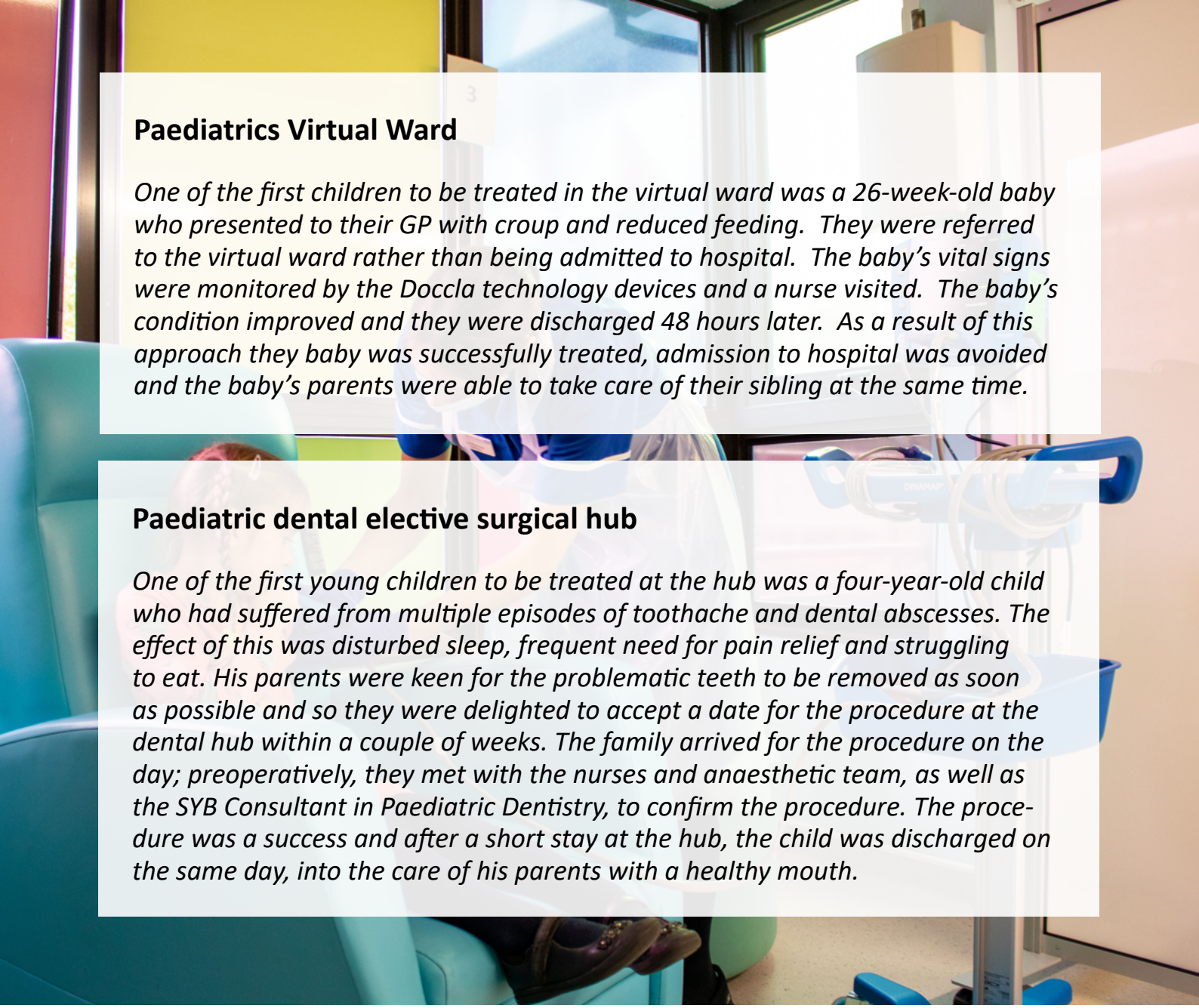
The programme is divided into five workstreams:

1. Care Closer to Home through Virtual Ward
2. Improving Access to Dental Elective Care
3. Improving Access to Nose and Throat Elective Care
4. Healthcare that works for Young People
5. Delegated commissioning for secondary care

Care Closer to Home through Virtual Ward

Aim	Progress summary
A virtual ward is a safe and efficient alternative to NHS bedded care.	Virtual wards support patients who would otherwise be in hospital to receive the acute care and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital. Virtual ward pilot projects for children at The Rotherham NHS Foundation Trust and Sheffield Children's NHS Foundation Trust were successfully launched. The first patients have begun to be successfully treated at home via virtual ward with positive outcomes.

Children and families, supported by Voluntary Action Rotherham, working with the South Yorkshire & Bassetlaw Acute Federation and Rotherham paediatric virtual ward team to co-design a storybook and cartoon to help children who are admitted to virtual ward.



Paediatrics Virtual Ward

One of the first children to be treated in the virtual ward was a 26-week-old baby who presented to their GP with croup and reduced feeding. They were referred to the virtual ward rather than being admitted to hospital. The baby's vital signs were monitored by the Doccla technology devices and a nurse visited. The baby's condition improved and they were discharged 48 hours later. As a result of this approach they baby was successfully treated, admission to hospital was avoided and the baby's parents were able to take care of their sibling at the same time.

Paediatric dental elective surgical hub

One of the first young children to be treated at the hub was a four-year-old child who had suffered from multiple episodes of toothache and dental abscesses. The effect of this was disturbed sleep, frequent need for pain relief and struggling to eat. His parents were keen for the problematic teeth to be removed as soon as possible and so they were delighted to accept a date for the procedure at the dental hub within a couple of weeks. The family arrived for the procedure on the day; preoperatively, they met with the nurses and anaesthetic team, as well as the SYB Consultant in Paediatric Dentistry, to confirm the procedure. The procedure was a success and after a short stay at the hub, the child was discharged on the same day, into the care of his parents with a healthy mouth.

Improving Access to Dental Elective Care

Aim	Progress summary
Access to paediatric dental elective care will be easier and quicker as we reduce waiting times.	Dental specialities represent the second largest waiting list for children aged 0-18 in South Yorkshire & Bassetlaw, with the latest data showing that over 4,000 children waiting for assessment and treatment, including over 1,500 on the admitted waiting list for surgery. The South Yorkshire & Bassetlaw paediatric dental elective surgical hub pilot was launched to reduce waiting times for patients. The hub takes a high intensity approach to surgery to maximise productivity and means that more children can be treated. The clinical team also takes a public health approach to oral health by incorporating preventative advice at assessment and treatment stages. The hub currently provides 112 additional treatments per month and will enable nearly 700 children to receive surgery per year. Evaluation data will be the basis for hub expansion into other surgical specialties. Feedback from patients and their families has been very positive.

Healthcare that works for Young People

Aim	Progress summary
Supports healthcare professionals to deliver personalised care in recognition of the changing biopsychosocial needs of young people.	The Healthcare that Works for Young People Statement of Intent has been co-developed with young people and the Mental Health, Learning Disability & Autism Provider Collaborative. A South Yorkshire & Bassetlaw training package has been co-developed with key partners and the National Institute for Health and Care Research to equip our people with the tools to deliver healthcare that works for young people requiring hospital care. Young people's transition leads have been appointed in most of our providers. The first South Yorkshire & Bassetlaw Healthcare that works for Young People Conference was held in March 2025 to disseminate best practice.

The Healthcare that works for Young People Statement of Intent was co-developed with patients and partners and sets out our commitment to deliver developmentally appropriate healthcare (DAH) for young people with acute/complex healthcare needs. It has been adopted by all secondary care providers in the patch.

Our 5 priority actions

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

2 Building capability and shifting our culture
- Library of training resources available in a shared workspace
- Electronic Staff Record (ESR) recorded training
- A Community of Practice

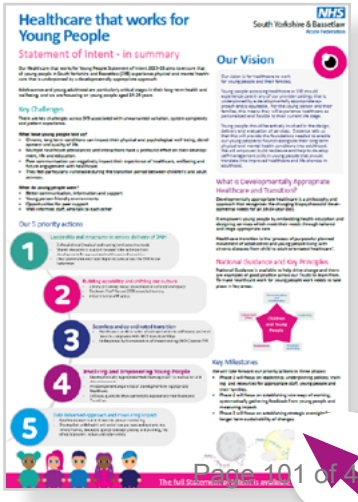
3 Seamless and co-ordinated transition
- Healthcare transition suite: all sub-specialties to self-assess and work towards compliance with NICE transition NG43
- Underpinned by Memorandum of Understanding (MOU) across SYB

4 Involving and Empowering Young People
- Developmentally Appropriate Healthcare approach to evaluation and risk assessment
- Measure patient experience of Developmentally Appropriate Healthcare
- SYB easy guides to Developmentally Appropriate Healthcare and Transition

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

Full Statement of Intent:

Statement of Intent summary document:



2.5 Plan for People

The plan aims to enable the Acute Federation to work at scale through collaboration, to improve quality, colleague experience and access and productivity and efficiency.

Education and Training Strategy

Aim	Progress summary
Develop an education and training strategy to ensure efficient use of resources and materials to support the workforce.	• Developed an outline education and training strategic framework to pool resources and materials and give all colleagues access to the same high-quality education and training. • Digital workforce and skills aligned to the SY digital workstream with a focus on learning and digitally enabled education activities. • Workforce planning to influence the trainee pipeline.

People Digital Systems

Aim	Progress summary
Standardise people digital systems to better inform workforce planning at a system level.	Worked with the ICB to identify opportunities to pilot electronic job planning software with allied health professional groups in diagnostic services.

Reform workforce models

Aim	Progress summary
Reform through new workforce models.	Identified options for workforce models through the Clinical Services Sustainability programmes.

2.6 Digital Convergence

To pursue joined up digital and data systems across South Yorkshire & Bassetlaw Acute Federation to release long term benefits from integrated working.

Education and Training Strategy

Aim	Progress summary
• Transform collaboration between partners and better enabling service design and delivery across the Acute Federation by adopting a common solution, common source of data, common data standards and enabling with high efficacy the sharing of patient data across South Yorkshire & Bassetlaw to support holistic, integrated care delivery. • To pursue digital convergence by default where it makes sense for patients and staff. • Transform patient experience across our healthcare system and improve patient safety equitably. • Improve staff experience.	Gained agreement to procure a joint contract for PACS/RIS to enable trusts to deliver radiology services as a network. The Acute Federation has agreed a digital convergence strategy which is focused on: • Improving patient care and decision making by giving trusts the freedom to redesign pathways to improve patient flows across the healthcare system. • Enabling clinicians to make decisions based on patient's full clinical history to deliver joined up clinically effective care. • Better patient choice of provider and treatment through data sharing and the ability to flow patients across the system. • Better efficiency and value for money gained by working at scale, reducing duplication and clinical and administrative efficiencies through collective problem solving, optimisation and standardised technologies and capacity and demand management across the system.

2.7 Pathology Service

The South Yorkshire & Bassetlaw Pathology Network has made notable progress in enhancing healthcare services across the region. A single unified South Yorkshire & Bassetlaw Pathology Service was formed on 1 April 2024, hosted by Sheffield Teaching Hospitals NHS Foundation Trust on behalf of the five Acute Federation Trusts. This paves the way for a future Target Operating Model, which will deliver quality and efficiency benefits for patients, staff and wider stakeholders, while creating opportunities for career progression across the entire workforce. These benefits could not be achieved by each Trust working in isolation.

Unified Pathology Service

Aim	Progress summary
South Yorkshire & Bassetlaw Pathology brings together the best in healthcare science and clinical expertise from some of the UK's leading specialist laboratories. By working together, the member trusts aim to transform patient care through leading pathology services, ensuring that the people of South Yorkshire & Bassetlaw have prompt access to excellent healthcare. The team is committed to the highest quality diagnostic services, reducing inequity and improving patient outcomes across the region.	• Establishment of a single South Yorkshire & Bassetlaw Pathology service from 1 April 2024, consisting of over 1,300 staff operating across eight laboratories. • Embedding new operational management and clinical governance systems and processes for the single South Yorkshire & Bassetlaw pathology Service. • Performance monitoring of key indicators across all laboratories enabling visibility to drive both improvements and equity of services for patients across the region. • Continued measures to improve histopathology performance including right first time, building capacity, workforce redesign and avoiding duplication. • Shaping longer term plans to consolidate histopathology services across South Yorkshire & Bassetlaw. • Increased consultant recruitment into histopathology despite the backdrop of national shortage in the profession. • Ongoing engagement with the market on a new long-term strategic partnership with a managed service contract provider bringing increased technology, innovation and economies of scale. • Full deployment of equipment and infrastructure across four sites to maximise quality and efficiency benefits from digital pathology in histopathology, for example remote reporting. • Introducing a new quality management system for use in all laboratories and to facilitate harmonisation of future standard operating procedures. • Early consolidation of immunology services to avoid service failure within the region due to key workforce shortages.

The Acute Federation Trusts have also worked collaboratively with partners across South Yorkshire & Bassetlaw to make progress in key healthcare areas

3.1 Cancer Alliance

The South Yorkshire & Bassetlaw Cancer Alliance brings together a range of organisations to help ensure the best possible cancer care and outcomes across the area. Progress has made working in partnership with the Acute Federation.

Urology

- Worked with the Urology Area Network to implement mutual aid for nephrectomies between Sheffield Teaching Hospitals NHS Foundation Trust and Chesterfield Royal NHS Foundation Trust, to help free up robotic surgical capacity.
- Developed capacity and demand arrangements across the network to effectively coordinate delivery of benign and cancer urology services across South Yorkshire & Bassetlaw.

Teledermatology

- Drafted a single South Yorkshire & Bassetlaw teledermatology service specification.
- Distributed quality and reporting standards reflective of British Association of Dermatology recommendations, for inclusion in local Place specifications.
- Secured provision of live teledermatology in all South Yorkshire & Bassetlaw places.

Head and neck cancer

Head and neck services including oral maxillofacial surgery (OMFS) experienced rising referral rates for cancer in 2024/25 compared to 2023/24.

- Gained system wide agreement to work together and create greater pathway resilience for OMFS.
- Collaborative work to broker cross system conversations regarding consultant in-reach models when changes in capacity caused service instability.
- Secured agreement to explore a regional head and neck diagnostic model.

Multidisciplinary Team Optimisation (MDT)

A significant volume of pathways are shared across trusts requiring both local and central MDT management. Pathway analysis work reveals there are significant delays between the faster diagnosis standard and decision to treat stages of some pathways, contributing to poor 62 Day treatment performance. The MDT Optimisation project was established to lead improvement work across cancer MDTs and has identified priority areas of improvement and shared standards of care protocols including for diagnostics.

3.2 Children and Young People's Alliance

The Children and Young People's Alliance takes a system wide consistent strategic approach to delivering the best care for children and young people aged 0-25 years. The Alliance works in partnership to create sustainable change, addressing the inequalities and inequity facing our children, young people and families.

Best Start in Life

- **Early Years, Bump Birth & Beyond Pilot Service:** Supporting pregnant women who have many vulnerabilities and complex wider social circumstances led by Barnardo's (VCSE partner). To date 72 families are actively engaged in the service and over 400 one to one sessions have been delivered with referrals from self-referral, GPs, midwives, health visitors, family hubs or other statutory services
- **Children and young people Voice, Influence, and Engagement:** Connect and amplify through the Children and Young People Alliance Community of Practice led by Chilypep (VCSE partner). Over 60 organisations are invited to this bi-monthly forum. On the 30th May 2024, South

Yorkshire Children and Young People's Alliance hosted their third annual conference. The 'Breaking Cycles' event took place in Sheffield with young people co-creating the conference. Over 100 children and young people from across South Yorkshire attended the conference, along with 100 key strategic decision makers from health, social care and wider partner services who came to hear what the children and young people had to say.

Long Term Conditions

- **Asthma:** Continue to coordinate delivery of asthma care bundle, including asthma-friendly schools. 218 schools have signed up to this initiative and 28 schools have gained accreditation. Over 2,000 people have accessed the asthma online training which incorporates environmental risks, and risks from smoking and vaping for children and young people with asthma.
- **Epilepsy**: Coordinate the delivery of epilepsy care bundle with a specific focus on transition and mental health support.
- **Diabetes**: Coordinate improvements in children and young people supported by GIRFT and the continuation of the family support work pilots in The Rotherham Foundation Trust and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.
- **Reducing Childhood Obesity:** Continuation of the Complications of Excess Weight Services, led by Sheffield Children's Foundation Trust, working with over 100 children and their families.

Children's Health Care in the Hospital

- **Youth Workers in Acute Settings:** Pilot led by The Rotherham Foundation Trust and Rotherham Children Young People and Families Consortium (VCSE). The service supports YP with long-term conditions (asthma, diabetes, epilepsy and mental health conditions) including those with complex care needs, and those transitioning to adult-led care. From July there have been over 53 young people supported by the youth worker team with 451 interventions completed. Referrals are being made via the emergency department and individual wards.
- **Paediatric Early Warning Scale:** Implemented through acute trusts, with funding for a lead to drive these changes in each trust.
- **Mental Health Champions:** Implemented through acute trusts with each trust having recruited a mental health champion.
- **Patient Safety Incident Response Framework:** Sharing system learning and improvements, with a particular focus on sepsis.

3.3 QUIT Smoking Programme - Embedding tobacco treatment in secondary care

Throughout 2024/25 QUIT teams have focused on increasing the number of patients at each stage of the smoking cessation pathway in order to improve people's health and outcomes and achieve return on investment.

Across South Yorkshire there has been a 19% increase on 4 week quit smoking rates from 2023 to 2024, achieving a total of 1,373 4 week quits in 2024. An additional 22,000 people have had a conversation with a tobacco adviser at hospital admission compared to 2023 levels, meaning a total of 136,859 admissions have had their smoking status recorded.

The QUIT programme was also nominated by four local MPs for an NHS Parliamentary Award in the Health Inequality category. The programme has worked in partnership with local authority partners to embed and promote the Swap to Stop offer, allowing smokers access to free vapes for up to 12 weeks.

At Sheffield Teaching Hospitals NHS Foundation Trust the scheme has been used to support over 70 members of staff to stop smoking.

A successful QUIT celebration event was held in recognition of the hard work of QUIT teams but more importantly their fantastic achievements.

3.4 Collaborative Procurement

The acute trusts have been working with other providers in the integrated care system on collaborative procurement to ensure they get the best value for

money on products, consumables and professional services. For the Acute Federation there were efficiency opportunities in medical equipment, cleaning products, safety equipment, information technology, patient transport and legal services amongst others. As a result, £1,167,268 has been saved this year.

3.5 Integrated Stroke Delivery Network

The South Yorkshire Integrated Stroke Delivery Network (ISDN) aims to ensure that the people of South Yorkshire have equal and fair access to the highest quality of stroke care across the whole stroke pathway.

2024/25 has been a productive and intense time of delivery and innovation across the Stroke Network in South Yorkshire. It has seen fundamental changes in some of our acute therapies and preparation for increased access to life changing interventions such as mechanical thrombectomy. Key achievements include:

Clinical leadership

- Change of therapy from alteplase to tenecteplase for acute ischemic stroke which offers several potential benefits, including easier administration, faster treatment times, and better functional outcomes.
- Increased thrombolysis rates.

Rehabilitation and life after stroke

- Mentorship Programme is now open to clinicians to expand their skills for leadership and service development.
- Integrated Community Stroke Service (ICSS) dashboard monitoring.
- Social prescribing projects which are ongoing from catalyst projects.

Stroke Survivors and Carers Group

- Roll out of the patient passport in all four acute trusts.
- Understanding vision problems in stroke.
- Directory of services for patients.

Stroke Quality Improvement Programme (SQUIRe)

We have delivered a wide range of specialist webinars:

- 'Increasing stroke rehab intensity' which had 114 attendees.
- 'Vision changes after stroke' which had 120 attendees.
- Post-stroke limb Spasticity Management' which had 115 attendees.

Prevention

Through the use of national funding administered by the ISDN, a range of presentation training and projects have been commissioned. This includes:

- Stroke Prevention Study Day which covered a range of new knowledge including exercise physiology in stroke, nutrition and barriers to prevention.
- Lipid monitoring clinic pilot at Doncaster.
- Lipid monitoring clinic at Barnsley (Kendray Hospital).

2025/26 - The Year Ahead

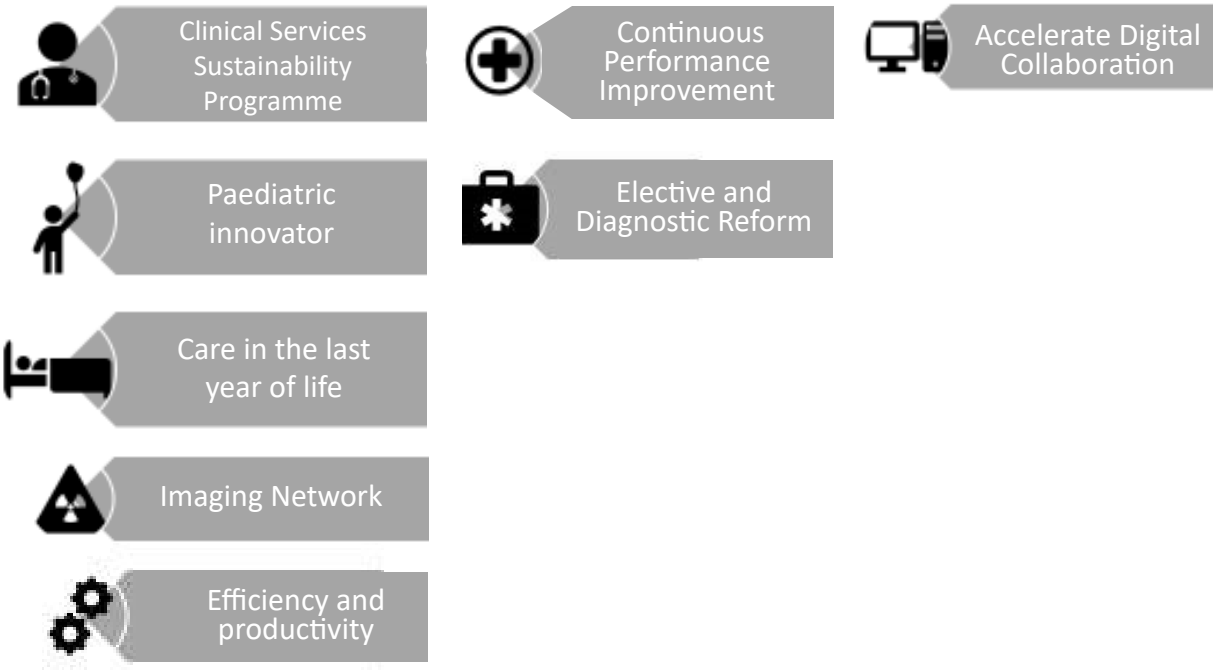
Our achievements in 2024/25 give us the opportunity to accelerate our work in the following areas in 2025/26 to improve quality, access and efficiency.

Our collective vision and purpose

Vision and Purpose					
Quality care	Health equality	Happy workforce	Great partner	Waiting times	Effective spending

Strategic Goals		
Acheive long term service sustainability	Deliver constitutional standards	Digital collaboration

Our portfolio of work to deliver three strategic goals to support quality, access and efficiency through collaboration



South Yorkshire & Bassetlaw
Acute Federation

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Board of Directors' Meeting
July 2025

The Rotherham NHS Foundation Trust

Agenda item	P/90/25
Report	**Update on the concerns regarding the Endoscopic Retrograde Cholangio-Pancreatography (ERCP) Service**
Executive Lead	Dr Jo Beahan, Medical Director Helen Dobson, Chief Nurse
Link with the BAF	P1: We will not embed quality care within the five year plan U4: We do not develop and maintain a positive culture
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. **Together:** Demonstrates that the Trust strives to ensure that quality improvement and the learning from incidents is achieved through a multidisciplinary approach.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	This paper updates Board about our interactions with patients and families following the delivery of substandard care provided to a group of patients who underwent a specialised endoscopy procedure, called Endoscopic Retrograde Cholangio-Pancreatography (ERCP) between 2016-2021. The paper describes the interactions with affected patients or their families that has occurred since June 2025. All numbers provided are correct as of 27th June and a further update will be given verbally in the meeting.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report has not been received at any other meeting.
Board powers to make this decision	No decisions are required.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Medical Director will continue to keep the Board appraised of the position.
Recommendations	It is recommended that the Board note the progress made in maintaining open and honest contact with patients and their families.

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1.1 Following the review into substandard care provided to a group of patients who underwent Endoscopic Retrograde Cholangio-Pancreatography (ERCP) between 2016-2021, we identified 68 patients who had died, suffered a complication within 30 days of the procedure or were included in the external review by independent experts. Overall the care of 58 patients was found to have had failures with 25 having suffered some degree of harm. It is important to note that ERCP has an inherent risk of harm and it isn't necessarily the case that a deficiency in care was the cause of harm.

1.2 The Trust attempted to contact all 68 patients or their families in early June to apologise, to explain what has happened and to outline what the external review has said about their individual care. In total, telephone contact was made with 53 of this cohort. Multiple attempts were made to contact all other patients / relatives.

1.3 Of the 15 cases where telephone contact was not possible, 11 had not sustained any harm. It was therefore agreed not to actively pursue making contact and these cases were closed as they did not require a formal Duty of Candour process. One case was identified where the patient had subsequently died with no next of kin and no further contact has therefore been made in this case.

1.4 Letters were sent to all patients where telephone contact had already been established and in the outstanding 3 cases where telephone contact had not been possible but a care deficiency (no harm) had been identified. The outcome from the receipt of letters is shown in the table below.

	Letter Sent	Responded	Instant Resolution	Follow up Call / Action	Follow up F2F	Open	Closed
A (No concerns)	4	0					
B (No Harm)	27	7	1	2	1 booked		3
C (Low Harm)	0	0	X	X	X	X	X
D (Moderate Harm)	19	7		3	4 booked		
E (Death)	6	0					
Total	56 (inc 3 unable to contacts of which 2 have since made contact)	14	1	5	5	53	3

1.5 There are 5 cases where a follow up action is currently progressing. Both of these where no harm occurred relates to answering a specific question. The action for the 3 moderate harms is to receive a copy of the report. These actions are in progress. 3 cases have been fully closed with 53 still in progress. 5 meetings have been arranged so far although none have yet taken place.

1.6 It was previously agreed that in the 25 cases where harm occurred, a follow up call would be made if there was no response to the initial letter. At present this equates to 18 cases.

Due to this case receiving media attention from 25th June, it was agreed that we would wait until at least a week after this before making these follow up telephone calls so these have not yet taken place. These are planned for w/c 7th July. An update on all numbers will be provided verbally at the meeting.

Board of Directors' Meeting
4 July 2025

The Rotherham NHS Foundation Trust

Agenda item	P/107/25
Report	**Patient Experience Annual Report**
Executive Lead	Helen Dobson – Chief Nurse
Link with the BAF	B1 Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meets regulatory standards
How does this paper support Trust Values	Ambitious – Developing an internal Patient Experience Improvement Plan, in addition to operational and Quality Priorities Caring – Demonstrating learning and Quality improvement from Patient experience feedback. Together – Pulling together all Trust Patient Experience work.
Purpose	Decision ☐ To note ☒ Approval ☐ For information ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Patient Experience Annual Report provides an overview of activity, key achievements and challenges during 2025/26. Data on numbers and themes relating to complaints, concerns and compliments is included. Feedback from a variety of other sources is also demonstrated. The new PALS service was opened in August 2024. This has been a positive development with key performance metrics and the impact on reduced numbers of concerns shown. The Trust continues to participate in all CQC patient experience surveys. Outcomes from the Adult In-patient survey and Maternity Survey were received during the year, both showing improvements. Quality improvement plans have been developed as a result of these to drive continuing improvement. All Care Groups presented their patient experience learning in 2024-25. The Patient Experience 2024/25 improvement plan is complete with updates on all elements of the improvement plan are included within the report. Additional staff and Patient Engagement work highlighted in this report includes: ▪ Dying Matters week ▪ This Is Me leaflet ▪ Complaints Monopoly Board training ▪ Organ Donation week ▪ Faith death mapping event ▪ Rottherham Show ▪ Carers and Care Partners Promise

	▪ Carers Rights day ▪ Remembrance Day ▪ Santa's visit ▪ Getting Social Packs ▪ Nutrition and Hydration week
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper was presented to the Patient Experience Committee on 28 April 2025 and Quality Committee on 19 May 2025
Board powers to make this decision	This has been presented to the relevant committees and is now being presented to Board of Directors.
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	The Trust Board is asked to note the annual Patient Experience Report

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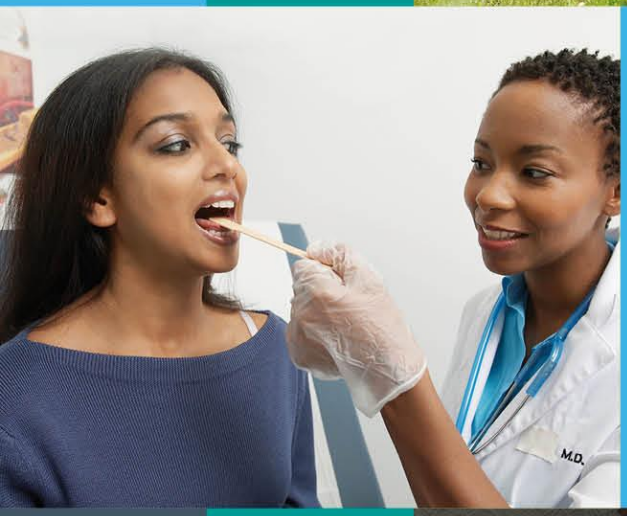
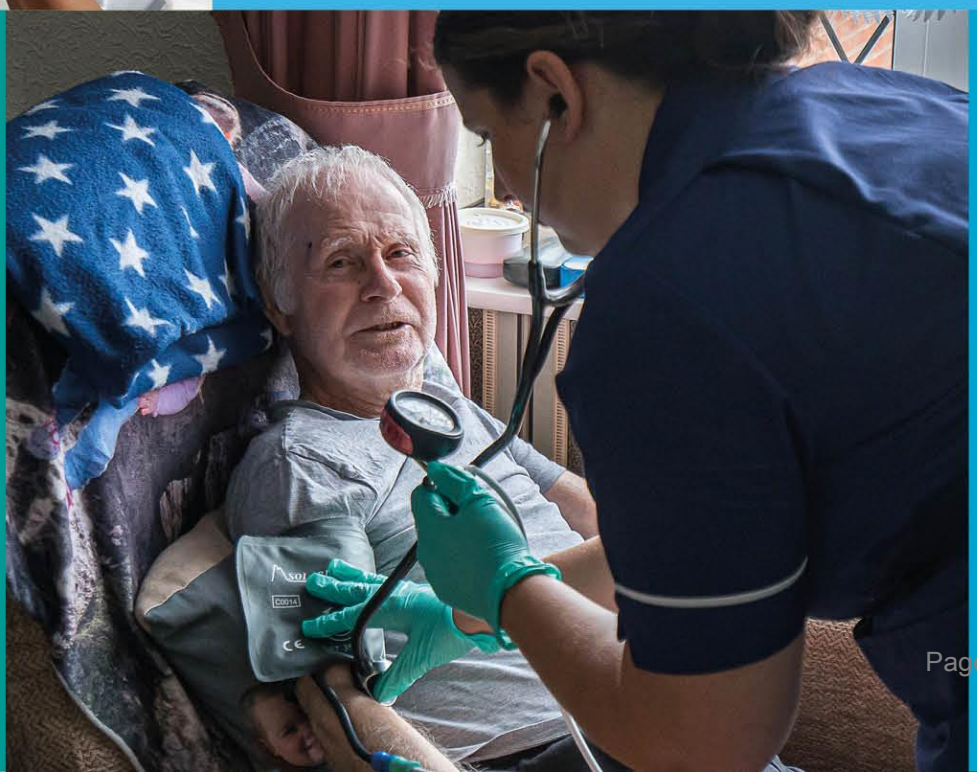
The Rotherham
NHS Foundation Trust



The Rotherham NHS Foundation Trust

Patient Experience Annual Report 2024/25



Ambitious
Caring
Together

1. Introduction

1.1 Good experience of care, treatment and support is increasingly seen as an essential part of excellent health and social care service, alongside clinical effectiveness' and safety. A person's experience starts from their very first contact with the health and social care system, right through to their last and includes end-of-life care.

1.2 The Local Authority Social Services and National health Service Complaints (England) Regulations (2009), Section 18 confirms the requirements for an annual report, specifying the number of complaints received, the subject matter of complaints and the way in which the complaint was handled. There is, however, no stipulation in the legislation that the annual report should only include complaints.

1.3 This report provides a summary of patient complaints received between 1 April 2024 and 31 March 2025 and includes details of the numbers of Patient Advice and Liaison Service (PALS), concerns received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman (PHSO) investigations and action taken by the Trust in response.

1.4 In the vast majority of cases patients, relatives and carers are satisfied with the care, treatment and services they receive. On the occasions where a patient, relative or carer is dissatisfied, it is important that they feel comfortable in raising their concerns so that the Trust can resolve any misunderstandings or failings and ensure that learning and improvements take place. Complaints are considered a vital source for identifying how services can improve.

1.5 The Trust continues to focus strongly on improving patient experience and this continues to develop and evolve. The Trust is committed to resolving any concerns at the earliest opportunity and all colleagues are encouraged to manage concerns raised in an effective and timely manner rather than letting them escalate to a formal complaint. This is often achieved through the patient, relative or carer discussing their concerns directly with the service.

Patient care is at the heart of what we do, and we are committed to improving the experience of our patients, but we know that we do not always get it right. This is why it is important to us that people find it easy to raise their concerns and complaints with us and that they feel their feedback is welcomed and dealt with in a timely manner.

1.6 Should the patient or carer feel that their concern should be formally investigated, they are able to make a formal complaint. The Trust's Patient Experience Team is accessible through email, in writing, telephone, NHS UK, Care Opinion and in person via PALS. The Trust aims to provide a response in as timely a manner as possible, setting an internal benchmark of 30 working days. The Trust also aims to remedy complaints locally through investigation and conciliation meetings, when appropriate. However, if the complainant remains dissatisfied, they have the right to refer their complaint to the PHSO as the second stage of the complaint process.

2. Purpose

2.1 The Patient Experience quarterly reports provide the Patient Experience Group/ Patient Experience and Inclusion Committee and then the Quality Committee with information relating to all the patient experience feedback received, leading to this annual report, presented to the Board of Directors. This includes:

- Headlines for the year
- PALS; numbers and top ten themes
- Concerns; numbers and top ten themes
- Complaints; numbers and top ten themes
- Compliments; numbers and top themes
- Friends and Family Test
- Social media patient feedback
- Headlines and analysis from the monthly In-patient experience survey
- CQC surveys
- Improvement work and feedback

2.2 This insight helps identify key priorities and outcomes that are measures through patient experience feedback and will outline our intention to implement and monitor performance, while demonstrating learning that has taken place across the Trust.

3. Context

3.1 The Trust's Concerns and Complaints policy describes the roles and responsibilities of colleagues in ensuring all concerns and complaints are handled as quickly as possible and in line with appropriate national guidance. The policy applies to all hospital and community services, sites, departments and areas within the organisation, buildings or the environment and to all permanent and temporary staff working within the Trust. The Trust's procedure invites both concerns and formal complaints and in line with national guidance uses the following definitions:

3.2 **Concerns:** A concern can be defined as a matter of interest, importance or anxiety which can be resolved to the individual's satisfaction within a short period of time without the need for formal investigation and formal correspondence. These are dealt with as proactively and as quickly as possible "real time". This may include meetings or telephone calls with an appropriate senior manager. We aim to resolve a concern within 10 working days although the vast majority can be resolved in a much shorter timescale.

3.3 **Formal complaints:** A complaint can be defined as an expression of dissatisfaction with the service provided or not provided or the circumstances associated with its provision which requires an investigation and a formal response in order to promote resolution between the parties concerned.

They are processed through a formal procedure which involves a written acknowledgement, conciliation meeting or written response from the head of the relevant service, together with a cover letter from the Chief Executive. We aim to respond to all formal complaints within 30 working days. If the complaint is complex, multi-faceted or involves several organisations a timescale of 40 or 60 working days can be allocated.

4. Data Collection, Analysis and Reporting

4.1 Data is recorded on the 'Complaints' module within Datix which allows for analysis against a defined set of categories. As part of the Trusts reporting mechanisms a quarterly Patient Experience Report is provided to the Quality Committee and South Yorkshire Integrated Care Board (ICB). Complaints and Patient Experience are also a monthly standing agenda items on the Divisional Performance dashboard, Patient Experience Group[1] (PEG) and Quality Governance and Assurance meeting. A sample of closed complaint files are also reviewed on a quarterly basis by a Non-Executive Director which also forms part of this annual report.

[1] PEG is accountable to the Patient Experience and Inclusion Committee which reports directly to the Quality Committee.

5. Headlines in 2023-2024

Welcoming complaints in a positive way An effective complaint system goes out of its way to create a positive environment in which complaints are welcomed and resolved at the earliest opportunity.	3,770 Compliments were received. 340 Formal Complaints were received 1646 PALS contacts 1620 Concerns were received
Promoting a just and learning culture An effective complaint handling system promotes a culture that is open and accountable when things do not go as they should. It puts in place clear ways to demonstrate how the organisation uses learning to improve.	Of the complaints closed: 79 of the complaints were upheld 170 partly upheld 86 were not upheld 5 Care Group presentations were heard through the Patient Experience Group (PEG)
Being thorough and fair An effective complaints system makes sure staff take a thorough, proportionate and balanced look into the issues raised by a complaint. It makes sure people receive a fair and open answer to their questions based on the facts and takes full accountability for mistakes identified.	Total number of re-opened complaints was 42 (12.54%) 100% of Complaints were acknowledged in 3 working days Complaint responded to in the agreed timescale was 100%
Giving fair and accountable responses An effective complaints handling system enables staff to give a fair and balanced account of what happened and what conclusions they have reached.	We continue to work on triangulating data on complaints that also resulted in moderate or severe harm There have been 59 disclosure requests relating to complaints 2 complaints have been accepted for investigation by the PHSO

6. Complaints, Concerns and PALS

6.1 In August the Patient Advice and Liaison Service (PALS) opened within the Trust. The purpose of PALS is to offer an open door service for patients, relatives and carers. Providing advice, information and guidance to those wishing to raise a concern or to signpost to relevant services. This allows patients, relatives and carers easy access to support. The key role for PALS is to provide an opportunity for users to discuss their concerns, enabling the issues to be appropriately identified and provide a timely response in a manner that will support a suitable resolution. As the service liaises with clinical services to help resolve concerns quickly and informally to the satisfaction of the enquirer.

In addition to the individual learning and improvements that result from enquiries, the PALS will analyse enquiries data to identify and share learning opportunities across the organisation. Prior to this the Patient Experience Team (PET) were performing the PALS function without the ability to record and report this correctly. Therefore, a lot of PALS contacts would have previously been reported as concerns are now report as PALS. In addition, the PALS office invites people in to leave feedback, some of which is anonymous, which is also record.

6.2 In 2024-5, the Trust received 340 formal complaints, 1,620 concerns and 1,646 PALS contacts. The table below compares the numbers in the last three financial years. There was a significant increase of 41% in the total number of complaints, concerns and PALS received in 2024-25 and this is directly linked to the introduction of the PALS service.

	2022/23	2023/24	2024/25
Formal complaints	282	277	340
Concerns	2,192	2,273	1,620
PALS			1,646
Total	2,474	2,550	3,606

6.3 To compare the number of complaints to patient attendances, the figure below breaks down the increase in attendances and ratio of complaints.

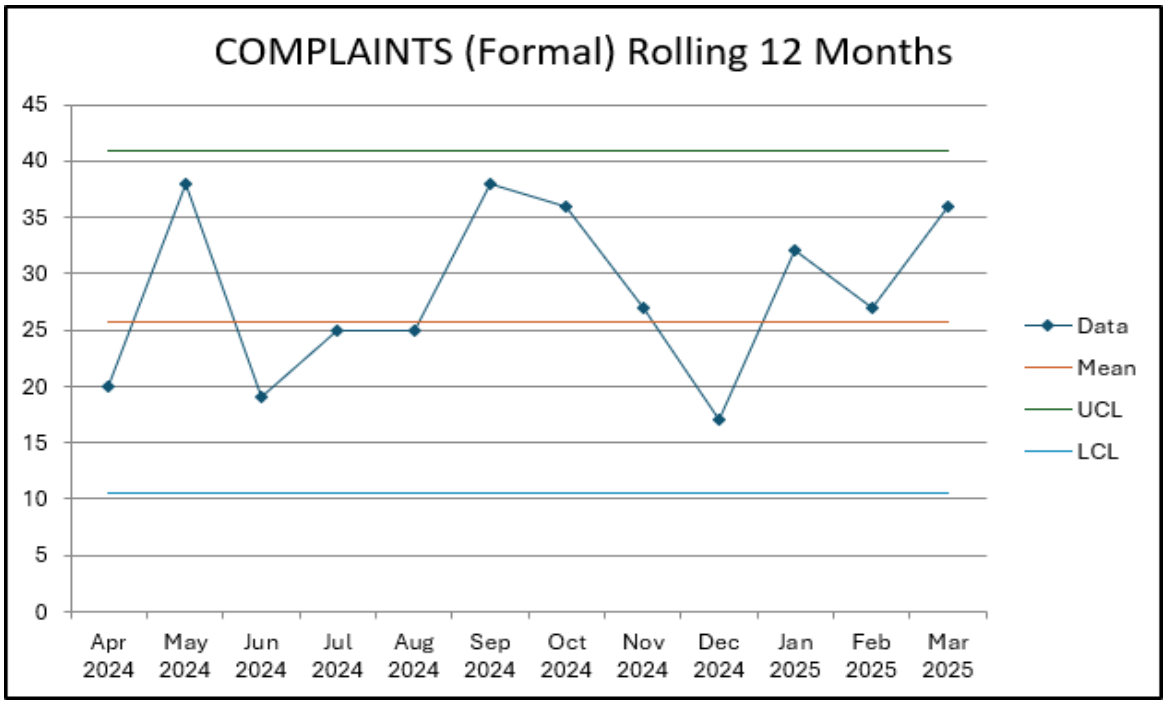
	2022/23	2023/24	2024/25
Inpatient Episodes			
Number of inpatient complaints	138	131	166
Inpatient Episodes	73,131	77,970	71,625
Complaints per 1000 episodes	1.89	1.68	2.32
Outpatient Attendances			
Number of outpatient complaints	50	79	102
Outpatient Attendances	250,232	258,562	282,983
Complaints per 1000 attendances	0.20	0.31	0.36

ED Patient Attendances			
Number of ED complaints	75	31	34
ED Attendances	92,333	97,039	104,892
Complaints per 1000 attendances	0.81	0.32	0.32

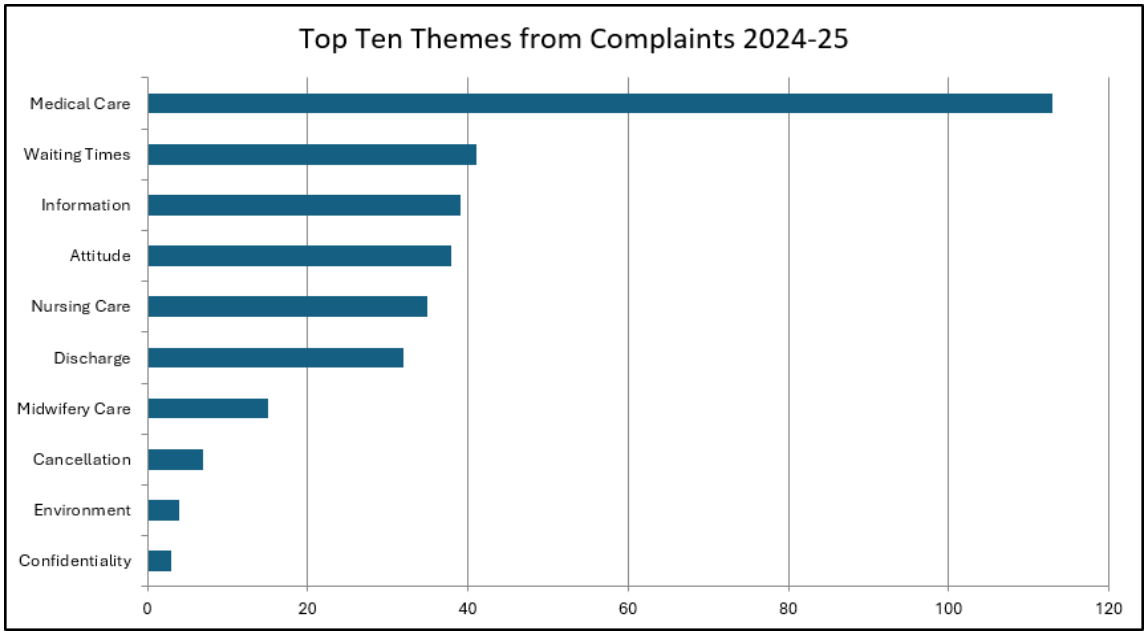
- Inpatient episodes have decreased over the last year, but the number of complaints has increased slightly per 1000 episodes.
- Outpatient attendances and complaints has increased per 1000 episodes.
- UECC attendances have risen but the number of complaints has remained.
- The remaining 38 complaints this year did not fit specifically into these categories for example corporate functions or Community Care.

6.4 Formal Complaints

There were 340 formal complaints received in 2024-25. This gives a rolling average of 25.71 complaints a month using Statistical Process Control (SPC). There is a pattern of decreased complaints in December each year which can be associated with the Christmas period.



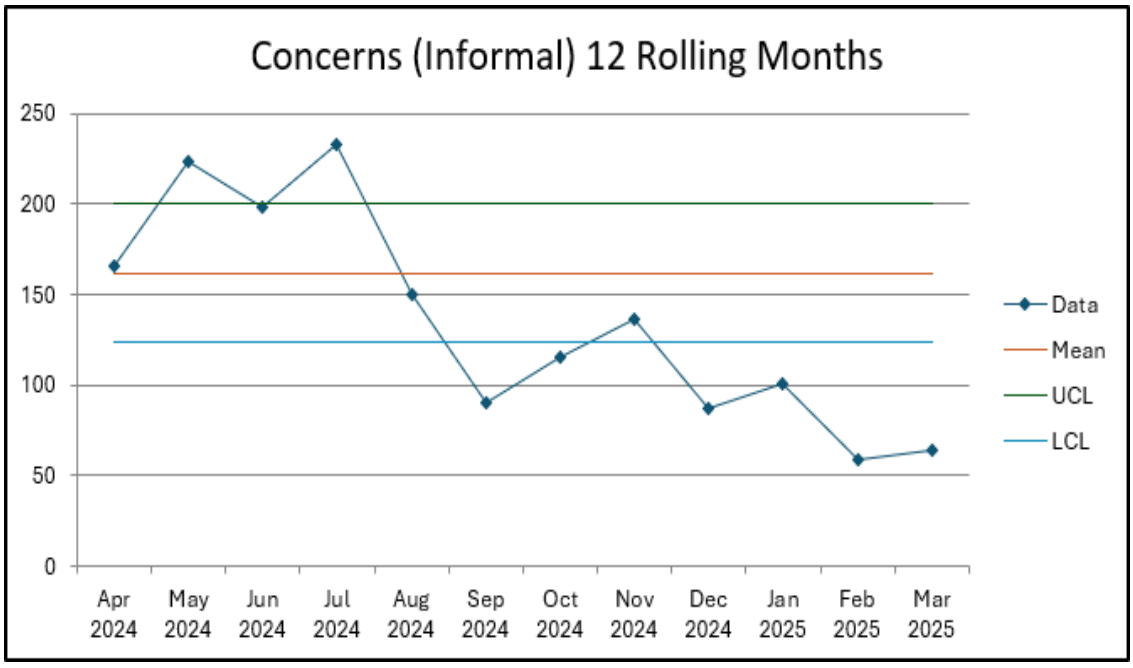
6.5 Themes from formal complaints



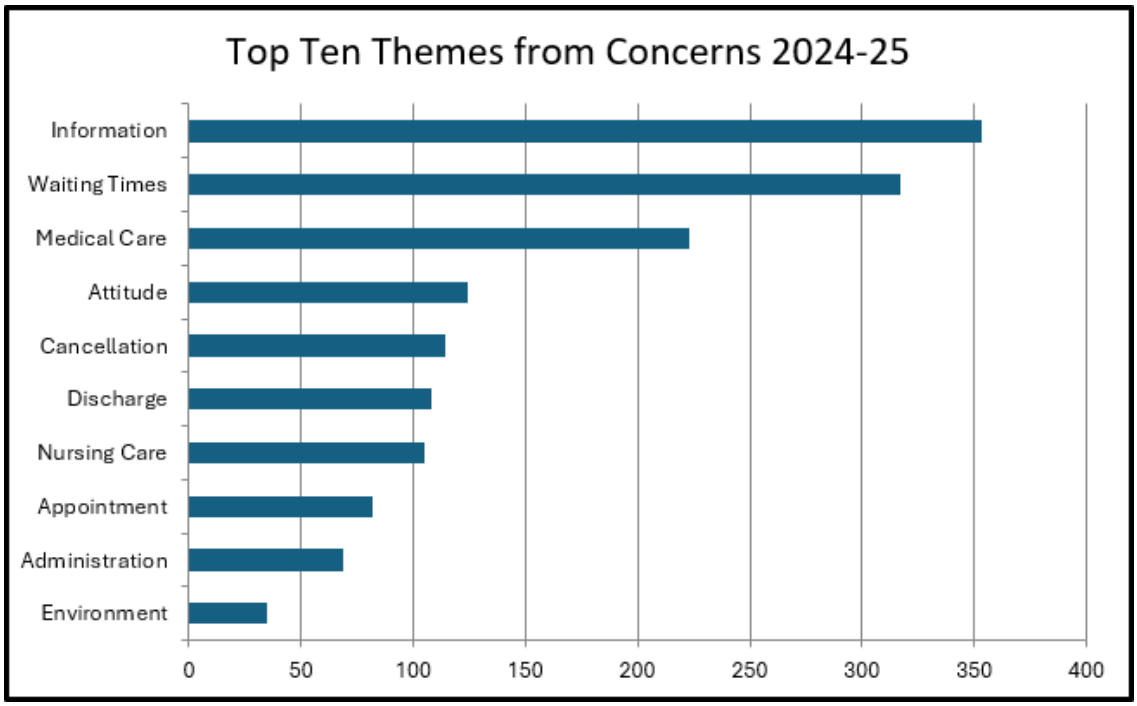
The opportunity to learn from complaints is an effective way of improving patient care and experience. Complaints are categorised by themes, and staff work to improve the quality of care in areas where recurring complaint themes emerge, or where practice is identified as requiring improvement. Data shows that the top five themes of formal complaints are primarily linked to medical care, waiting times, information/communication, attitude and nursing care. Other factors also influenced the number of complaints received, such as Discharge, environment, and cancellation of scheduled appointments.

6.6 Concerns

There were 1620 concerns received during 2024-25, giving a rolling average of 161.67 concerns a month using SPC. It should be noted that the decrease in concerns is directly associated with the introduction of the PALS service.



6.7 Themes from Concerns

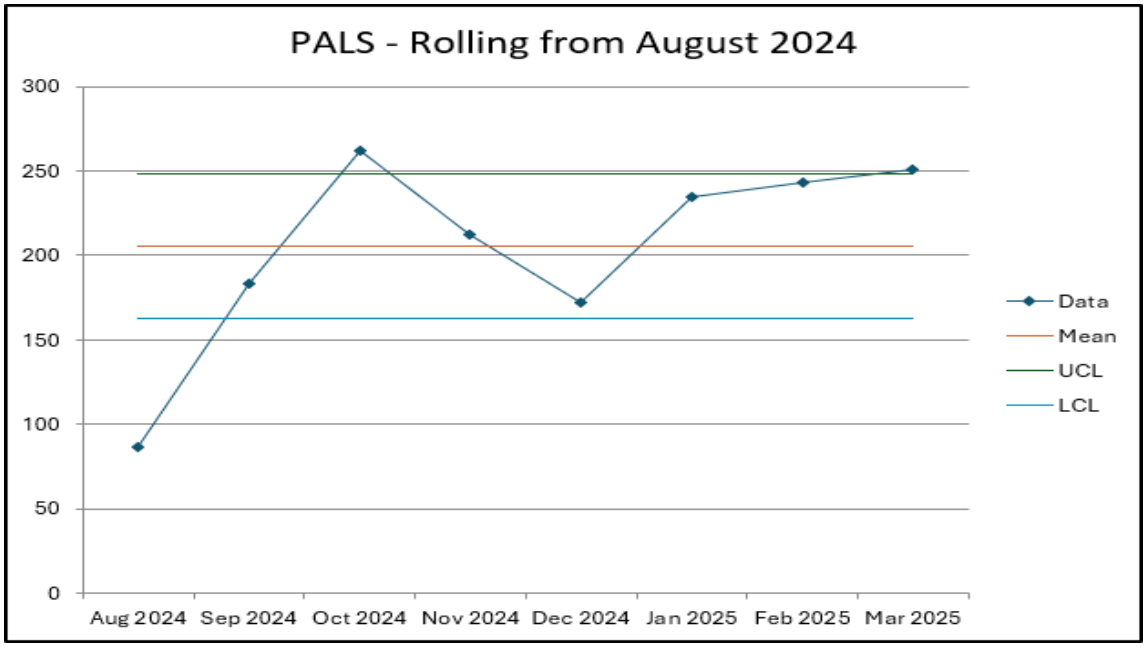


Concerns were primarily linked to the lack of information/communication, followed by waiting times, Medical Care, Attitude and Cancellation of scheduled appointments. Other factors also influenced the number received, such as discharge process, appointment waits, cancellation and environment.

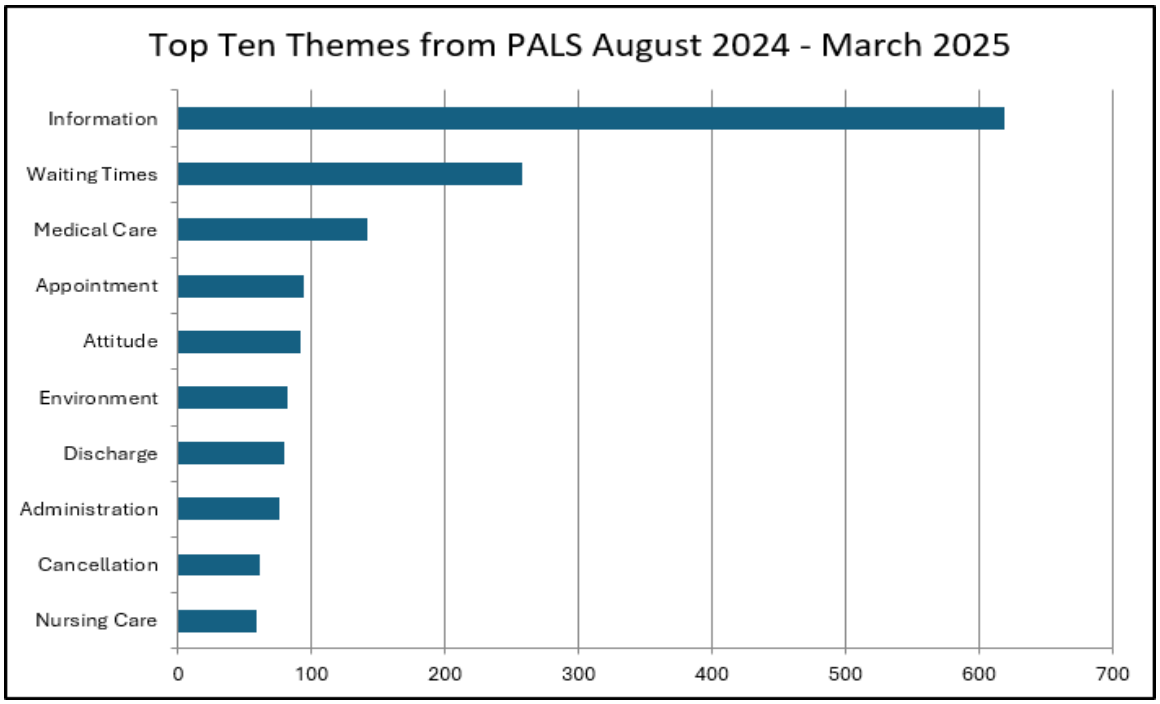
It should be noted that staff attitude continues to appear in the top 5 themes of both formal complaints and concerns.

6.8 PALS

There were 1,646 concerns received during the 8 months the service was open, giving a rolling average of 205.63 PALS contact a month using SPC.



6.9 Themes from PALS



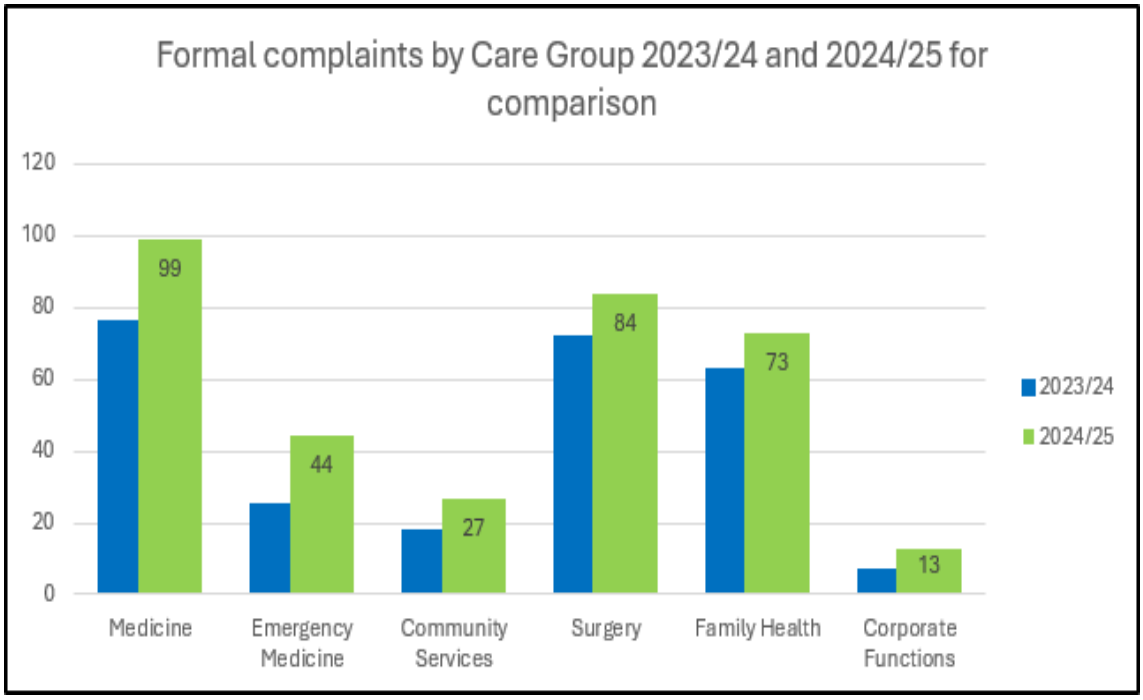
PALS contacts are primarily linked to the lack of information/communication, followed by waiting times, Medical Care, Appointments and Staff Attitude.

7. Complaints by Care Group and Speciality

7.1 Complaints by Care Group

With the realignment of services within Clinical Support Services (CSS) Division and the transfer of all Rotherham laboratory colleagues to South Yorkshire and Bassetlaw Pathology. Changes were also made to the structure of some of our services, moving away from six Clinical Divisions to four Care Groups. This would ensure services are appropriately aligned, with the name better reflecting the care that we give to patients. The realignment of the remaining services of CSS as follows:

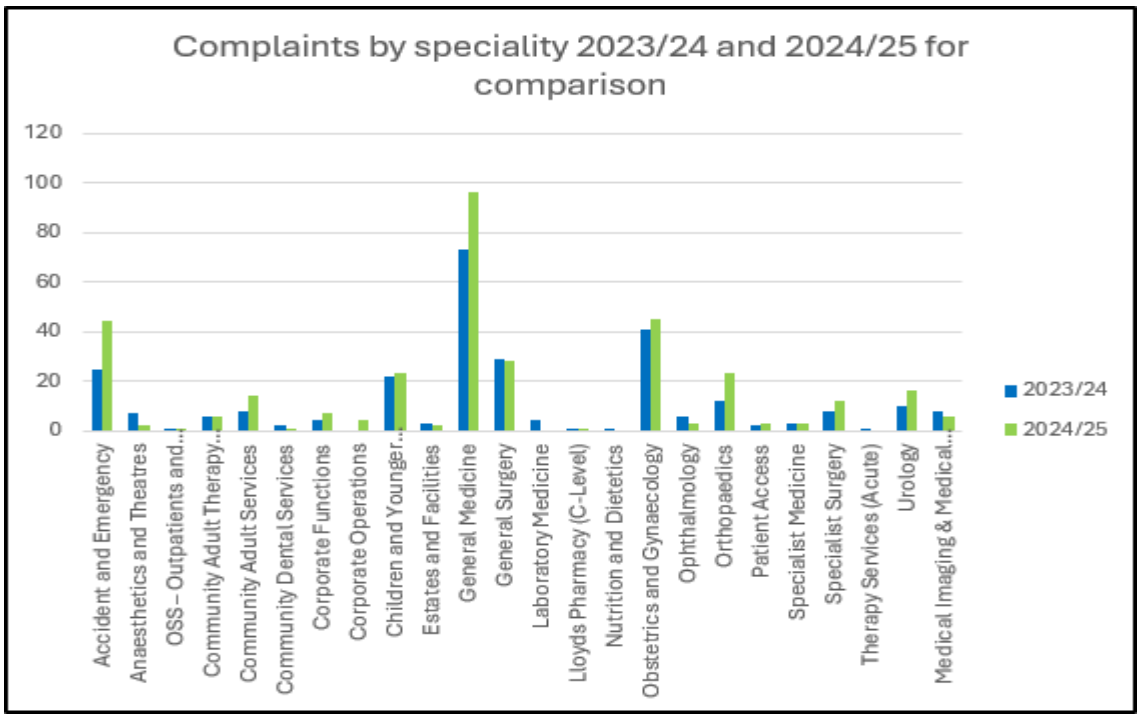
- Pharmacy, Patient Access, Outpatients and Support Services moved to Family Health, Care Group 3
- Radiology, Medical Physics and Medical Illustration services moved to Community Services, Care Group 4
- UECC and Medicine also merged to form Care Group 1



Care Group 1 (Medicine and UECC) received the most formal complaints during 2024-25 (143) followed by Surgery (84) and Family Health (73).

7.2 Complaints by speciality

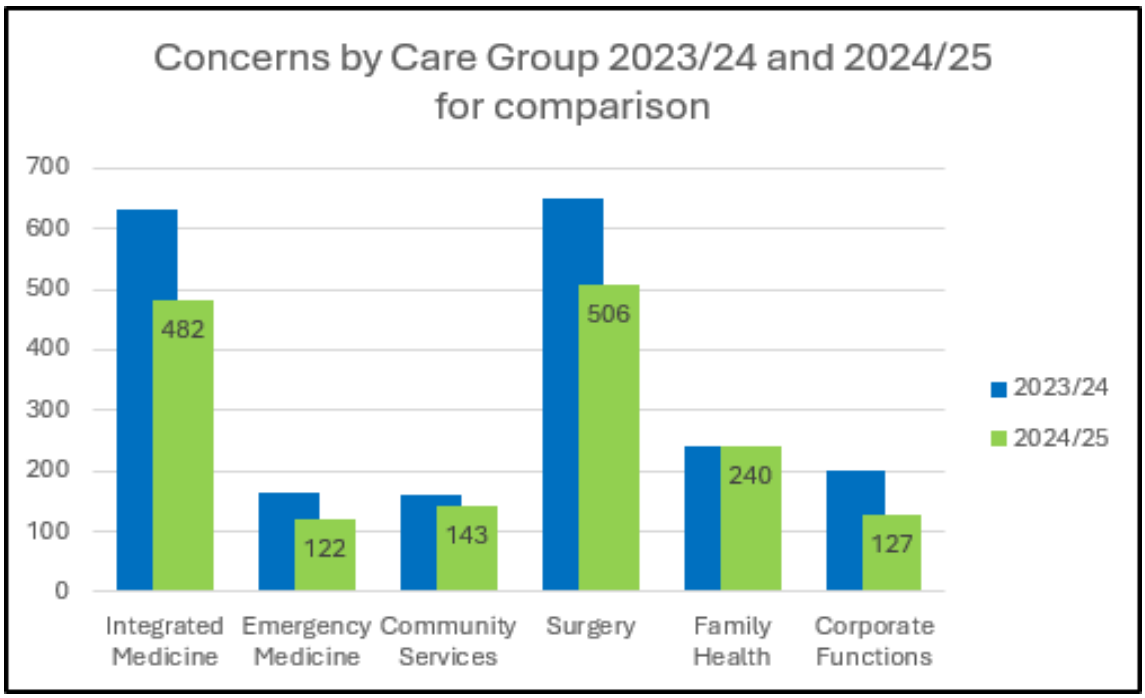
General Medicine received the greatest number of formal complaints, in comparison this was also reflected in 2023-24. Obstetrics and Gynaecology also received comparable data.



It should be noted that Urgent and Emergency Care and Orthopaedics saw an increase in the number received.

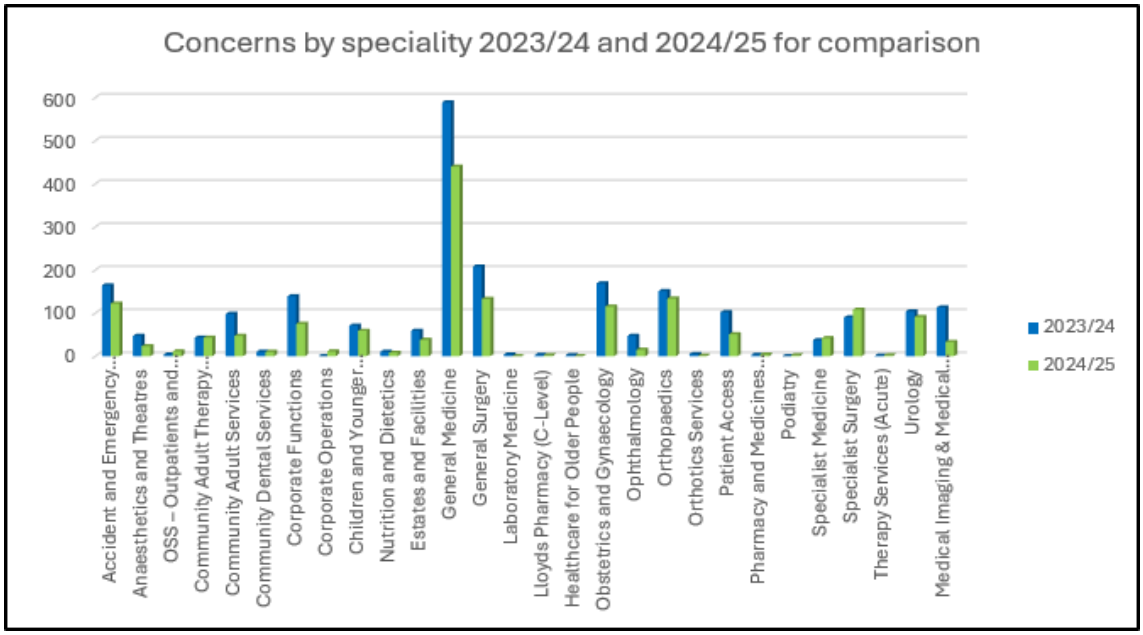
7.3 Concerns by Care Group

All Care Groups have experienced a decrease in the number of concerns received, which is due to the opening PALS. This was expected as PALS contacts would have previously been reported as concerns. Care Group 1 received the highest number followed by Surgery. It should be note that Care Group 1 includes both UECC and Integrated Medicine.



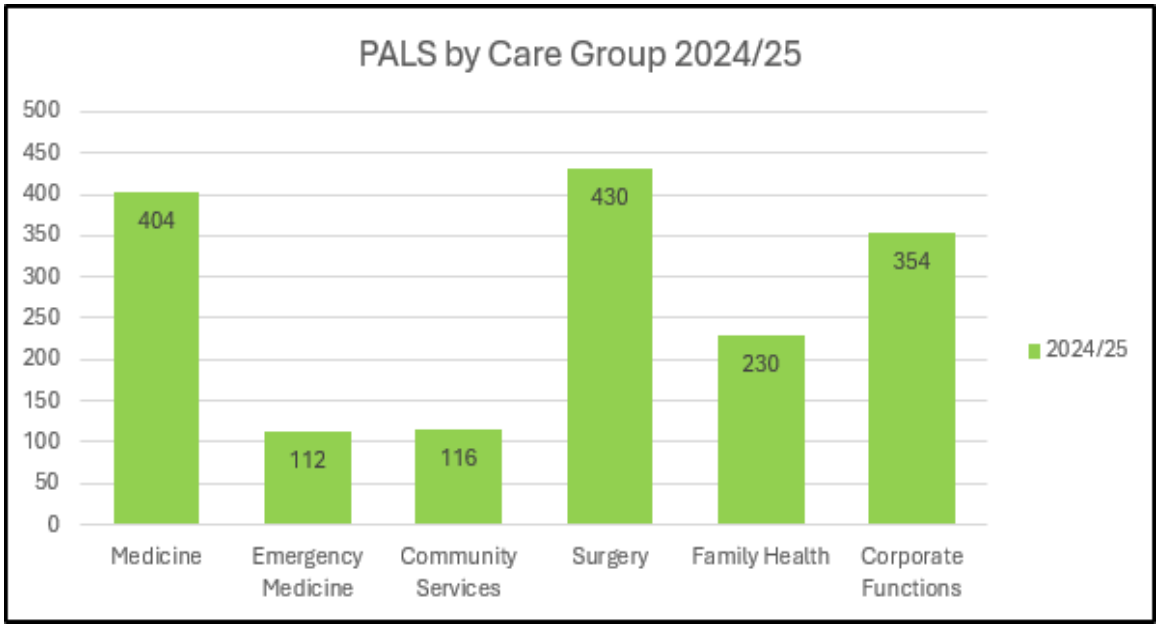
7.4 Concerns by Speciality

General Medicine received the greatest number by speciality. Due to the PALS opening all Care Groups have experienced a decrease in the number of concerns received, this was expected.



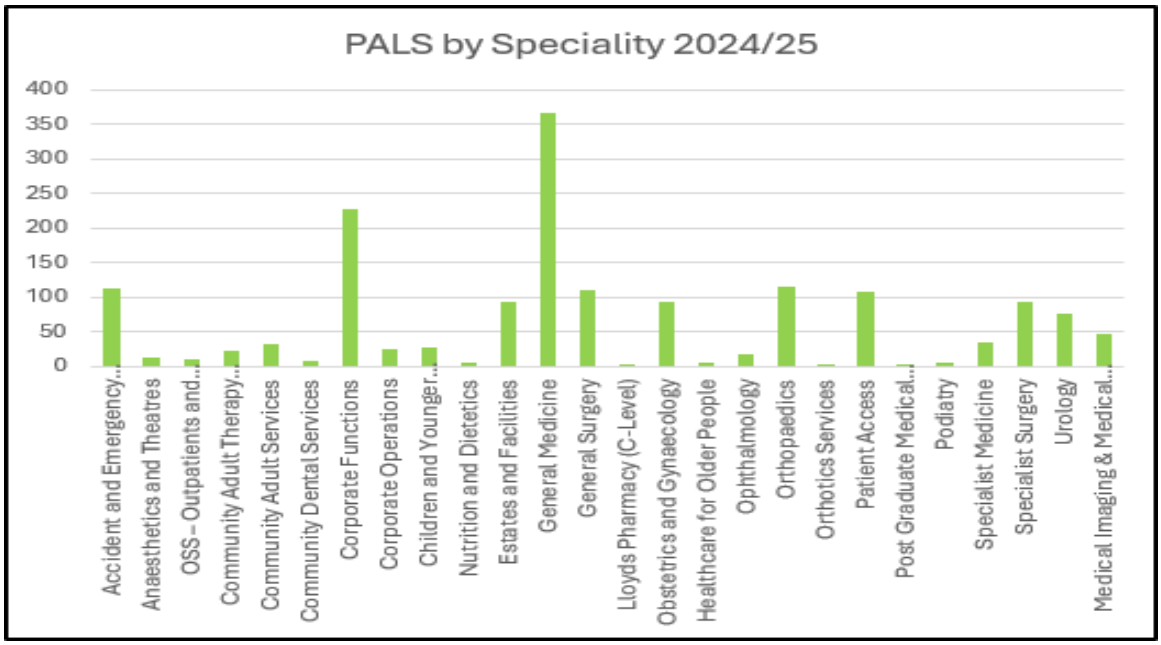
7.5 PALS by Care Group

The data below only shows the number of contacts for the 8 months the service was open. Care Group 1 (Medicine and UECC) received the greatest number, followed by Surgery.



7.6 PALS by Speciality

When broken down into speciality General Medicine received the greatest number, followed by Corporate Functions. It should be noted that corporate function contacts were in relation to members of the public seeking information and advice and not in the main raising concerns regarding services within the corporate team.



8. Grading and risk rating

8.1 Complaints are triaged on receipt using the National Patient Safety Agency (NPSA) risk rating matrix guidance.
This is a systematic and effective method of identifying risks. It also encompasses the processes of risk analysis and risk evaluation with colour rated scoring, green being minor through to red being major.

8.2 The initial grading is determined by the Patient Experience Team based on the content of the complaint and is reviewed by the division for appropriateness. As part of this triage, complaints that highlight potentially Patient Safety Incident Investigations (PSII) or have Care Quality Commission (CQC) involvement are discussed with the Head of Patient Experience and Involvement upon receipt and are routinely reviewed by colleagues, they may also be linked to a PSII under the Duty of Candour (DoC).

8.3 There were no red complaints in 2024-25. It should be noted that if a complaint was to be investigated as PSII, which would include a formal Duty of Candour letter being sent to the patient and or family. An explanatory letter is sent to all complainants in these circumstances to explain that their complaint is being investigated through a different process. However, they do have the option to return to the complaints process once the PSII investigation is complete should they remain dissatisfied.

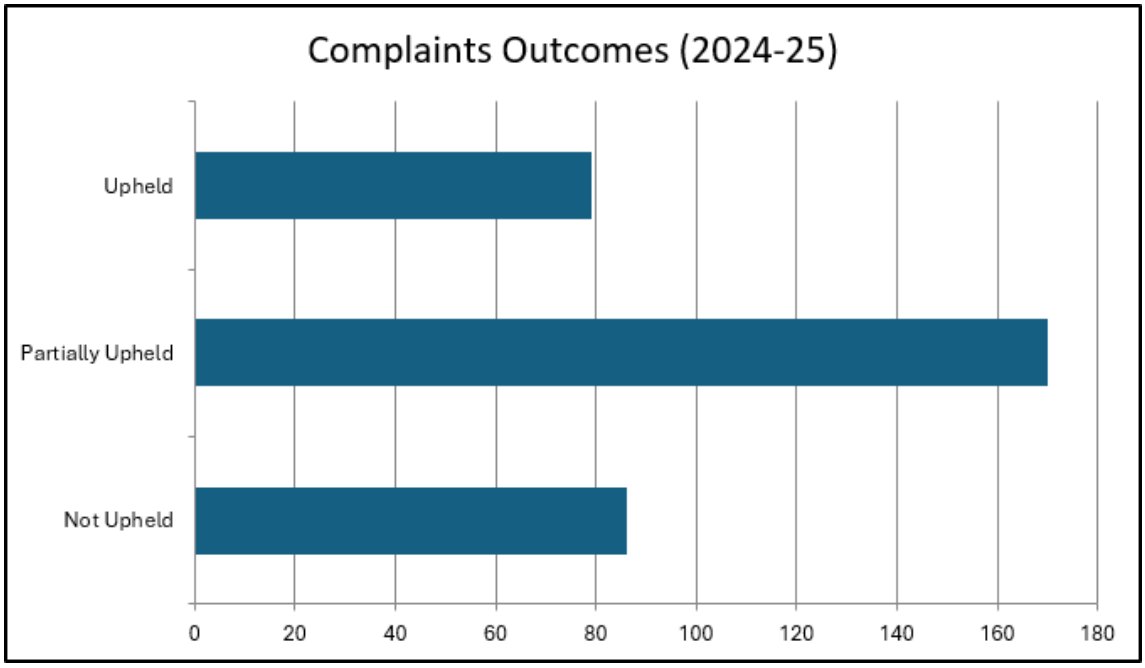
Year	Green	Yellow	Amber	Red
2022/23	0.0%	62.0%	37.6%	0.4%
2023/24	0.3%	63.2%	36.5%	0.0%
2024/25	8.2%	56.2%	35.6%	0.0%

9. Complaint outcomes

9.1 Complaints often relate to more than one issue. In line with the NHS complaints regulations, if failings are found in all the issues raised and substantive evidence, based on which a fact is proven, is identified to support the complaint then the complaint is recorded as ‘upheld’. If failings are found in one or more of the issues, but not all, the complaint is recorded as ‘partially upheld’. Where there is no evidence to support any aspects of the complaint made, the complaint is recorded as ‘not upheld’.

9.2 This is in line with the Parliamentary Health Service Ombudsman (PHSO) and Care Quality Commission (CQC) standards.

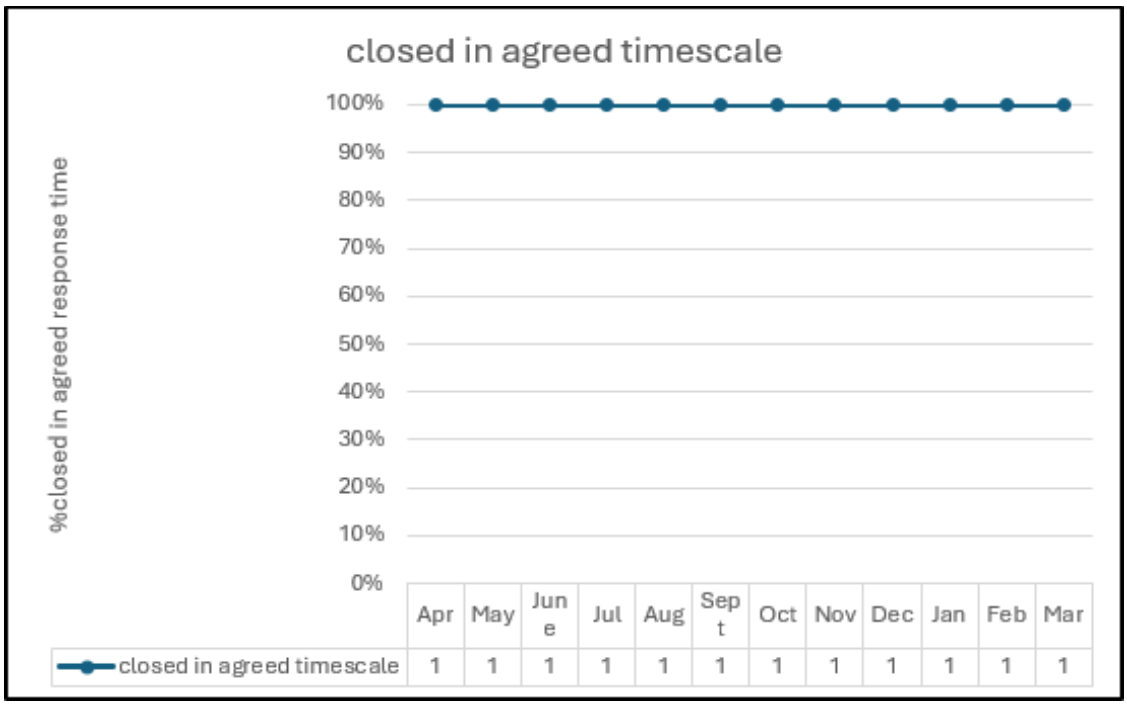
9.3 Of the 335 formal complaints closed in 2024-25. 23.58% (79) were upheld, 50.75% (170) partially upheld and 25.67% (86) not upheld.



10. Responding to Complaints within the agreed timescale

10.1 The Trust complaints policy aims to respond to all formal complaints within 30 working days and the responsibility for ensuring timely responses is shared between the patient experience team and divisions. If the complaint is complex multi-faceted or involves several organisations a timescale of 40 or 60 working days can be allocated.

10.2 In 2024-25 the Trusts internal target remained unchanged to respond to 95% of formal complaints within the agreed timeframe. It should be noted that for the year the Trust again exceeded this target by reaching 100%, for the third consecutive year.



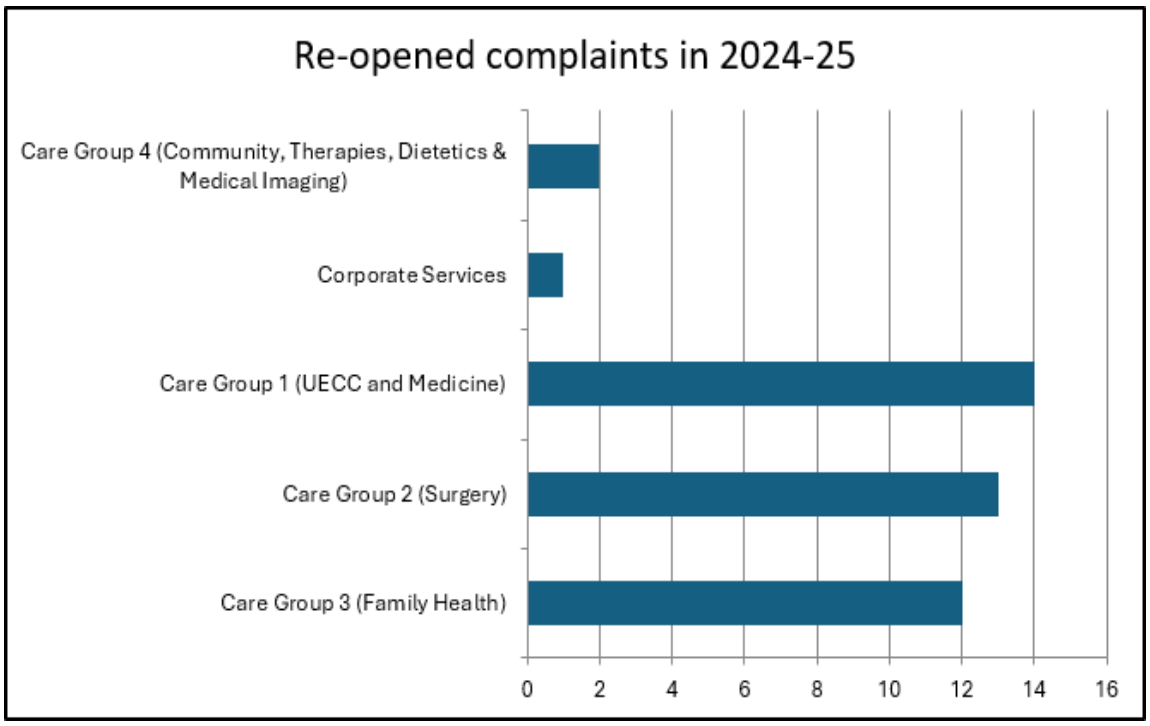
11. Complaints returned for further local resolution.

11.1 Complaints returned for further local resolution can be an indicator of how well a response is explained, how comprehensive the complaint investigation and response has been, or how satisfied complainants are.

11.2 Re-opened complaints need additional time and focus, and where possible and if not already provided, these discussions need to take place through the conciliation process. Complaints can be re-opened several months after the response has been closed, which can sometime be in the new financial year.

11.3 Out of the 335 formal complaints closed in 2024-25, 12.54% (42) were re-opened. This was a significant increase compared to the financial year of 2023-24 when 29 were re-opened.

11.4 The Care Group 1 received the greatest number of re-opened complaints.



11.5 A complaint is considered ‘re-opened’ if any of the following categories can be applied:

- Where there is a request for a local resolution meeting, following receipt of the written response.
- When new questions are raised, following information provided within the original complaint response.
- The complaint response did not address all issues satisfactorily.
- The person raising the complaint expresses dissatisfaction with the response.

12. Parliamentary Health Service Ombudsman (PHSO)

12.1 Although we aim to resolve all complaints at a Trust level, once local complaints resolution is complete, if the complainant remains dissatisfied, they may ask the PHSO for consideration of their case by providing details of the way in which they consider that the Trust has failed to answer the issues.

12.2 The PHSO is commissioned by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS England (NHSE) and UK government departments. The PHSO make final decisions on complaints that have not been resolved fairly and without taking sides. The PHSO considers and reviews complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or fairly, or has given a poor service, and has not put things right. In addition to outcomes and reports from PHSO investigations being shared with the senior leadership teams they will also be shared the Trust's executive team for oversight of the findings and recommendations.

12.3 There are many factors that influence the number of complaints and the PHSO advises that this data should not be treated as an attempt to rank the performance of Trusts across England. Organisational size, specialities, and patient demographics all have an impact on the number of complaints about different Trusts. The accessibility of each Trust's complaints service and how well a Trust signposts to the PHSO service, may also have had an impact.

12.4 Below shows that two cases were received for investigation in 2024-25 which remain open, and one case was closed and one case from 2022-23.

Speciality	Primary subject matter	Outcome	Recommendations
12352 Specialist surgery	Concerns raised regarding management of throat cancer	Closed	Partly upheld
12668 Medicine	Concerns raised about patient remaining in hospital longer than necessary, patient contracted Covid and passed away	Closed	Partly upheld
12997 Surgery	Concerns raised following cataract surgery and subsequent treatment	Closed	Partly upheld

Speciality	Primary subject matter	Outcome	Recommendations
14572 Surgery	Concerns raised regarding potential delay in diagnosis of cancer, patient passed away	ongoing	Final report received, complaint upheld. Completion of the is Action plan required before closure
15783 UECC	Concerns regarding treatment and care following head injury	Closed	Not upheld
18533 Medicine	Concerns raised about delay in receiving cardiology care, patient passed away	ongoing	
18495 Maternity	Concerns raised regarding care provided during pregnancy.	ongoing	

13. Review of closed Complaints

13.1 On quarterly basis a review of the complaints closed within the financial year is undertaken by one of the Non-Executive Directors (NED) of the Board on a rotating basis. The NED randomly selects several files from the complaints closed, by DATIX number.

The analysis includes subject areas, structure and content of the complaint files, timeliness and quality and actions of the investigation.

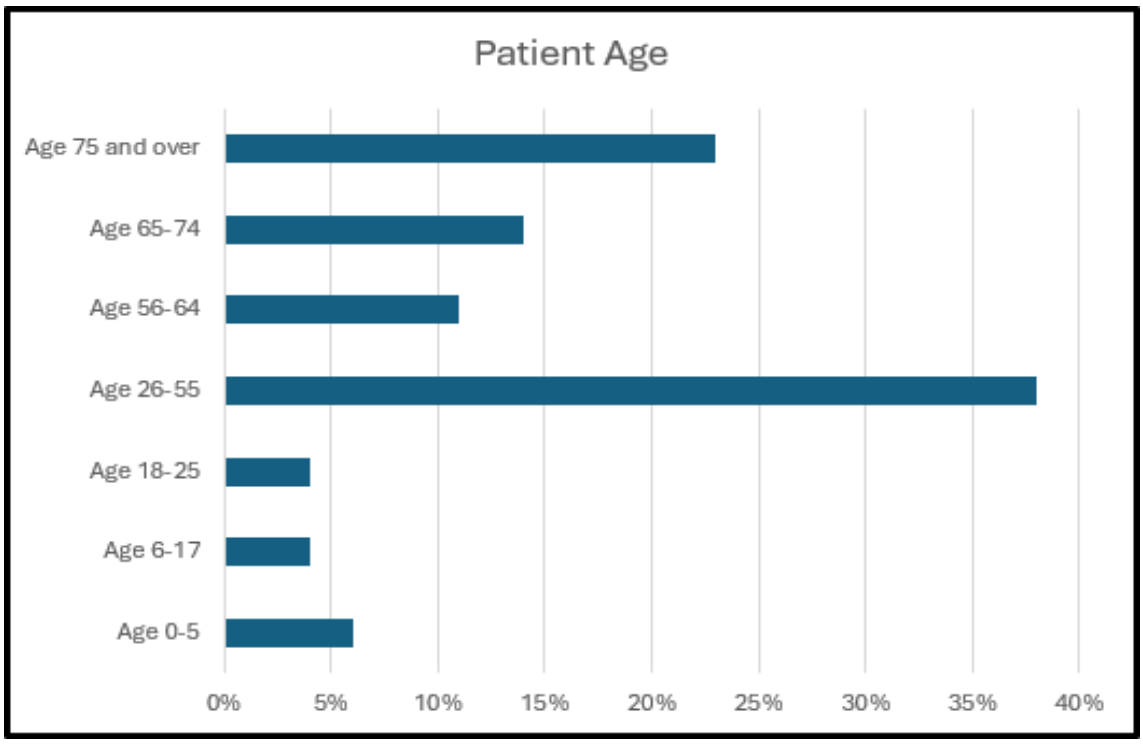
13.2 For each quarterly review the main areas of complaint were identified; although it should be noted that clearly some of the complaints had multiple areas of concern.

13.3 Responses to the complainants were written in plain English, were explanatory, non-defensive and showed good care and empathy for the concerns raised and their impact on others. The style of the written response mirrored the complaint in some of the cases, ensuring it is easy for the recipient to follow.

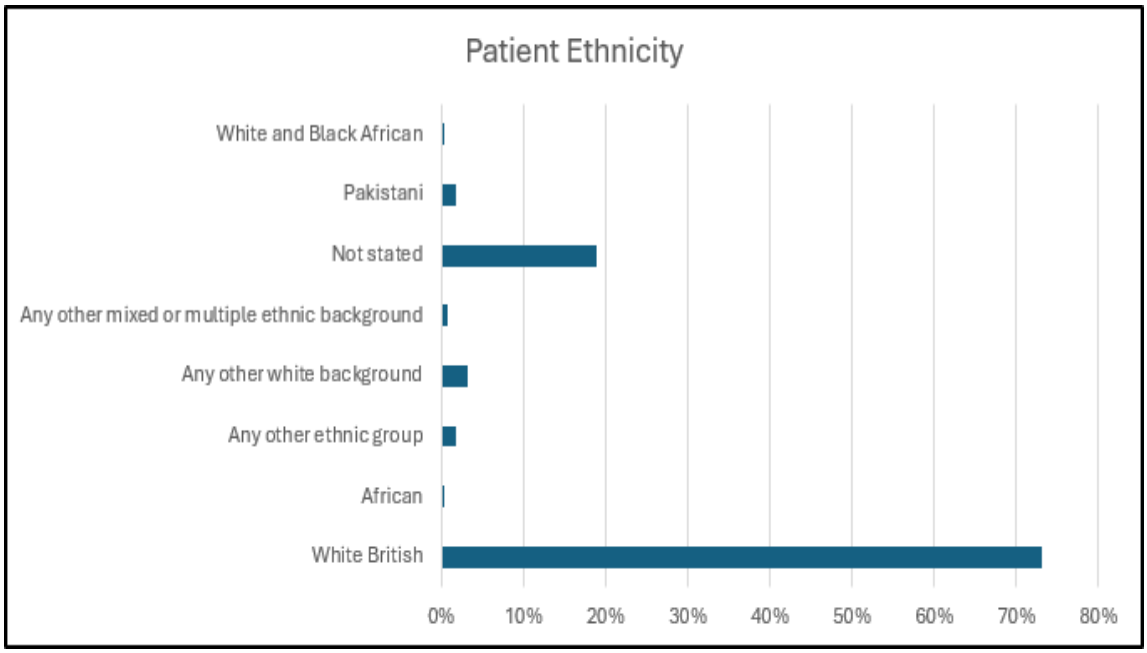
13.4 From the reviews undertaken it was evident the structure, timeliness of handling and responding to the complaints remains compliant with the Trust complaints policy. The files managed by the PET were well organised and contained copies of all correspondence.

14. Demographics

14.1 The age of the patients making formal complaints is demonstrated in the figure below. The majority being within the 26 - 55 age range.



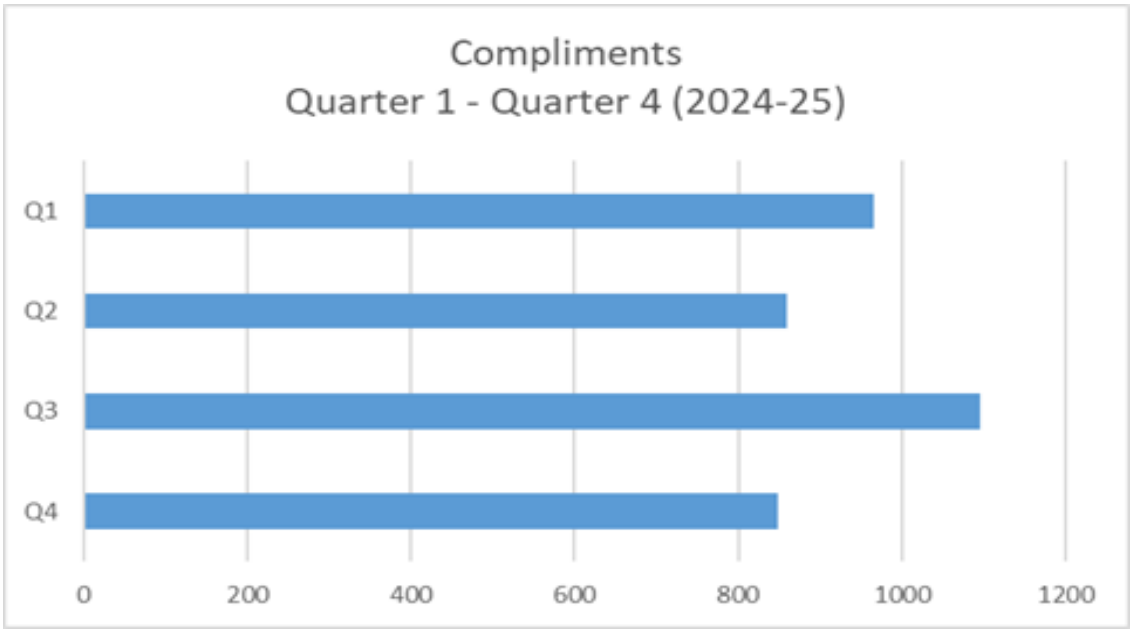
14.2 The ethnicity of patients making formal complaints overleaf shows that over 70% were white British. This also mirrors the demographic responding to the CQC patient surveys.



15. Compliments

15.1 Our staff strive to deliver exceptional care and a positive experience for all of our patients. When this is recognised by patients and families in the form of a compliment, this valuable insight also helps us understand what is important to patients and how we can share learning in a positive way.

15.2 The Trust received 3,770 compliments in 2024-25. These were generated by various expressions of gratitude including thank you cards, letters, or positive reviews posted on the NHS website and token gifts such as Chocolates or biscuits. Feedback received via the Patient Experience Team is shared with staff/team(s) involved and recorded.



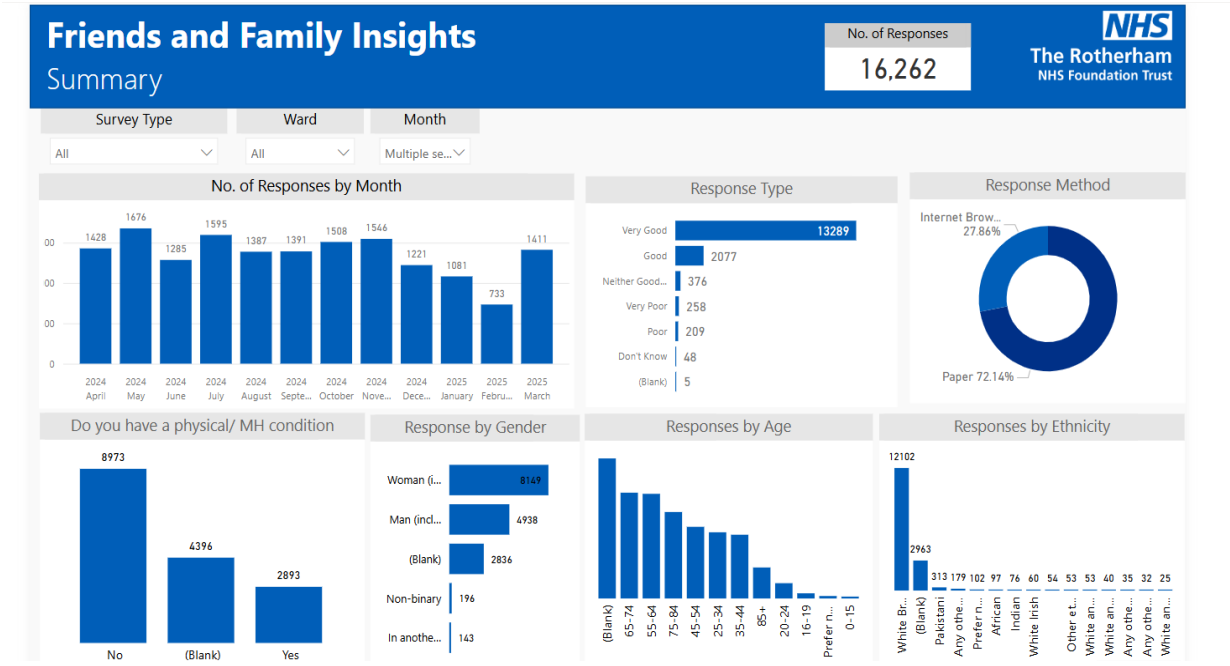
15.3 Work is in the final stages to record all compliments to DATIX so that data can be captured and recorded in the same format as PALS, concerns and complaints. When patients tell us care has gone well, this always reflects the individuals the patient has come into contact with.

Porters, hostesses, cleaners, nurses, therapists, doctors, receptionists and volunteers are named as helping to put patients at ease, provide the right information, being kind, supportive and caring for people.

We know that kind, friendly, responsive colleagues, working to put patients first, helps to make the patient experience a positive one, even when the patients' outcomes aren't always what they would have wanted.

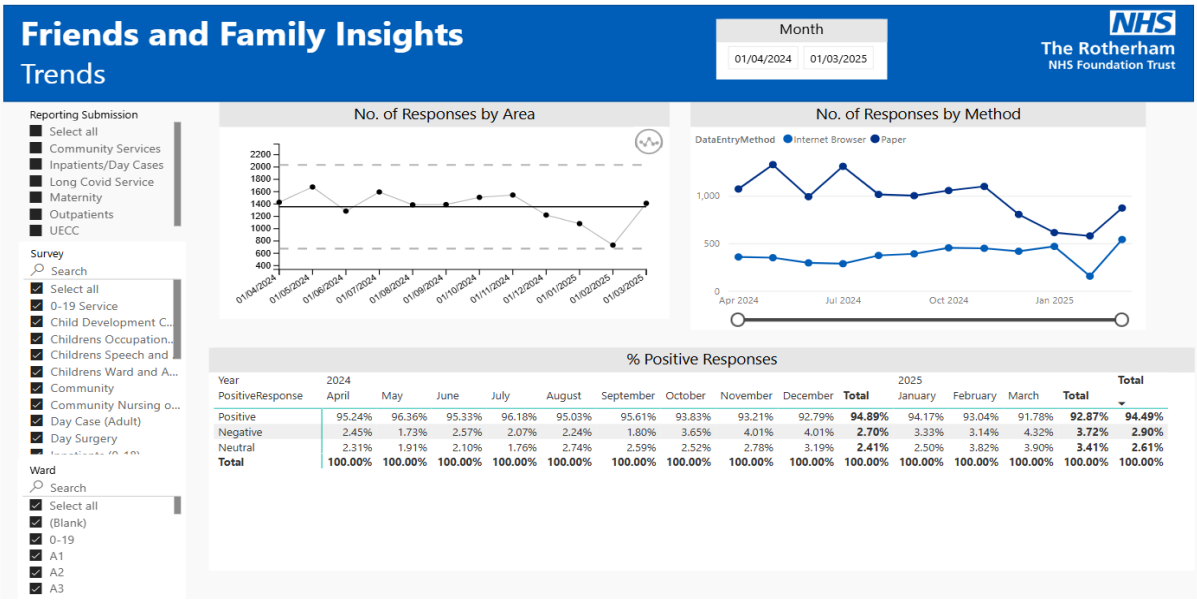
16. Friends and Family Test

16.1 There were 16,262 responses for the Friends and Family Test (FFT) in the year. Of these responses, 94.49% were positive, which is less than a 1% decrease compare to 2023-24. 2.90% were negative and 2.61% neutral. A detailed report of the FFT data is shared at the Patient Experience Group on a quarterly basis.



16.2 72.14% of feedback was submitted by completely the paper form and 27.86% by text and internet browser. The majority of feedback was by white British ethnicity, with over half by women.

16.3 It should be noted that there had been a number of system problems in January and February, including information updates and Cyber security issues due to the Trust's current version not being compatible, which required updating. Unfortunately, this meant in February a significant amount of data was lost due to the Cyber security work which could not be retrieved.



17. External Feedback narrative for the year

17.1 We received 32 comments via Care Opinion and NHS UK, using the star classification as a type of rating system of one to five, with five being the highest rating. Feedback is shared with relevant clinical teams for learning. The main negative themes relate to long waiting times in UECC. The main positive themes relate to short waiting times in UECC,

18. In-patient experience audit

18.1 Following the end of patient experience Tendable audit, work was undertaken to progress the in-house digital option to focus on the questions most important to patients. These were developed in line with improvement work being undertaken to establish the impact of the work.

18.2 The implementation of the survey commenced in April 2024 to co-inside with the beginning of the financial year. The survey is sent out the fifth day of each month and is sent randomly to patients who have been discharged the previous month. Patients score each question 0 – 10 which is the same scoring used by Picker the Trust's chosen partner to run the NHS National Survey programme. Their surveys used the following questions.

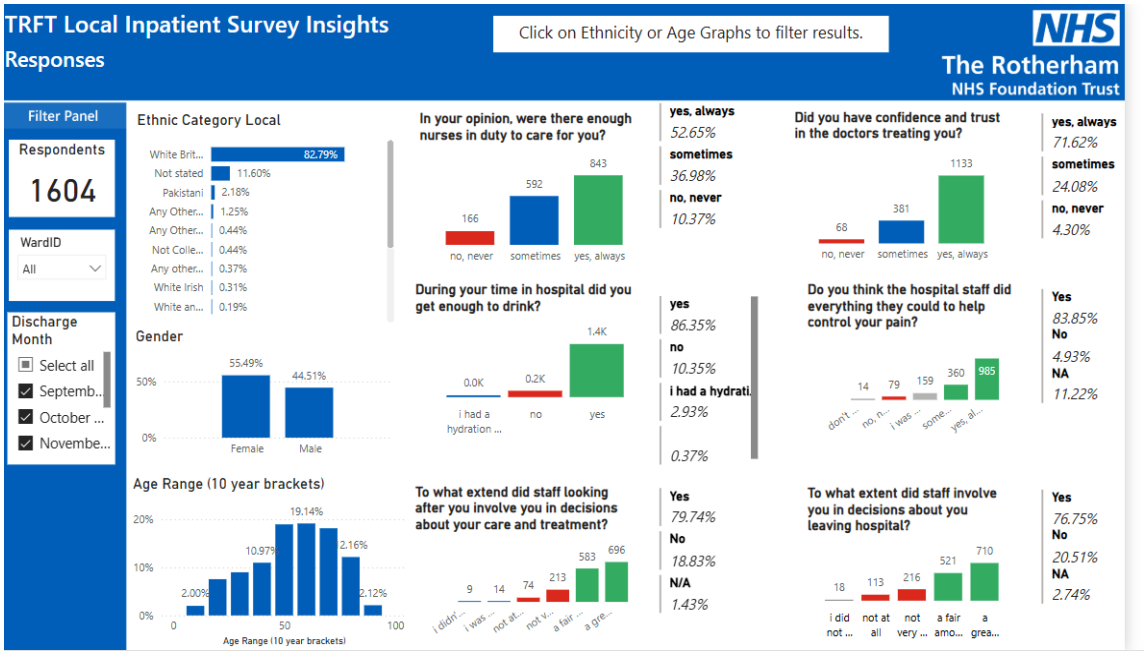
1. Did you feel there was sufficient nursing staff to look after you whilst you were on the ward?
2. Did you have confidence and Trust in the doctors treating you?
3. Was your pain appropriately managed?
4. Did you have enough to eat and drink whilst in hospital?
5. Were you involved in decisions about your treatment whilst in hospital?
6. Did you feel you were involved in your discharge from hospital?

18.3 The questions were revised in Q2 of this year and aligned to reflect those in the CQC in-patient survey as follows:

- Do you think the hospital staff did everything they could to help control your pain?
- During your time in the hospital, did you get enough to drink?
- To what extent did staff looking after you involve you in decisions about your care and treatment?
- To what extent did staff involve you in decisions about you leaving hospital?
- Did you have confidence and trust in the doctors treating you?
- In your opinion, were there enough nurses on duty to care for you in hospital?

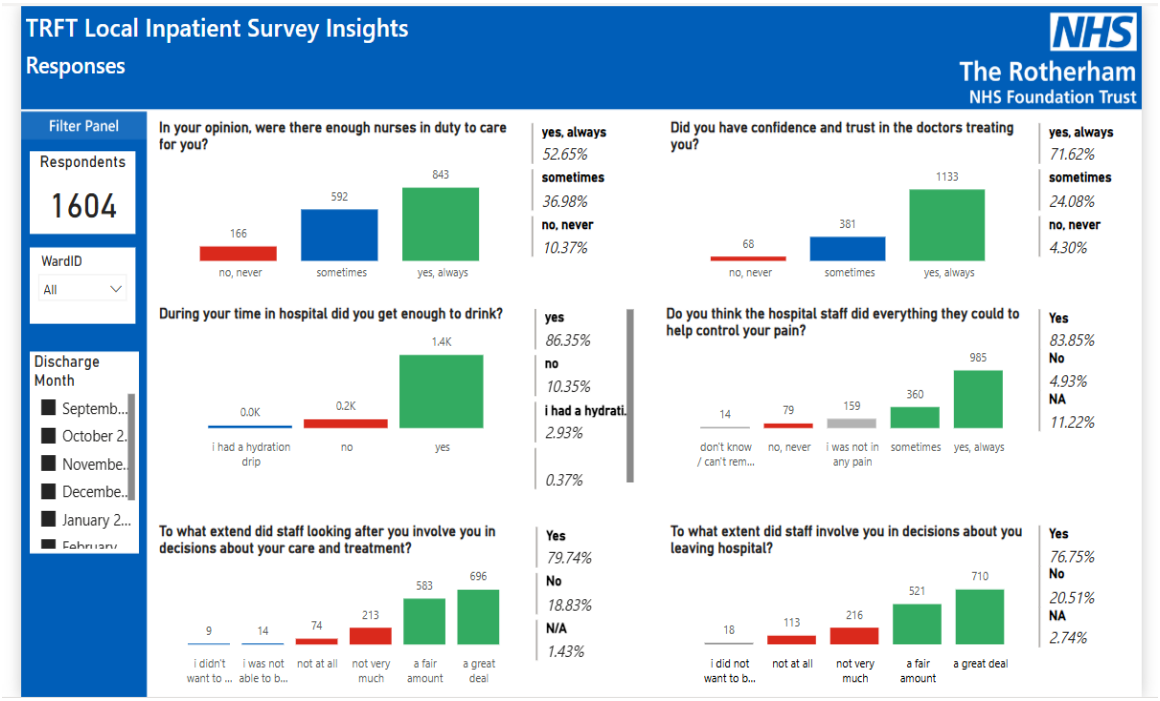
The survey now includes age and ethnicity and gender.

18.4 Number of responses



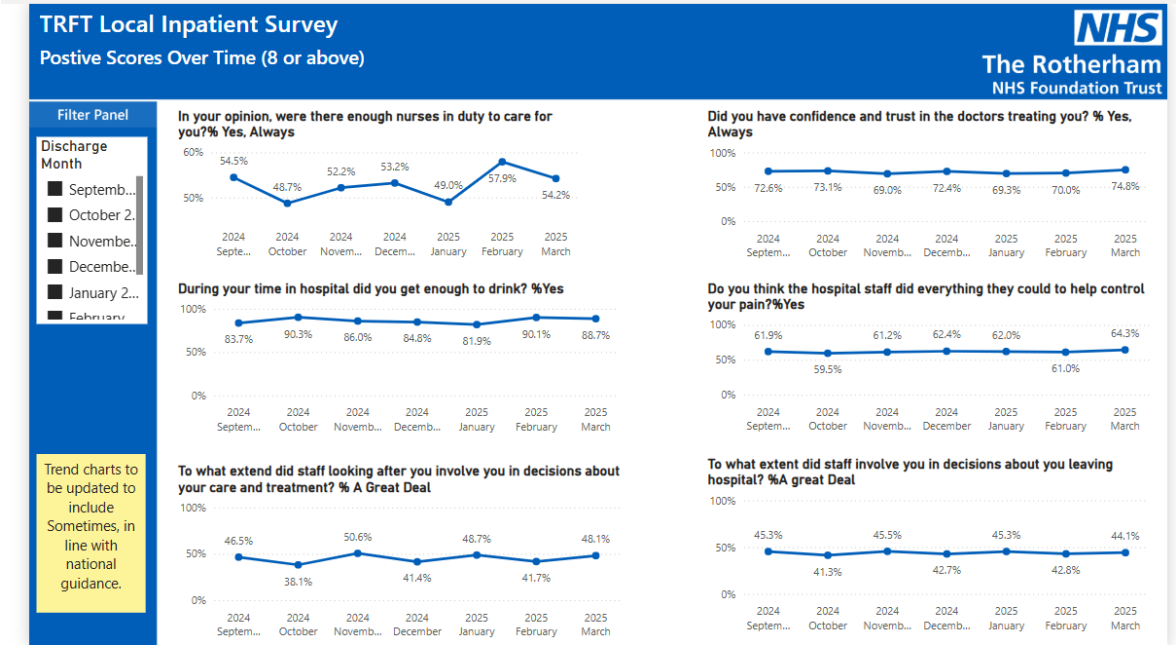
From July 2024 to March 2025 there were 1604 responses of which 82.79% ethnicity was white British, the majority was within the age range from 50 to 70. 55.49% were female.

18.5 Responses



Of the responses received only 10% thought there were never enough nurses on duty to care for them. 86.35% felt they had enough to eat and drink during their stay, 87.24% felt they had enough to drink whilst on the ward, 79.74% felt they were involved in decisions about their care and treatment, 76.75% also agreed that staff involved them in decisions about their discharge and 83.85% felt that their pain control was well managed.

18.6 Positive score



From the monthly score above it is clear that further work is required from ward staff to involve patients in their care, treatment and discharge.

19. The National CQC Patient Experience Surveys for Acute Trusts

19.1 Maternity Survey

The Maternity Survey 2024 was published in November 2024 and looked at the experience of women and other pregnant people who had a live birth in early 2024, including ethnic minorities, in February 2024.

Responses were received from 124 people and the Trust scored about the same as other Trust within the 3 sections.

19.2 Adult Inpatient Survey

The adult inpatient survey 2023 was published in August 2024 and looked at the experiences of patients who stayed at least one night in hospital as an inpatient.

To prepare for the adult inpatient survey 2024, a series of workshops were held to share learning on patient experience and a business card was developed to give to patients discharged in November 2024 to try and increase response rates.

Responses were received from 448 people out of 1250 people invited to take part. All 11 sections, scored about the same when compared with other Trusts.

19.3 Urgent and Emergency Care Survey

The Urgent and Emergency care survey was published in November 2024 for people who attend in February 2024 and looked at the experiences of people who received care from urgent and emergency care services.

Responses were received from 308 people out of the people invited to take part. Out of the 11 different sections, all were about the same when compared to other Trust's. Which is an improvement on the previous year.

19.4 Children and Young Peoples Survey

The 2024 CYPS will be published in May 2025. A feedback exercise will be organised with the Care Group and Picker to enable an improvement plan to be developed.

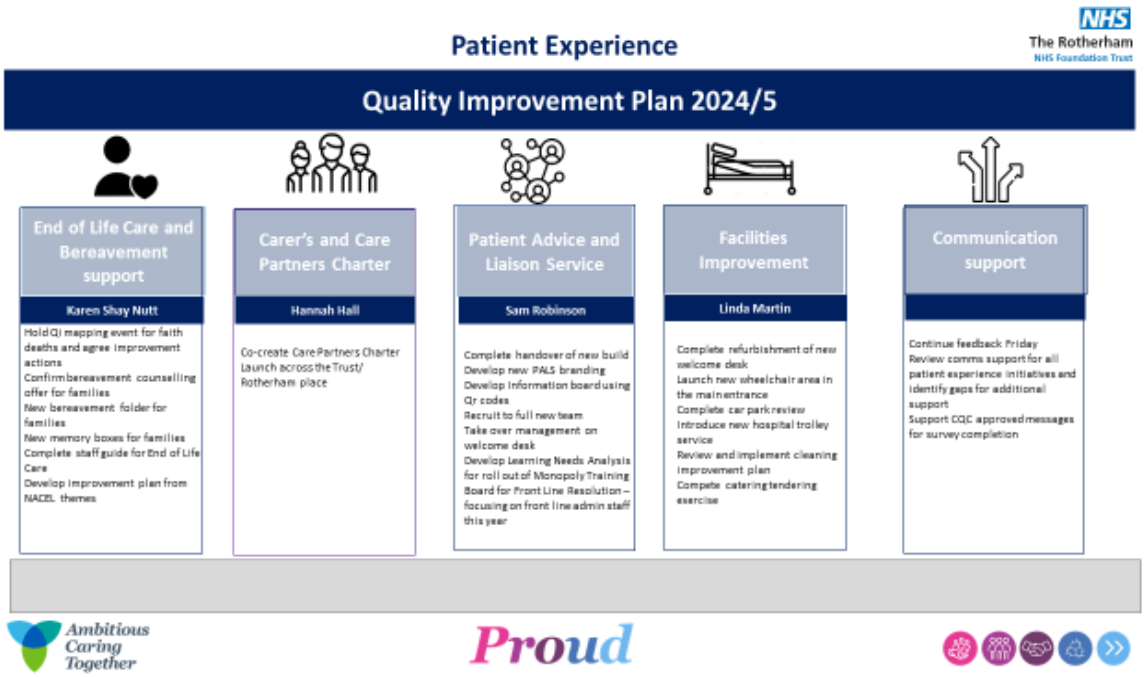
19.5 Learning and improvement from patient experience surveys

Throughout 2024, Care Groups were invited and attended a facilitated workshop, provided by Picker to go through the results and statistical significance.
Findings from these surveys are triangulated against other sources of patient feedback including patient's giving compliments, raising concerns or complaints, data from the Friends and Family Test (FFT), feedback from local and national advocacy services, healthcare experience websites and social media.

Rather than each Care Group creating action plans from this thematic analysis, a Quality improvement plan was developed to ensure all areas were working towards a coordinated improvement plan.

20. Thematic analysis from patient experience data

20.1 The thousands of pieces of patient experience data (compliments, complaints, concerns, PALS contacts, Inpatient Survey, FFT and CQC surveys) we collect by month, quarter and annually, are all things that are important to patients and they want us to know about. Thinking of the main themes to focus on, and a quality improvement approach to those themes the Patient Experience Improvement Plan 2024/25 was developed over leaf.



20.2 End of life and bereavement support

The Trust bereavement guide has been re-written to incorporate more signposting and help for bereaved families as well as information on tissue donation.

The purple butterfly in memory giving model of care focuses on the needs of patients and their loved ones. The purple butterfly symbol indicates that a patient and their loved ones are facing uncertainty, deterioration, or the end of life. To help guide staff on what this means a new End of Life Staff Folder has been written.

A Registered Nursing Associate developed personalised memory boxes which can be filled with special items belonging to the patient to help families cherish their memories of their loved one. These have now been rolled out Trust wide and have been put together by the lead nurse for the supportive care team. The boxes contain:

- Inkless fingerprints to capture a unique imprint
- A storage container for a lock of hair
- An angel keyring symbolising protection and guidance
- Forget-me-not seeds to nurture a person's memory in a living plant
- A bereavement book to help support families through what to do after a loved one dies

- The box also includes a pair of crocheted hearts. One is kept by the patient while the other is for the family. 100 hearts have been kindly provided by keen crafters so far after a call to action through the Trust's social media accounts.

The first of the faith death mapping event was held in August with Key stakeholders including community groups. The event identified 4 work streams to review current process:

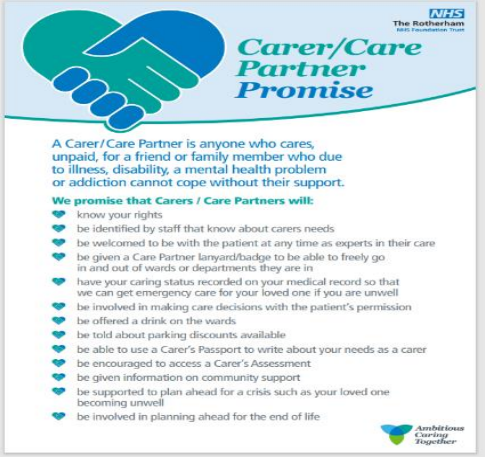
- Process
- Information
- Communication
- Education

Work with PLACE is underway reviewing the standard of local bereavement support in addition to the national information provided within the with bereavement booklet provide to all families within the Trust following a loss.

20.3 Carers and Care Partners Promise

Nationally more than 1.4 million people are providing more than 50 hours a week for a partner, friend or family member, making a significant contribution to society and the NHS.

Recognising that each time we give someone a diagnosis of a long term condition, we potentially create a new Carer. Developed with Rotherham Carers, the Engagement and Inclusion Lead has produced a Carer/ Care Partners Promise.



To help identify Carers and Care Partners, the Trust charity has supported the purchasing of bespoke lanyards and badges to offer carers.

20.4 Patient Advice and Liaison Service

The PALS service commenced in August. Prior to this the Patient Experience Team were performing the PALS function without the ability to record and report this correctly. Therefore, the majority of PALS contacts were been reported as concerns are now report as PALS contacts. This allows the team the ability to register all contacts correctly including the option to record any support / information / advice the service provides. The official opening of the service was held on 5 November.

20.5 Facilities Improvements

25.5.1 With the agreement for the new Car Parking proposal, this will create 150 additional spaces on site. The new works will include some resurfacing. The installation of Automatic Number Plate Recognition, ANPR technology and payment machines have already been installed. App based payments are available and blue badge holders are also able to pre-register.

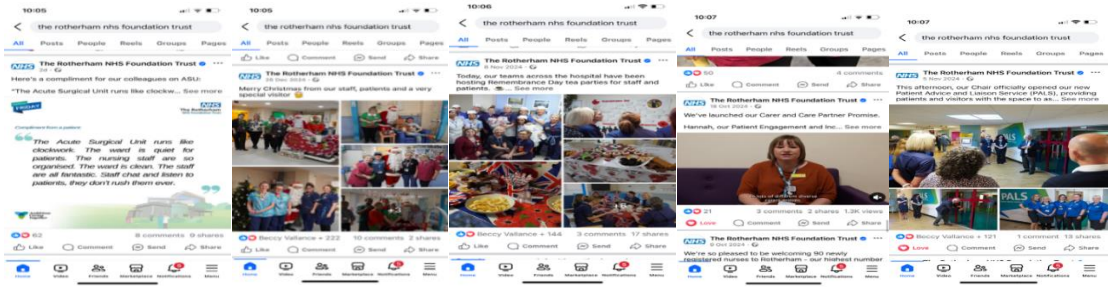
20.5.2 A new wheelchair station has been built in the main entrance on C level. The wheelchairs use the coin system to ensure they are returned. Graphics to support this new facility were mirrored those of new PALS.

20.5.3 A new Hospital Trolley service was introduced. Run by the internal catering company ISS and have a daily supply of puzzle books, magazines, drinks and snacks for patients.

20.5.4 With regards to the cleaning improvement plan, the National Standards of Healthcare Cleanliness 2021 have been reviewed and responsibilities between cleaners, clinical staff and hostess confirmed. These have now been re-launched across the Trust and an improvement in the cleaning scores noted.

20.6 Communication Support

The communications team continues to support with feedback Friday and all patient experience initiatives.



21. Shared learning from Patient Experience

21.1 To move away from individual action plans in response to one incident, Divisions are encouraged to triangulate all patient experience data and use a Quality Improvement approach to evidence their response the themes from their feedback. The method to triangulate patient experience is the (evidenced based)

Yorkshire Patient Experience Toolkit. During 2024/5 the following Care Group presentations were heard on the following dates:

- June 2024 – Care Group 1 (Medicine and UECC)
- September 2024 – Care Group 2
- December 2024 – Care Groups 3 & 4 Community Care, including Therapies, Dietetics and Family Health (Children's) / Clinical Support Services
- March 2025 – Care Group 1 (Medicine and UECC)

22. Additional Staff and Patient Engagement work achieved during 2024-25

22.1 Dying Matters week was held in May 2024 and the team planned a series of roadshows across the Trust. These were also in partnership with the Rotherham Hospice, the Purple Butterfly Bus and NHSBT.

22.2 Work to complete a Trust version of 'This Is Me' was completed and in use across Care Group 1. 'This is me' is a simple leaflet for anyone receiving professional care who is living with dementia or experiencing delirium or other communication difficulties.

This is me

Information to help you support me in hospital

Space for a photograph

Using a photograph is optional, but it can be really helpful for hospital staff

Full name

What I like to be called

22.3 In conjunction with the opening of PALS, the education of front line resolution is being provided by the Head of Patient Experience and Involvement, Complaints Monopoly Board. Feedback has been extremely positive, as this training is interactive and focus' on team work and staff engagement.

22.4 A Calendar of Events was developed to help plan out occasions that celebrate real life events patients and staff can get involved with. This has been shared with clinical teams and was supported by the Hospital and Community Charity.

22.5 The first of the events in 24/25 was the organ and tissue donation week with "Wear It Pink" tea-party throughout the Trust.

22.6 The Rotherham show was held in September with over 150 responses received over the weekend in relation to population Health Management within Rotherham.

22.7 It was Cares rights day in November and lots of groups joined the Engagement and Inclusion Lead in the main entrance foyer.

22.8 Remembrance Day tea parties were held for remembrance on Friday, 8 November. The winning ward for the coveted tea-pot hamper was Ward B5. The judges partook in a sample of the delicious treats, provided along with a remembrance themed afternoon tea for patients and staff together. Information stands on support for the armed forces community were in the main entrance.

22.9 Santa and his elf's took time out of their busy scheduled to pay a visit to our wards and add some festive cheer to our patients and staff. Christmas presents were donated by the Rotherham community. Patients visited by the District Nurses also received a gift on Christmas day.

22.10 With the support of RHCC, in February saw the distribution off “Getting Social packs” on wards for patients on discharge. These packs include local information on ways to connect with others in their communities. This is associated with better health outcomes. The pack comes with a pack of biscuits and 2 teabags to invite someone over for a cuppa.

22.11 As part of Nutrition and Hydration week staff members across the Trust got involved to highlight and educate people in the value of food and drink in maintaining health and wellbeing in health and social care and held its global tea party on the 19 March. The winning ward received a Tea-Pot hamper prize for their efforts.

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22.13 In February 2025, the new Experience of Care Framework was released by NHS England. This framework combines policy guidance with the reasons the Care Quality Commission (CQC) most frequently give for rating trusts as ‘outstanding’, based on a review of CQC reports from 2018 to 2023. This voluntary self-assessment tool will be used as a tool to improve outcomes and experiences for people using services, unpaid carers, staff, volunteers and communities as a whole. Work has now started with all key stakeholders to benchmark where we currently are on leadership, organisational culture, how we collect feedback, how we analyse feedback and how we learn for improvement.

24. Conclusion

24.1 The Trust is grateful to those patients, families and carers who have taken the time to raise their concerns, complaints and compliments and acknowledges their contribution to improving services, patient experience and patient safety.

24.2 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 place a statutory duty upon the Trust to acknowledge complaints within 3 working days. Complaint handling has performed strongly with:

- 100% of complaints acknowledged within 3 working days.
- 100 % of complaints were graded upon receipt

- Response rate to formal complaints responded to in the agreed timescale was 100%.

24.3 The opening of the PALS service has improved face to face access for local residents and patients accessing care and treatment at the hospital. Although the numbers of formal complaints and PALS contact and concerns combined shows a significant increase. This was expected with the opening of the PALS office. This is also in line with the increased numbers of patient demand in out-patients and UECC attendances.

24.4 The introduction of the PALS service also aligns with the implementation of changes to the complaints process in accordance with the new PHSO NHS Complaints Standards, which set out how organisations providing NHS services should approach complaint handling. The Complaints Standards support organisations to provide a quicker, simpler and more streamlined complaint handling service. They have a strong focus on: early resolution by empowered and well-trained people; all staff, particularly senior staff, regularly reviewing what learning can be taken from complaints; and how all staff, particularly senior staff, should use this learning to improve services.

24.5 Standardised dashboard reports have been created, providing Care Groups with a detailed breakdown of their complaint, concerns and PALS contact numbers, themes and responsiveness at an organisational, divisional and departmental level.

24.6 The Trust website has been updated to reflect the introduction of PALS, including the new leaflets and posters.

24.7 The Head of Patient Experience and Involvement has held several complaints monopoly sessions with more planned for 2025-26. The sessions are for any member of staff who has patient contact including members of the Senior Nursing teams, Governance Leads, Nursing staff and administration. The aim of these session is to focus on increased local resolution at the point of contact and a reduction in the overall number of complaints.

24.8 For the CQC patient experience surveys, Care Groups attended facilitated feedback sessions, provided through Picker. These have been well attended with clinical teams increasing understanding of what is important to patients and what needs to improve.

24.9 To better understand if the improvements have made a difference, patient experience is no longer collected by the Tendable app. Instead an In-patient survey, using a several of the CQC questions has been developed and a selection of patients are randomly selected following discharge on a monthly basis.

24.10 Continued areas for improvement and development during 2025-26 include:

- Continue to roll out Complaints Monopoly training across the organisation.
- Standardised Trust compliments process.
- Continued focus on a digitally led approach to handling complaints to improve responsiveness, including investigations, reports and communications.

- Strengthen shared Trust learning from PALS and Complaints to drive improvements to patient experience and care and treatment, through work alongside Safeguarding, Quality Governance and Legal Departments.
- Implement the Patient Experience Improvement plan 2025-27
- Celebrate the 2025-26 Calendar of Events with patients and staff.
- Benchmark ourselves against the Experience of Care Framework and build recommendations for what good care would look like.

Board of Directors' Meeting
4 July 2025

The Rotherham NHS Foundation Trust

Agenda item	P/108/25
Report	**Annual End of Life Care Report 2024/25**
Executive Lead	Helen Dobson – Chief Nurse
Link with the BAF	B1 Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meets regulatory standards
Purpose	Decision [ ] To note [x] Approval [ ] For information [ ]
Executive Summary (including reason for the report, background, key issues and risks)	The palliative care team picked up 1242 referrals in 2024/5. This is an increase of 14% from the previous year. Of the 1242 referrals a total number of 3028 reviews took place, 2407 patient visits. The highest reason for referral was for symptom management with pain and psychological support. The numbers of patients given tailored care through the last days of life care plan averaged 59.7% against a national average of 75% This metric is now triangulated with the NACEL data to identify further improvements. The National Audit of Care at the End of Life (NACEL) data is included in the report. This includes the case note results, family feedback and staff survey. The case note review has demonstrated opportunity to improve recognition of the dying phase for patients so patients and families can be involved in decisions about end of life care. The quality survey (completed by bereaved families) has seen an improvement in all areas apart from support for the dying person to eat or receive nutritional support. The staff survey reported confidence in dealing with end of life care but feeling the organisation needed to offer more education on this subject. Dying Matters week was held in May with this year's theme being 'the way we talk about Dying Matters' The team held roadshows in partnership with the hospice, big purple bus and NHSBT. 'Letters to Loves Ones' and the 'Wind Phone' were also launched and now have a permanent home in the hospital chapel. The bereavement book, giving practical advice to bereaved families after the death of a loved one has been re-written. A new staff guide to end of life care has also been written as an education tool for all clinical areas who may need help and guidance when providing end of life care.

	The new purple butterfly boxes have launched across the Trust. These contain the bereavement book, staff guide to end of life care and the new memory boxes. The memory boxes were created after a quality improvement project on ward A5 by a Registered Nursing Associate and are a way to make lasting memories for loved ones. A faith deaths mapping exercise was performed in August 2024 with representation from the Muslim community, coroner's office, council, bereavement office and clinical areas. There are four main themes from this piece of work (communication, information, process, education) which are being worked through. A new Trust web page for Palliative Care has been developed and is now live. The Palliative Care team continue to work in partnership with NHSBT on tissue donation and have been recognised for their exceptional partnership working. The Fuller report phase one was acknowledged and a report from the Histopathology Discipline Lead for South Yorkshire and Bassetlaw Pathology provided. There are 17 recommendations in the report. This is also discussed at the Mortality Group. A ReSPECT audit has been undertaken demonstrating fantastic progress in Rotherham across Acute, Primary and Community Care, but still more to be done. From the audit (in the hospital) too many ReSPECT forms are still being used a DNACPR rather than emergency care planning documents. On some occasions, capacity assessments are not completed and there is inadequate next of kin information. New policies relating to end of life care are for approval at the November Patient Experience Committee with three further policies under development. There were two live risks in relation to end of life care found on a search by the corporate governance office. A full review of all NICE guidance relating to end of life care has been undertaken with 10 different guidelines noted and partial compliance in three of these. Work is ongoing to reach full compliance in these areas.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper was presented to the Patient Experience Committee on 28 April 2025 and to Quality Committee on 19 May 2025.
Board powers to make this decision	N/A

Recommendations	The Trust Board is asked to note the content of the paper
Appendices	**Appendices are available in the reading room** Appendix one – NACEL case note review Appendix two – Quality survey

Ambitious Caring Together

The Rotherham NHS Foundation Trust

End of Life Care

Annual Report

April 2024 – March 2025

purple butterfly

In Memory Giving

1. Introduction

1.1 End of life care is support for people who are in the last months or year of their life. End of life care should help patients to live as well as possible until they die and to die with dignity. The way we provide care should ask about patient's wishes and preferences and take these into account as we work to plan care. End of life care should also include support to family, carers or other people who are important to patients.

1.2 Patients have the right to express your wishes about where they would like to receive care and where they want to die. They can receive end of life care at home, in a care home, hospice or be cared for in hospital, depending on their needs and preference.

2. Referrals

2.1 The supportive care team pick up referrals through via Meditech/System One Monday to Friday between 08.00 –18:00. The team review patients who require palliative care support/symptom management or those approaching end of life, patients presenting with acute oncology emergency or cancer of unknown primary.

2.2 The palliative care team cover specialist palliative and end of life care, supported by a consultant in palliative medicine working 4 sessions each week in the Trust. The consultant also covers Rotherham hospice and community nursing as well as providing on-call support. There remains a vacant palliative care consultant post.

The nursing team consists of:

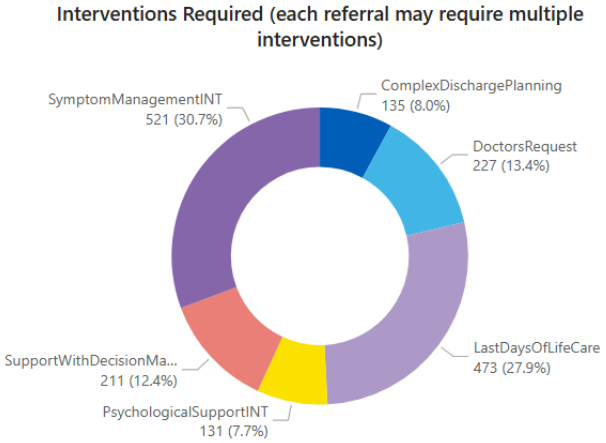
1.0 WTE lead nurse, 3.69 WTE Band 7 palliative care clinical nurse specialists (CNS) and 1.0 WTE supportive care support worker.

2.3 Between 1 April 2024 and 31 March 2025, the palliative care team had 1242 referrals. This is an increase of 14% from the previous year. Of the 1242 referrals a total number of 3028 reviews took place, 2407 patient visits, with the average time spent with the patient as 18.64 minutes per visit.

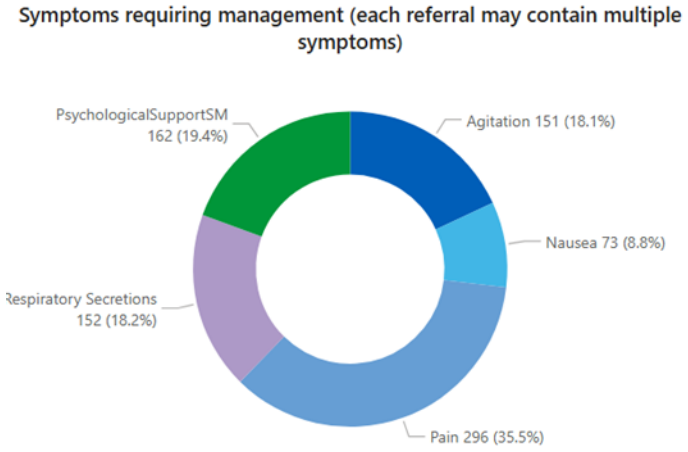
Month	Referrals
April 2024	97
May 2024	92
June 2024	66
July 2024	105
August 2024	72
September 2024	70

October 2024	132
November 2024	100
December 2024	114
January 2025	156
February 2025	106
March 2025	132
Total	**1242**

2.4 Themes from the referrals over 2024/5 are below. The highest reason for referral for support with symptom management, followed by support for patients at the end of life.



2.5 Further analysis on the type of symptom management has shown that pain management, followed by psychological support are the main reasons for referral. Many patients have multiple reasons for referral so the team may be supporting many different problems.



3. Individualised Last Days of Life Care Plan

3.1 The Last Days of Life Care Plan was implemented at Rotherham in March 2022. The plan itself is a comprehensive document which not only records care delivery and decisions taken but also notes conversations with patients and their families so that their needs are taken into account.

3.2 During 2024/5, an average of 59.7% of patients were given tailored care through the Individualised Last Days of Life Care Plan. This is against a national average of 75%.

Month	Deaths	Patients on individualised plan of care last days of life	Percentage
April 2024	81	54	66.7%
May 2024	77	53	68.8%
June 2024	61	37	60.7%
July 2024	74	46	62.2%
August 2024	64	32	50.0%
September 2024	54	26	48.1%
October 2024	75	47	62.7%
November 2024	69	41	59.4%
December 2024	99	57	57.6%
January 2025	111	73	65.8%
February 2025	77	43	55.8%
March 2025	92	49	53.3%
TOTAL	**934**	**558**	**59.7%**

3.3 Acknowledging there may always be patients who suddenly deteriorate while in hospital, there remains work to do to meet the expected 75% of all patients on the Last Days of Life Care Plan. This metric is now build into ward/exemplar accreditation.

4. National Audit of Care at the End of Life (NACEL)

4.1 The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person (18+) and those important to them during the last admission leading to death. The audit monitors progress against the five priorities for care set out in One Chance to Get It Right, 2014 and NICE Guideline (NG31) and Quality Standards (QS13 and QS144).

4.2 NACEL now includes continuous case note audits, family bereavement surveys and staff questionnaires. During 2024/5, 140 case notes were reviewed (appendix one). 524 family surveys were sent out with 88 responses received (appendix two).

2024-2025	The Rotherham NHS Foundation Trust				Nacel Family Survey Data	
Month	Number of elegible deaths	Number Sent	Email	Letter	Completed surveys Recieved	Comments
Apr-24	58	54		54		*1 patient opted out & 3 no address of NoK
May-24	64	56		56		
Jun-24	42	38		38		
Jul-24	54	47		47		1* patient opted out
Aug-24	46	41		41		3 opted out & 2 no address for NOK
Sep-24	46	43		43		3 patient opted out
Oct-24	65	65		65	88	
Nov-24	45	37		15		Return date of questionnaire was 31st December so no more sent out
Dec-24	52	0		0		Return date of questionnaire was 31st December so no more sent out
Jan-25	111	95		95		*2 patients opted out/14 no address/NoK
Feb-25	77	48		48		** 9 patients opted out/13 no address/Nok/7 still to send
Mar-25	76					surveys sent a month after death so no data as yet
Total	736	524		502		

4.3 Early analysis from NACEL supported the quality improvement work in 2024/5 which included the conversations around Dying Matters, faith deaths, rapid discharge and the memory boxes. There remains more work to do for clinicians to have open conversations with patients and those important to them when a patient is dying.

5. Dying Matters Week

5.1 Every year, people around the country use Dying Matters Awareness Week as a moment to encourage communities to get talking in whatever way, shape or form works for them. This year's theme, 'The way we talk about Dying Matters', focuses on the language that we use, and conversations we have, around death and dying – specifically between healthcare professionals and patients, and those important to them.

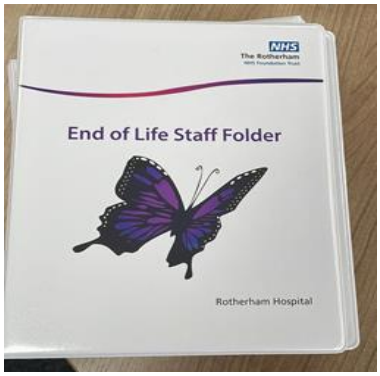
5.2 The palliative care team, worked with Rotherham hospice and NHS Blood and Transplant specialist nurse to develop a roadshow to take to the different areas across the Trust, including wards, departments and breathing space.

5.3 A new purple post box called 'Letters to Loved' ones was made and is now in a permanent position in the hospital chapel. Bereaved families can write a letter with things they never got to say and post this to the purple post box to support bereavement.

5.4 The Wind Phone is an unconnected phone where loved ones can hold one-way conversations with loved ones who have died. The team have made a Wind Phone and after the dying matters road show – have set this up in a permanent position in the hospital chapel.

5.5 The Bereavement Book, given to all bereaved families after the death of a patient has been re-written. This now includes more information on bereavement support and signposting for families who may wish to return to the bereavement book after the initial practical steps have been taken.

5.6 A new staff guide to care at the end of life has also been written to help guide staff on the role of healthcare staff, not just leading up to the death of a patient but to include the physical care given by healthcare staff following death in all care settings (previously known as last offices). The new terminology of care after death is intended to reflect the on-going support we should be offering to families and carers.



5.6.1 The Memory Boxes rolled out across the whole hospital site in October 2024. These include:

Battery operated Candle: This is to be placed on the nurse's station and to be turned on if and when a patient passes away on the ward.

Butterfly symbol: The use of the butterfly symbol to be placed on curtains if a patient is receiving end of life care again as a symbol of respect and so staff can be respectful to noise and conversations.

Doppler: The use of a non-medical doppler that relative can use to record their loved ones heartbeat prior to death so they have got a lasting memory.

Memory Boxes: These are a way to make lasting memories for loved ones. There are opportunities for finger, hand or lip prints to be taken, an angel, a small pot if a lock of hair is wanted, a small candle, forget me not seeds that can be planted as a lasting memory and reminding the person who is left behind that the person who has died is not forgotten. The memory boxes are for families to put in whatever they wish to build that lasting memory.

6. Education

6.1 Education on palliative and end of life care has been delivered throughout the year and the numbers are below:

Course Title	Staff Group	Number Trained
Healthcare support workers induction	Health Care Support workers	42
Person Centred Care days	Multi-professional Teams	97
Preceptorship	Registered Nurses	38
End of Life Care Plan	Registered Nurses/Health Care Support workers.	36
Shadowing	All staff	40
Ward Champions	Ward staff	16
Nacel presentation	PGME All staff	37

7. Faith Deaths Qi Event

7.1 Following feedback on some negative experiences of people with Muslim faith, particularly out of hours, a Qi event was held on 16 August 2024. The event was opened by the Deputy Chief Executive and key stake holders invited. These included representatives from our Muslim community, Coroner's office, registrars, medical examiner, mortuary staff as well as ward teams and matrons, with the help and support from the Quality Improvement team.

7.2 The mapping event has identified areas of improvement and therefore there will be four further work streams needed. These should take into account the medical examiner office function and streamline all of the services involved in the delivery of care after death.

7.3 The four main themes from this event were information, process, education and communication. These will be progressed over the next six months to ensure changes are embedded.

8. New Web Page

8.1 To support delivery of the Trust strategy, a new web page has been developed, in consultation with the palliative care team and engagement and improvement lead. This is aimed at helping patients and families and gives some honest and compassionate advice on what to expect.
https://www.therotherhamft.nhs.uk/services/palliative-care

The sub headings are:

- Keeping you informed
- Visiting
- Purple butterfly rooms
- Can they go home
- Comfort, care and changes to medications
- Changes that might occur in the last days and hours of life
- Spiritual and pastoral care
- Meeting the needs of children
- Memory boxes
- Organ and tissue donation
- What to do if someone dies

9. Partnership working with NHS Blood and Transplant (NHSBT)

9.1 The Palliative Care Team have made **58 referrals to NHSBT** this year with eight pairs of corneas successfully retrieved. The breakdown of number of patients screened and referred by the Palliative care team referred and accepted is below;

9.2 A further 3 pairs of corneas were retrieved from donors at TRFT. Two were referred by the specialist nurse for organ donation and one referred by UECC.

2024-2025 The Rotherham NHS Foundation Trust				
Month	**Screened**	**Referred**	**accepted**	**Time spent mins**
Apr-24	15	7	3	570
May-24	8	2	0	115
Jun-24	18	3	0	245
Jul-24	19	9	1	330
Aug-24	22	6	2	285
Sep-24	8	2	1	105
Oct-24	21	2	0	255
Nov-24	27	11	0	855
Dec-24	21	2	0	340
Jan-25	17	8	0	540
Feb-25	10	3	2	265
Mar-25	11	2	0	170
Total	197	57	9	4075

9.3 In recognition of the exceptional work undertaken by the palliative care team, the lead nurse for Yorkshire organ donation service has awarded the team with a certificate of recognition. This is to recognise the excellent partnership working between the Trust and NHSBT.

10. End of Life Care (EoLC) Butterfly Volunteers

10.1 The EoLC) Butterfly Volunteer helps to enhance the experience of patients identified as being in the last days of life by being with them in the absence of visitors or when those important to the patient need additional help, support or a short break. The EoLC Butterfly volunteers also help to re-stock valuable items for the Purple Butterfly rooms. Volunteers attend a 1-day training session (led by the EoLC Team along with other key clinical colleagues from the Trust), before joining the scheme.

10.2 The activity from the Trust EoLC Butterfly volunteers is below:

2024-2025	The Rotherham NHS Foundation Trust					
	Number of Active Volunteers	Hours by the Bedside	Number of Patients Visited (First Visit)	Return Visits	Number of Visitors Supported	Total Visits
Apr-24	2	6	13	2	15	15
May-24	2	11	14	3	19	17
Jun-24	2	7	8	2	12	10
Jul-24	2	6	11	2	11	12
Aug-24	2	11	20	0	31	20
Sep-24	2	8	14	0	10	14
Oct-24	2	9	14	0	12	14
Nov-24	2	9	11	3	14	14
Dec-24	2	6	6	0	7	6
Jan-25	2	9	14	2	16	16
Feb-25	3	11	17	4	24	21
Mar-25	3	7	10	6	23	16
Total	N/A	**76**	**117**	**17**	**148**	**133**

11. Fuller Report

11.1 The Fuller Report (phase one) on matters relating to David Fullers actions at Maidstone and Tunbridge Wells NHS Trust was published in November 2023 with the phase two interim report published in October 2024. Phase 2 of the Inquiry looked at the broader national picture and considered if procedures and practices in other hospital and non-hospital settings, where deceased people are kept, safeguard the security and dignity of the deceased.

11.2 The Histopathology Discipline Lead for South Yorkshire and Bassetlaw Pathology provided an assurance report, received in August 2024 which contained the 17 recommendations from the phase one report. These were noted at the end of life quality governance group in September and Mortality / learning from deaths group in October 2024.

11.3 The recommendations include compliance with Trust policy on criminal record checks and re-checks for staff, which is to also include sub-contractors. The Chief Nurse has explicit responsibility for assuring the Board that mortuary management is delivered in a way that protects security and dignity of the deceased.

12. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

12.1 ReSPECT was introduced across Rotherham on 1 October 2023, with the aim of providing patients and clinicians an opportunity to proactively discuss options for care in an emergency situation (e.g. supporting admission avoidance or directing clinical responders towards preferred interventions). A ReSPECT audit was performed over 2 days with inpatient notes reviewed and shared at the Patent Experience Committee in November.

12.2 Although there has been fantastic progress in Rotherham across Acute, Primary and Community Care, there is more to be done. From the audit (in the hospital) too many ReSPECT forms are still being used a DNACPR rather than emergency care planning

documents. On some occasions, capacity assessments are not completed and there is inadequate next of kin information.

13. Policies in relation to End of Life Care

13.1 A full review of all policies and SOP relation to end of life care has taken place and new policies are being written from scratch.

Approved Policies

- Guidance for staff responsible for care after death (last offices)
- End of Life guidance for management in the last hours and days of life
- Verification of expected death

13.2 Further policies under development are:

- Syringe Drivers
- Rapid discharge for patients at the end of life

14. Risks in relation to End of Life Care

14.1 There are two current risks in relation to End of Life Care in a search performed by the corporate governance office

ID	Handler	Title	Care Group / Division	CSU/OSU	Risk Type	Risk level (current)	Approval status	Review date	Date REVIEWED
Corporate Services									
5022	Rod Kersh	DNACPR - failure to engage with national standards of care	Corporate Services	Corporate Functions	Quality – Patient Safety (including complaints and claims) (Risk Appetite)	Moderate 8	Approved Risk	06/01/2025	03/10/2024
7184	Ian Watson	Systems still running on old Core network	Corporate Services	Corporate Functions		Moderate 8	Risk undergoing refinement / additional analysis	31/10/2024	22/08/2024

15. NICE guidance in relation of End of Life Care

15.1 A review of all NICE guidance related to end of life care has taken place and was presented to the Patient Experience Committee in full. The main guidance NG142 was last reviewed in 2017 and a full review to achieve partial compliance now taken place. This work will continue to achieve full compliance by 2025.

a. Further work took place to link in with Children and young person's Lead Nurse to ensure we are fully compliant with NG213, NG96 and QS160

NICE Guidance:	Publication Date	Title	Implementation Status	Progress Comments
NG61	01-07-19	End of life care for infants, children and young people with life-limiting conditions: planning and management (December 2016)	Fully Achieved	Children and Young People's Advance Care Plans (CYPACP) launched in the Trust to support NG61 & QS160. ACTION: Await confirmation of implementation status as Fully Achieved. Confirmation required by Supportive Care Lead Nurse CYPS if the local SOP has been agreed and is now in place (CYPs).
QS160	01-09-17	End of life care for infants, children and young people with life-limiting conditions: planning and management	Partially Achieved - Accepted	24/7 palliative support is currently not offered in our region and local hospice services are limited due to funding constraints. ACTION: Confirmation required by Supportive Care Lead Nurse CYPS if this has been risk assessed and approved through the Governance infrastructure. Risk ID required.
NG142	01-10-19	End of life care for adults: service delivery	Partially Achieved – Improvement Needed	Re-reviewed by the Lead Nurse (Supportive Care Team) for a Trust wide overview of implementation Oct 24 – status changed from Fully Achieved to Partially Achieved Improvement Needed. Await ratification of the EoLC Policy Dec 24. Actions to be entered into the AMaT.
QS13	02-09-21	End of life care for adults	Fully Achieved	The Baseline Assessment Tool is currently being completed by the Lead Nurse (Supportive Care Team) for a Trust wide overview of implementation. Previous BATs completed by specialties in 2022 following the guidance publication.
NG213	09-03-22 (revised 13-01-23)	Disabled children and young people up to 25 with severe complex needs: integrated service delivery and organisation across health, social care and education	Partially Achieved – Improvement Needed	Recommendation 1.9: End of life care 1.9.2 EOLC - request a review of the education, health and care (EHC) plan (if they have one). We are not currently able to lead on making an end of life plan of care. (see comment for no. 1.9.8 below) 1.9.8. - 1.9.9 'Interagency teams should arrange regular joint reviews of EOLC' is currently a gap re. medical end of life plans because of the closure of Bluebell Wood hospice. To embed advance Care plans ?RESPECT for all children with CCN and review EOLC ACTION: Supportive Care Lead Nurse for CYPS to risk assess non-compliance with implementation, register on datix and gain Governance approval.
NG96	11-04-18	Care and support of people growing older with learning disabilities	Fully Achieved	Reviewed in 2018. Currently being reviewed by the Lead Nurse (Supportive Care Team) for a Trust wide overview of implementation for Recommendation 1.6: End of life care.
NG150	01-01-20	Supporting adult carers	Fully Achieved	Reviewed in 2020. Currently being reviewed by the Lead Nurse (Supportive Care Team) for a Trust wide overview of implementation for Recommendation 1.9: End of life care.
NG42	23-07-19	Motor neurone disease: assessment and management	Fully Achieved	Reviewed by Stroke and Neurorehab Nov 23. Currently being reviewed by the Lead Nurse (Supportive Care Team) for a Trust wide overview of implementation for Recommendation 1.7: End of life care.
NG31	16-12-15	Care of dying adults in the last days of life	Fully Achieved	The Baseline Assessment Tool is currently being completed by the Lead Nurse (Supportive Care Team) for a Trust wide overview of implementation. Previous BATs completed by specialties in 2016 following the guidance publication.
QS144	**01-03-17**	**Care of dying adults in the last days of life**	Fully Achieved	Baseline Assessment Tools are currently being completed by the Lead Nurse (Supportive Care Team) for a Trust wide overview of implementation. Previous BATs completed by specialties in 2017 following the guidance publication.

16. Trust Strategy in Palliative and End of Life Care

16.1 The Trust published its Strategy on Palliative and End of Life Care in 2023. This was based around the publication of the national ambitions for palliative and end of life care. The achievable objectives are now complete with work moving on from the changes to NACEL to form an annual improvement plan through the Patient Experience Committee.

17. Conclusion

17.1 There has been a significant amount of work undertaken by the lead nurse for the supportive care team since January 2024. This has included leading Dying Matters Week, re-writing the

new Bereavement Book, writing the Staff Guide to End of Life Care, introducing Letters to Loved ones, the Wind Phone and writing the charitable funds bid for the Trust wide roll out of the memory boxes. The lead nurse has also put together all the components for the memory boxes in her own time to ensure all out patients can receive this deeply personal touch.

17.2 A Qi event for faith deaths has also been undertaken to identify gaps for improvement in different faith groups. The main theme being early referral to the chaplaincy team to support the clinicians.

17.3 Improvements have been noted in NACEL since the revised audit launched on 1 January 2024. This is encouraging and has enabled a more focused improvement plan for next year.

17.4 The next step to improve care for patients is to launch the initiative ‘Taste For Pleasure’ This means that when a person can no longer eat or drink in the last days of life, we give them regular mouth care to make sure that their mouth is clean, moist and feels as comfortable as possible. Providing mouth care with patients favorite flavours, for example, fruit juice, tea, chocolate mousse, custard or even alcohol can also give them ‘taste for pleasure’.

17.5 The Role Specific Training for 2025/6 is being reviewed to focus on end of life care (starting with the least year of life). This will include oncology emergencies, managing people with Dementia at the end of life, managing people with Learning Disability at the end of life, breaking bad news, ReSPECT and Organ and Tissue donation.

17.6 Work is ongoing to achieve compliance across all NICE guidance relating to end of life care.

Board of Directors' Meeting
4 July 2025

The Rotherham NHS Foundation Trust

Agenda item	P/109/25
Report	**Quality Strategy 2025 - 2027**
Executive Lead	Helen Dobson, Chief Nurse 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 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	The strategy demonstrates ambition to improve the quality and safety of care. It is an inclusive strategy that is applicable to all trust employees.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This ambitious Quality Strategy sets out our vision, priorities and approach to continuously improving the services we provide across both acute and community settings. Rooted in the principles of person centred care, clinical excellence and collaboration, this strategy reflects the voices of our patients, staff and partners. It is our roadmap to ensuring that every individual we care for experiences outstanding healthcare, every time. The strategy includes 7 key aims and identifies objectives to achieve these with associated timescales and measures of success. Once approved, the strategy will be implemented within all Care Groups and Corporate Teams, utilising the framework of the underpinning operational plans. Achievement of objectives will be monitored through the appropriate committees reporting into the Quality Committee. A six monthly report on progress delivering the strategy will be presented to the Board of Directors.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This strategy has been discussed at various stages with a wide range of staff groups including Senior Leaders, Executive Team, Quality Committee and Board of Directors. The strategy was recommended for approval to the Board of Directors by the Quality Committee on 25th June, subject to some minor amendments what have now been incorporated.
Board powers to make this decision	The Board has the authority to approve the Quality Strategy
Who, What and When (what action is required, who is the lead and when should it be completed?)	Once approved, the Chief Nurse and Medical Director will lead on delivery of the strategy with oversight from the Quality Committee.
Recommendations	It is recommended that Trust Board approve this strategy.

TRFT Quality Strategy 2025-2027

Introduction

At The Rotherham NHS Foundation Trust, our unwavering commitment to delivering high quality, safe and compassionate care underpins everything we do. This ambitious Quality Strategy sets out our vision, priorities and approach to continuously improving the services we provide across both acute and community settings. Rooted in the principles of person centred care, clinical excellence and collaboration, this strategy reflects the voices of our patients, staff and partners. It is our roadmap to ensuring that every individual we care for experiences outstanding healthcare, with optimal outcomes, every time.

Patient safety is the cornerstone of quality care. We are committed to fostering a culture where safety is everyone's responsibility—from board to bedside. Through robust clinical governance, continuous learning, and transparent reporting, we will minimise avoidable harm and strengthen our systems of care. We will support our workforce to speak up, learn from incidents, and drive improvements, ensuring our patients receive care that is consistently safe, evidence-based, and reliable.

We believe that excellent care is not only clinically effective but also deeply compassionate and responsive to individual needs. Listening to patients, carers, and families helps us to shape services that are respectful, inclusive, and personalised. Through active engagement and co-production, we will embed the voices of those we serve at every level of our organisation. Our aim is to ensure that every patient feels heard, valued, and treated with dignity throughout their care journey.

Addressing health inequalities is a moral and strategic priority. We recognise that too many people face barriers to accessing care or experience poorer outcomes due to social, economic, or demographic factors. We will use data and insight to identify gaps, target interventions, and ensure our services are equitable and inclusive. By working in partnership with communities and local stakeholders, we will strive to eliminate disparities and improve outcomes for all—especially for those who need us most.

Strategic Ambitions

The Rotherham NHS Foundation Trust has an established set of ambitions – PROUD. The Quality Strategy embraces and builds upon these ambitions.

Patients

We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them.

Rotherham

We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve.

Our partners

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

Us

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

Delivery

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

Link to Trust Strategies and Enablers

The Quality Strategy is one of six key strategies that underpin the Trust's vision and ambition:

The strategy also supports delivery of the Operational plan that is agreed by the Board of Directors each year. The 2025/26 plan is shown below.

There are a number of existing improvement plans that will support delivery of the Quality Strategy. These enablers sit within the three domains of patient safety, experience of care and clinical effectiveness, with continuous, quality improvement underpinning practice in each domain.

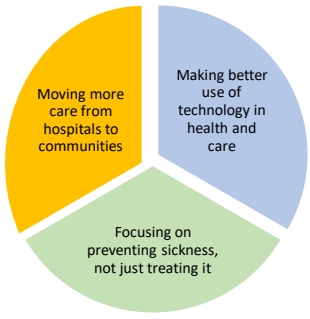
Each of these enablers has a key document to influence care delivery; the Patient Safety Incident Response Plan, the Experience of Care Annual Improvement Plan and the Clinical Effectiveness Strategy. Multiple other enablers exist within each domain as shown in the table with Health Inequalities a consistent theme across all three.

Patient Safety	Patient Experience	Clinical Effectiveness
Patient safety incident response plan	**Experience of Care annual improvement plan**	**Clinical effectiveness strategy**
Medication safety improvement plan	End of life care	NICE guidance
Learning from deaths	Engagement and inclusion	GIRFT
Safeguarding	Nutrition and Hydration	National clinical audits
Infection Control		National confidential enquiries
Health Inequalities		

National and Local Drivers

The Quality Strategy aligns closely with national drivers and key policy documents, including the NHS Long Term Plan (2019), which emphasises integrated care, population health, and reducing health inequalities. The strategy supports the ambitions of the Health and Care Act (2022) by promoting collaboration across sectors to deliver joined-up, person centred care. It also reflects the Core20PLUS5 approach to narrowing health inequalities and aligns with the Care Quality Commission's single assessment framework, focusing on safety, effectiveness, responsiveness, and patient experience across care settings. Furthermore, the strategy complements the principles of the NHS Patient Safety Strategy and the People Plan by fostering a culture of continuous improvement, staff well-being, and system-wide learning to enhance care quality across both acute and community services.

The NHS 10 year plan, expected in the summer of 2025, is anticipated to focus on three themes as shown in the diagram. The strategy has been designed to support delivery of these principles.



Objectives & Scope of the Quality Strategy

This Quality Strategy applies to all individuals and teams across our integrated acute and community services. It encompasses everyone working within the Trust—clinical and non-clinical staff, from hospital wards to community clinics, frontline services to corporate functions. It also extends to our partners across the wider health and care system whose collaboration is essential to delivering joined-up, person centred care.

Importantly, the strategy is centred on the people who use our services—patients, carers, families, and communities. Their experiences, needs, and outcomes are the driving force behind our quality ambitions. By working together across settings and roles, we will deliver safe, effective, and equitable care that meets the diverse needs of our population.

The key aims of the Quality Strategy are to:

- **Deliver consistently safe, effective and timely care by embedding robust clinical governance, learning from incidents, and applying evidence-based practice.**
- **Empower and support our workforce to lead quality improvement, speak up for safety, and foster a culture of continuous learning and accountability.**
- **Improve experience of care through personalised, compassionate care that reflects the needs, values, and voices of patients, carers, and families.**
- **Reduce health inequalities by identifying and addressing disparities in access, outcomes, and experience, with a focus on underserved communities.**
- **Strengthen integration and collaboration across acute, community, primary care, and partner organisations to ensure seamless, coordinated care.**
- **Use data, insight, and innovation to drive decision-making, monitor impact, and continuously improve the quality and equity of our services.**
- **Promote sustainability and resilience by aligning quality with long-term system goals, resource stewardship, and population health priorities.**

Strategic Aims & Measures of Success

Aim 1

Deliver consistently safe, effective and timely care by embedding robust clinical governance, learning from incidents, and applying evidence-based practice.

Timeline for completion: March 2027

What we will do:

- Deliver care in accordance with identified best practice (e.g. Patient Safety Incident Response Plan, Medication Safety Improvement Plan)
- Comply with national audits including the NCAPOPs (national clinical audit programme and clinical outcome review programme) and NCEPOD (national confidential enquiry into patient outcome and death) and recommendations from these national programmes.
- Comply with national and local safety standards (e.g. NatSSIPS 2 (national safety standards for invasive procedures), sepsis screening, NEWS2)
- Monitor performance and outcomes through appropriate governance processes and act upon variations from desired outcomes
- Reduce avoidable harm events (e.g. falls, pressure ulcers, medication errors)

Measure of Success:

- Improvements in key clinical outcomes (e.g. hospital acquired infection rates, readmission rates, mortality indicators (SHMI)).
- Reduction in the number of incidents where there were opportunities for improvement
- Increased proportion of Patient Safety Incident Investigations (PSII) or After Action Reviews (AAR) with completed learning action plans and evidence of change.
- Staff survey results showing improvements in perception of standards of care

Aim 2

Empower and support our workforce to lead quality improvement, speak up for safety, and foster a culture of continuous learning and accountability.

Timeline for completion: March 2027

What we will do:

- Continue to deliver the Quality Improvement Strategy (2024-2028) including delivery of Qi training
- Deliver the Freedom to Speak Up (FTSU) Strategy and increase the number of FTSU champions across all areas of the Trust
- Increase use of research and innovation to support delivery of evidence based practice
- Recruit to Patient Safety Partner roles and embed into incident review process

Measure of Success:

- Staff survey results showing improvements in safety culture, morale, and engagement.
- Staff involvement in quality improvement projects (e.g. number trained in Qi, number of Qi initiatives led by staff).
- Able to demonstrate a skilled workforce with advanced leadership skills in clinical areas
- Uptake of training in areas such as human factors, speaking up, and clinical leadership.

Aim 3

Improve Experience of Care through personalised, compassionate care that reflects the needs, values, and voices of patients, carers, and families.

Timeline for completion: December 2026

What we will do:

- Develop and deliver an annual Experience of Care Improvement Plan in response to the feedback from national patient surveys and the Experience of Care Framework
- Consider the needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities, taking into account their priorities, preference and wishes
- Develop and deliver a Trust Nutrition and Hydration plan
- Continue to strengthen our commitment to carers, giving the recognition and support they need, while engaging with community groups to support widespread co-production of experience of care in quality improvement.
- Deliver the cancer patient experience improvement programme
- Engage with patients and service users through a range of processes to ensure their voices are heard

Ensure cultural considerations are embedded in all aspects of education and development across the Trust.

Measure of Success:

- Positive feedback scores from surveys (e.g. Friends and Family Test, CQC inpatient/UECC/Children's/Maternity surveys).
- Reduction in complaints and increased resolution of concerns through PALS
- Improved position in the National Audit of Care at the End of Life (NACEL)
- Development and delivery of the Nutrition and Hydration plan and all key milestones met
- Patient and carer involvement in Quality improvement across the Trust
- Positive results in the annual cancer patient experience survey
- Increased number of engagement events with a broad spectrum of representation to reflect the community we serve

Aim 4

Reduce health inequalities by identifying and addressing disparities in access, outcomes, and experience, with a focus on underserved communities.

Timeline for completion: March 2027

What we will do:

- Complete the NHSP Health Inequalities self-assessment and develop a workplan to address gaps
- Roll out our Making Every Contact Count (MECC)+ training programme
- Reduce missed appointments for the most vulnerable groups
- Signpost and support more elective pathway patients into waiting well services (physical activity, smoking cessation, weight management, etc) at the point of being added to the waiting list

Measure of Success:

- Equity audits identify narrowing gaps in outcomes (e.g. by ethnicity, deprivation, geography).
- Progress against NHS England's Core20PLUS5 indicators (e.g. smoking reduction at time of delivery, early cancer diagnosis).
- Culturally appropriate and accessible service materials and outreach programmes in place.

Aim 5

Strengthen integration and collaboration across acute, community, primary care, and partner organisations to ensure seamless, coordinated care.

Timeline for completion: March 2027

What we will do:

- Develop plans to apply for Teaching Hospital status
- Increase jointly delivered care pathways / shared care plans across services/sectors
- Develop joint quality improvement initiatives with system partners (e.g. Acute Federation, ICS, Social Care).
- Continue to develop and expand Virtual Ward capabilities

Measure of Success:

- Successful achievement of Teaching Hospital status
- Improved patient-reported experience of coordinated care, especially at transition points (e.g. discharge from hospital to community).
- Shared data usage and interoperability between systems to support continuity of care.

Aim 6
Use data, insight, and innovation to drive decision-making, monitor impact, and continuously improve the quality and equity of our services.

Timeline for completion: March 2027

What we will do:

- Continue to develop Exemplar Accreditation Programme to include a greater number of clinical areas with clear evidence of actions planned to support improvement
- Continue to implement digital tools that support care quality and efficiency (e.g. remote monitoring, AI enhanced functions)
- Provide regular quality reporting with clear actions and feedback loops from data to frontline teams, board and external partners

Measure of Success:

- Real-time quality dashboards in place and used at board and clinical levels.
- Exemplar Accreditation embedded in all clinical areas with evidence of improvement demonstrated and reported to Board level
- Improved metrics in relation to quality elements of benchmark data when compared to peer organisations (e.g. Model Hospital data)

Aim 7
Promote sustainability and resilience by aligning quality with long-term system goals, resource stewardship, and population health priorities.

Timeline for completion: March 2027

What we will do:

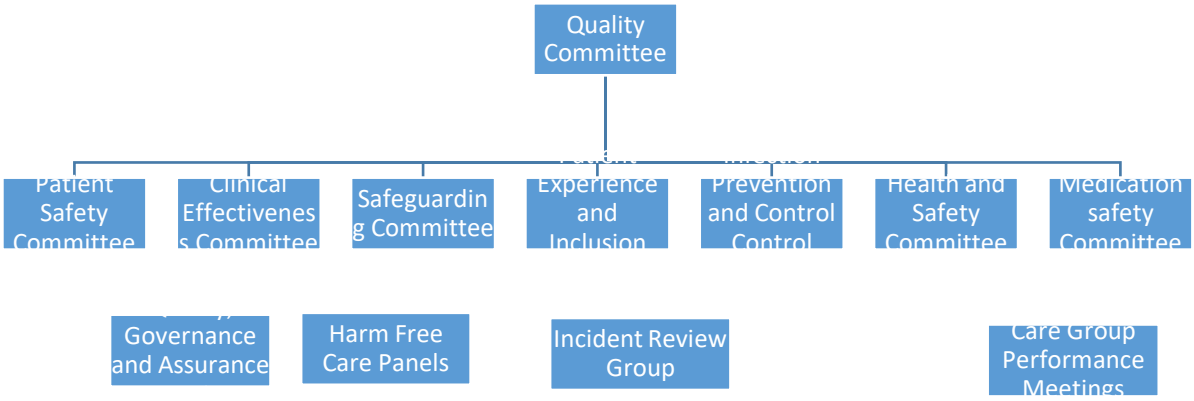
- Deliver care in the right place, at the right time by the right staff
- Reduce waits and harmful delays in care
- Deliver quality improvements that also contribute to sustainability (e.g. reductions in waste, improved patient flow)
- Reduce variation in service quality across sites and teams
- Increase the number of volunteers by 25%

Measure of Success:

- Improved performance metrics compared to baseline 2024/25 position and national benchmarks (e.g. 4 hour access standard, 18 week waits, DM01)
- Resilience assessments completed and acted upon (e.g. winter planning, continuity plans)
- Quality strategy objectives embedded in business and workforce planning
- Increased numbers of volunteers from diverse backgrounds

Governance, Accountability and Delivery

Delivery of the Quality Strategy will be monitored by the Quality Committee, on behalf of the Board of Directors. Performance monitoring against individual aims will be devolved to the appropriate committee as shown on the structure below. The Executive Leads for delivering this strategy are the Chief Nurse and the Medical Director. A six monthly report on progress will be presented to the Board of Directors



Board of Directors
4th July 2025

Agenda item	P110/25
Report	Workforce Plan 2025-2028
Executive Lead	Daniel Hartley – Director of People
Link with the BAF	This item supports and enables all areas of the BAF
Purpose	Decision [ ] To Note [ ] For Approval [✓] For Information [ ]
Executive Summary (including reason for the report, background, key issues and risks)	The current Trust 5 year Workforce Plan ran from ran from 2019 to 2024 and work has been taking place in recent months to develop a new workforce plan to replace it. The period of the plan has seen significant improvements delivered across the Trust in terms of filling the establishment, improving retention and reducing agency spend. It is also true that in 2025 the environment the Trust operates in is significantly different and one that contains many challenges as well as opportunities. The development of the plan has seen engagement with care groups and professional leads, corporate teams and through discussions at People and Culture committee and a Board strategy session. The purpose of the plan is to set out how we will build and develop our workforce to underpin our quality, people and culture, financial sustainability and access to care objectives for patients. In doing so our focus will be on ensuring we have the right number of people with the right values and skills, working together at the right time, place and cost to deliver excellent healthcare for the people of Rotherham. As well as setting out the 'what' this plan also sets out the 'how' we will do workforce planning in a bottom up, service specific way via a new approach, trilled in UECC. Oversight of the delivery of this plan will be through the Executive Team, People and Culture Committee and ultimately the Board of Directors.
Recommendations	The Board of Directors are asked to; • Approve the Workforce Plan 2025-2028 and agree to receive an annual update against progress over the life of the plan
Appendices	TRFT Workforce Plan 2025-2028

The Rotherham NHS Foundation Trust

The Rotherham NHS Foundation Trust

Workforce Plan 2025 – 2028

'The right number of people with the right values and skills, working together at the right time, place and cost to deliver excellent healthcare for the people of Rotherham'

Ambitious Caring Together

Contents

Welcome

1. Introduction 3

Progress made and new operating context

2. Recap from 2019-2024 workforce plan 4
3. Trust workforce profile in 2025 5
4. National, ICB and Rotherham place context 6
5. Rotherham 7
6. Labour market trends and context 8
7. Professional pipelines and developments 9

Workforce Planning as a key enabler of delivering excellent healthcare

8. Different lenses for workforce planning 10
9. Trust objectives to deliver excellent healthcare for patients 11
10. Multi-year financial plan 13
11. Digital Innovations 14
12. Developing workforce planning at TRFT 15
13. Anchor role and skills 16

Action Plan

14. Priority action areas - Years 1/2/3 17

Appendix

A. Workforce profile 19
B. Services provided by TRFT 21

1. Welcome and introduction

Welcome to the new **Workforce Plan 2025–2028**, a key enabler of our overall Trust strategy, Our Journey to Excellence. The purpose of this plan is to set out how we will build and develop our workforce to underpin our quality, people and culture, financial sustainability and access to care objectives for patients.

The plan has been developed through engagement with care groups, professional leads, corporate teams and through discussions at People and Culture Committee and Trust Board of Directors. It builds on many significant achievements over the life of the previous workforce plan whilst recognising the changed context in 2025 and areas of challenge as well as opportunity.

Effective workforce planning is vital to enabling the Trust to build and sustain the workforce needed to meet the evolving needs of patients. This plan considers the national, system and local context as well as broader themes on labour market trends, professions and services as well as our role as an anchor institution in Rotherham.

Over the next three years, our focus will be on ensuring we have the **right number of people with the right values and skills, working together at the right time, place and cost to deliver excellent healthcare for the people of Rotherham**.

In doing this we will be guided by our ACT values of **Ambitious, Caring and Together**. This plan should be considered in conjunction with our Integrated Equality, Diversity and Inclusion Plan, which together support our People and Culture strategy.

In addition to specific Trust wide approaches, this workforce plan also sets out ‘how’ we will do workforce planning in a bottom up, service specific way via a new approach. It is through both ‘top down’ and ‘bottom up’ approaches and delivering the actions set out here that we will build and develop the right workforce over the next few years. Oversight of the delivery of this plan will be through the Executive Team and People and Culture committee, and ultimately the Board of Directors.

Thank you to colleagues who have contributed to shaping this plan.

Dr Richard Jenkins
Chief Executive

2. Recap of 2019-2024 Workforce Plan

The purpose of the 2019-2024 Workforce Plan was to;

Develop, consider and deliver a workforce capable of delivering new and efficient models of care by covering the permanent and temporary workforce and providing for the right staff with the right skills in the right time and right place.

It was designed to mitigate against the impact of professional skills shortages and high levels of staff turnover, reducing the need for agency and temporary workers to fill skills gaps and provide a more sustainable and adaptive workforce model for the future. It also covers the Covid period which had an impact on the healthcare workforce more than any other.

The Trust's 5-year Workforce Pan 2019 – 2024 aimed to address workforce challenge across all sections of the workforce (represented in the image as workforce 'pillars'), based on a foundation of improved Recruitment, Retention and Education as well as Training and Workforce Reconfiguration.

The period covered by the plan represents a success story for the Trust. Over the last 5 years the Trust's **substantive workforce grew by approximately 750 whole time equivalents (WTE**) and improved retention has seen **turnover reduce from 13% to 8.5%.** In the same period, significant cost efficiencies have been delivered through rigorous management of bank and agency expenditure. Trust expenditure on **agency staff has reduced by 78%** during the period with **bank expenditure rising 46%.** This has delivered better value for money for taxpayers.

The Trust employs over 220 WTE more nursing and midwifery staff and over 130 WTE medical and dental staff at the end of the period. A big focus on improvements to culture as well as greater engagement with colleagues saw an increase in support for staff, leading to improved retention. This growth is also a reflection of the improvements in the Trust's employer brand and ability to attract staff to a historically challenged environment.

3. Trust workforce profile in 2025

As at the end of March 2025 the Trust employs **5097 staff (4,200 WTE)** made up of a diverse range of professionals. The workforce is made up of a variety of clinical and non-clinical roles including acute and community nursing, healthcare support workers and care support workers, midwives, allied health professionals, advanced clinical practitioners, healthcare scientists, estates & facilities staff, medical & dental, pharmacy as well as corporate roles such as human resources, finance, governance, communications and administrative staff. The Trust is organised into 4 care groups and corporate teams. **Appendix A** sets out a more detailed workforce profile and includes other important workforce metrics.

Professional staff group	Headcount
Scientific and Technical	96
Clinical Services	1023
Administrative and Clerical	998
Allied Health Professionals	507
Estates and Ancillary	355
Healthcare Scientists	72
Medical and Dental	498
Registered Nursing and Midwifery	1548
Grand total	**5097**

The period of workforce growth set out above is also a result of the growing size of the organisation. Compared with 2019 the Trust treats considerably more patients, has **20% more beds**, **15% more wards** as well as **15% more staff.**

The Trust EDI plan sets out that we are committed to having a diverse workforce at all levels to deliver the best possible care to our patients, whilst ensuring equality of opportunity and tackling workforce exclusion. In terms of diversity profile, 18% of the workforce are BAME, 6% of our colleagues have a disability, and 3% of colleagues are LGBTQ+. 82% of the Trust's workforce are female, with 18% male.

The Trust EDI plan, Workforce Race Equality standard, Workforce Disability Equality stand and Gender pay gap reports set out actions to make further improvements in workforce Equality, Diversity and Improvement.

4. National, Integrated Care Board and Rotherham place context

National context

The NHS is undergoing significant changes including the planned abolition of NHS England and its integration into the Department of Health and Social Care (DHSC). The upcoming **10 Year NHS Plan** will set out how the government intends to create a modern health service designed to meet the changing needs of the population. This will be focused on the three shifts set out in the graphic all of which will play a key role in the delivery of healthcare over the medium to long term. Key success measures in respect of **public attitudes to the NHS** require a renewed focus on reducing waiting times, improving patient experience, and increased efficiency. These changes include a shift towards neighbourhood based care, increased use of digital technologies, a focus on prevention and an anticipated streamlining of performance targets.

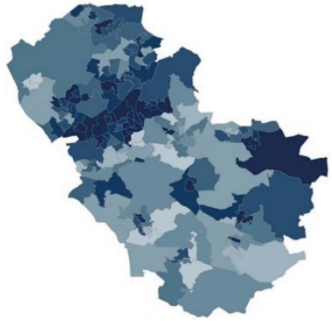
National workforce plan

The current NHS Long Term Workforce Plan outlines strategies for training, retaining, and reforming the workforce in response to the challenges posed by an aging population and existing vacancies. It aims to ensure the NHS remains sustainable for future generations. It is expected that this plan is refreshed in 2026 following the publication of the 10 year plan.

South Yorkshire ICB/ System

South Yorkshire ICB has clear ambitions to make an impact in early years; strengthening prevention and early identification; increasing economic participation and collaborating to support the whole health, care, voluntary sector and unpaid carer workforce. ICB's in England are undergoing significant changes, including a 50% reduction in running costs and a shift in focus towards strategic commissioning. ICBs will be organised around a model ICB blueprint and are likely to have a reduced role in NHS workforce planning going forward.

5. Rotherham



The health of people in Rotherham is generally poorer than the English average. People are living shorter lives than they should and are living in poorer health for longer than they should. 35% of the population of Rotherham live in the 20% most deprived communities of England. Inequalities in access to the wide range of determinants (and protective factors) of health have led to inequalities in health outcomes. The Rotherham place partnership focusses on a range of areas to make a difference to these measures.

What we know about our population:

- Rotherham ranks as the 35th most deprived upper tier local authority in England out of a total of 151 upper-tier authorities
- No neighbourhoods in Rotherham are in the least deprived 10%
- People in the most deprived areas spend around a third of their lives in poor health, twice the proportion spent by those in the least deprived areas

Rotherham Economic Activity:	Health Behaviours and Disease Prevention:
• Economic inactivity is a big problem for the borough, with over 44,000 economically inactive residents, 1 in 3 of the working population, as of September 2024. • In 2023 (Jan-Dec) there were 18,100 workless households in Rotherham, which equates to 22.8% of households. • Of the 44,100 residents (aged 16-64) who were economically inactive, 6,100 (13.9%) wanted a job and 38,000 (86.1%) did not want a job (Oct 2023-Sept 2024). • In January 2025, Rotherham's JSA/UC claimant count (as a proportion of residents aged 16-64) was 4.4%. Although this is lower than the count in January 2021 (6.9%), it has still not returned to the pre-Covid level of 3.6% seen in January 2020. ***Source: JSNA: Socio-Economic – Rotherham Data Hub***	Rotherham has a high prevalence of behaviours likely to cause harm. But many of the risk factors associated with the main diseases are modifiable and we can have impact on these early deaths by focussing on our role in prevention within the workforce and wider population. • 16.9% of the Rotherham population smoke • 68.3% of Rotherham residents are overweight or obese • Deaths from drug misuse in Rotherham, 2018-20, were 6.4 per 100,000 compared to the England rate of 5.0 per 100,000. • 69% of residents in Rotherham indicated they used natural environment for health and exercise purposes compared to 82% for England (2017). ***Source: Rotherham Place Plan 2023/25***

6. Labour Market Trends and Context

Theme	Details
National and Regional Pressures	• NHS vacancy rates remain high—averaging 10% across the sector, especially among many registered professionals including allied health professionals, nurses and doctors • The NE and Yorkshire's working-age population is projected to decline by 1.4% by 2040 • School leaver numbers will rise until 2030, offering a talent pipeline opportunity • Policy intent is a greater emphasis on British workers with a more restrictive visa environment
Demographic Shifts	• Ageing workforce (see Appendix A) with early access to NHS growing • By 2030, economically active people aged 65+ are expected to grow by one-third driven in part by rising state pension age and cost of living concerns • Four/five generational workforce (Baby Boomers to Gen Z/Gen A) with distinct expectations
Changing Workforce Expectations	• Staff seek flexible working, inclusive leadership, and increasingly bespoke development • TRFT promotes flexible and part-time roles • Teams are empowered to tailor working patterns locally • Importance of TRFT delivering the People Promise and maintaining strong retention
Generational and Succession Challenges	• Reducing pool of senior nurses, doctors in numerous specialties and limited succession planning currently in place • TRFT invests in apprenticeships, schools outreach and Skills Street
Employee Relations environment	• Non pay elements of national pay awards require implementation e.g. Nursing and Midwifery national profiles for bands 4-9 • Industrial action considerations given dissatisfaction over multiple national pay awards
Strategic Direction	• Shifting to proactive workforce planning • Better understanding of impact of digital, AI and automation on workforce • Embedding equality, diversity, and inclusion as core principles

7. Professional pipelines and development

Nursing and Midwifery Workforce - Significant progress on retention and recruitment has resulted in a very small number of nursing vacancies at TRFT and a virtually full midwifery establishment. The number of acceptances via UCAS has risen slightly for the first time since 2021. The largest intake of student nurses takes place in September each year followed by a smaller intake in March. TRFT works closely with other Trusts in South Yorkshire to co-ordinate recruitment and has a strong focus on preceptorships in the year after qualifying to support the transition from student nurse to graduate nurse.

Medical workforce - The recent trend of less than full time trainees is expected to continue. The trust continues to develop Specialist Associate, Specialist and Speciality Doctors. The national shortage of consultants in a number of specialities continues e.g. dermatology, anaesthetics and critical care. More new resident doctors are female compared to males for the first time in the last two years and the Trust is attracting and successfully appointing more consultants in recent times.

Allied Health Professional Workforce - The pipeline of professions is challenging due to a reduced skilled labour market. TRFT is focusing on 'growing our own' in more specialist roles and developing the education and training offer. Nationally four AHP roles were identified as vulnerable of which TRFT employs three – Orthotists, Podiatrists and Operating Department Practitioners (ODPs). To support colleagues all of the Therapies & dietetics, ODPs and Diagnostic Radiographers are now participating in the multi professional preceptorship academy.

Healthcare Scientists - Whilst healthcare scientists working under the South Yorkshire Pathology Network transferred to Sheffield Teaching Hospital in 2024 the Trust employs a number of Healthcare scientists primarily in Clinical imaging, ear care and audiology and clinical engineering.

Advanced Clinical Practitioners - Advanced clinical practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy. They are healthcare professionals educated to Master's level and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients. Changes to apprenticeship funding poses a risk to higher level development.

8. Different Workforce Planning Lenses

When considering workforce planning it is important to focus on multiple lenses. People are unique human beings who can be supported to fulfil their potential. People work in professions each with their own developments, challenges and pipelines. Professions allow specialisation and professionals work together in teams. Effective team working is essential to the delivery of quality healthcare. Together, teams deliver services to patients whose experience of care is impacted by every interaction with our people. We work in partnership with others and have a responsibility as an anchor organisation and the largest employer in Rotherham to inspire the future and provide opportunities for local people.

A. **People** - importance of culture, staff experience, inclusion and retention. links to People and culture strategy and Trust EDI plan

B. **Professions** - medical and dental, nursing and midwifery, allied health professionals, healthcare scientists, operational management, estates & facilities, corporate services – finance, hr, digital, governance, communications, administrative links to specific issues

C. **Teams** - multi-disciplinary teams are at the heart of excellent healthcare and the importance of effective team working

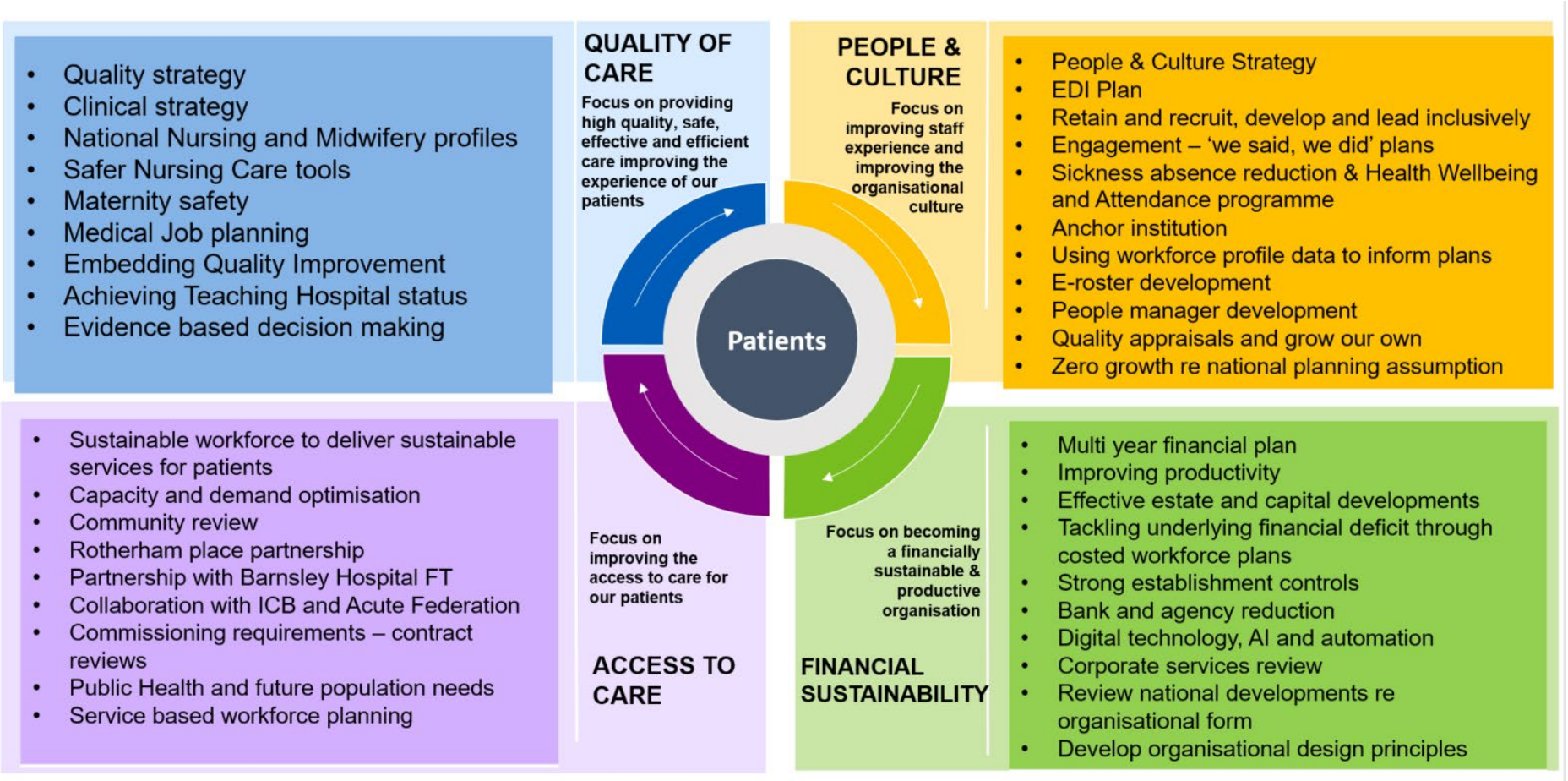
D. **Services** – delivered by care groups and corporate teams

E. **Partnerships** – multiple partnerships e.g. at Rotherham place, joint delivery of services with Barnsley Hospital NHS FT, the SY Acute Federation, South Yorkshire ICB etc.

F. **Rotherham** – place and TRFT Anchor role as largest employer in the town/area.

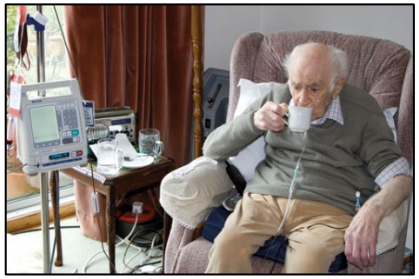
9. Trust objectives to deliver excellent healthcare for patients

Key aspects of the quadrants are set out below in relation to workforce planning.



A number of significant developments at the Trust are summarised below, enabled by intentional changes to ways of working and/or the development of the attractiveness of the Trust as a place to work.

Community and Neighbourhood care - Further development of the Trust's virtual ward approach providing support for long term condition management which helps people stay at home and get back home sooner from hospital. Recent innovations include home chemotherapy and mobile x-ray scanning, with teams working differently to improve the experience of care and patient outcomes.



Bed base reconfiguration - the Trust is reviewing its inpatient bed requirements and a reconfiguring the bed base to provide improved services to patients and a better staff experience. This will provide surge capacity and result in fewer staff (particularly nursing and healthcare support staff) being asked to move wards at short notice, which reduces morale and can impact attendance.

UECC and SDEC - fully established UECC roster with the introduction of a purpose built Same Day Emergency Care (SDEC) and a new green areas for UECC housing minor injuries and primary care. This will improve patient care and experience and positively impact on admission avoidance. This has been enabled by optimising the workforce and focussing on cohesive teams as well as blended approach to workforce across acute and emergency care, including community teams.

Theatre productivity - full establishment review taking place as part of our Theatre Transformation Programme to maximise utilisation of theatres in Rotherham as well as the Mexborough Elective Orthopaedic Centre delivered in partnership with Barnsley and Doncaster Trusts.

Endoscopy Programme – the Trust is investing in the endoscopy department following a full review of its workforce. This is part of our Endoscopy Transformation Programme and will support activity through both increased capacity as well as improved productivity. It is also a key aspect of the Trust achieving Joint Advisory Group (JAG) accreditation.

Achieving Teaching Hospital Status - the Trust is applying to be a Teaching Hospital. This offers a range of benefits particularly in relation to workforce development. It will support the retention and recruitment of high-calibre staff by enhancing education, training, and professional growth and improve the Trust brand.

Health Wellbeing and Attendance Programme - there is a significant programme of work in place to reduce sickness absence and improve attendance. Stress, anxiety and depression the largest single reason for absence (Appendix A). Improving attendance a key enabler of reducing bank expenditure.

10. Multi-Year Financial Plan

The NHS is expected to deliver 2% efficiencies of controllable spend over the period of this plan. This plus the Trust's underlying deficit forms the basis of the financial savings requirement to 2028. The Trust's Multi Year Financial Plan is based on 6 key lines of enquiry as follows each of which represent opportunities and will guide our approach to workforce over the period in the pursuit of delivering excellent healthcare for the people of Rotherham. Effective workforce planning is essential in order to deliver these improvements and in doing so can enable financial sustainability for the Trust.

KLOE	Financial Plan focus
A.	Medical workforce focus **-** fragile services and **reducing premium medical costs and insourcing costs/**income
B.	Reducing **sickness absence, improving staff availability, job planning, reducing bank and agency costs**
C.	Capacity and demand; **operational productivity,** benchmarking, delivery of constitutional standards
D.	Workforce structure **– budget and establishment controls, service workforce plans, corporate services review, organisational design, career development, appraisal, succession planning -** medical, care group leadership and operations profession focus
E.	Income, costs, partnerships **esp. with Barnsley Hospital NHS FT, review national developments re organisational form**
F.	**Grip, control and effective budget management – cost improvement programmes** both trust wide e.g. procurement, medicines and **service specific through the Trust's cost improvement programme**

11. Digital Innovation

The Trust's Digital strategy links to the themes the workforce plan. It will release time to care and create business intelligence platforms to support the development of workforce insight. It will enable the automation of routine tasks through artificial intelligence and robotics. This for example, might include corporate processes, and enable greater levels of employee self-service - but will require new skills being acquired.

A number of strategic and tactical developments are underway in the digital space. This plan sets out joint work to deliver an understanding of the opportunity that digital, AI and automation presents in terms of augmenting the workforce, and carrying out routine tasks more efficiently. In addition to this the following developments and capacity building measures are taking place.

Microsoft Co-pilot Rollout

- 250 licences deployed across HR, Clinical Governance & corporate teams (NHS England-supported)
- 2,000+ uses (May 2025) – accelerating tasks like presentation drafting
- Early feedback: significant time savings & efficiency gains

Secure AI Hub (Soft Launch)

- Natural language search across 2,700+ Trust policies
- Automated meeting minutes via AI assistant Haiden
- Document simplification for Clinical Governance
- Conversational IT support with AI agent Ian

Workforce Readiness

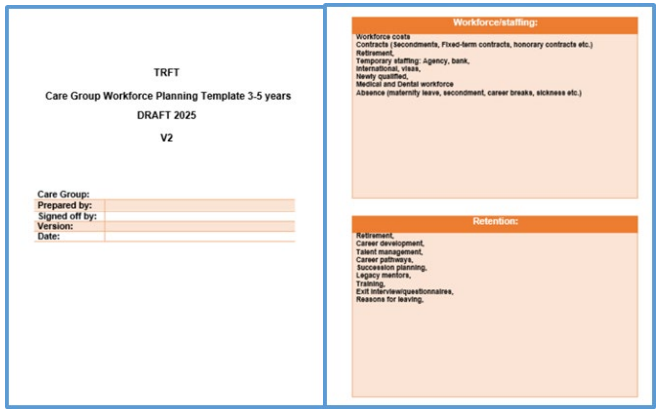
- 100 staff trained in "Generative AI 101"
- 16 apprentices in Data & AI programmes (via Multiverse)

Clinical Innovation Pilots

- Ambient AI for clinical notes (Colorectal & ICU)
- DNA prediction model to reduce missed appointments (due to launch)

12. Developing Workforce Planning at TRFT

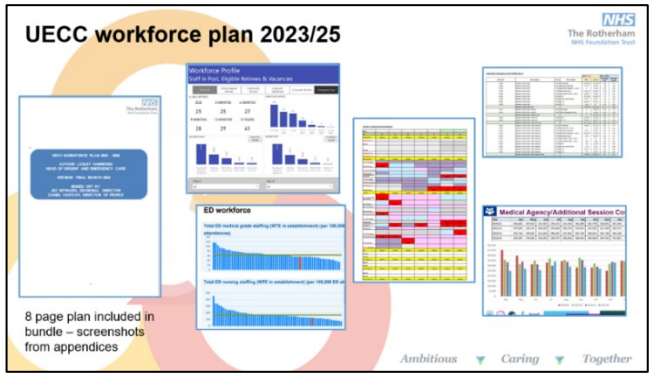
Improvements Delivered:	Areas for Further Focus:
• Staff experience as per the staff survey • Retention rates • Filling the establishment • Reducing agency spend • Trialing of new service workforce planning methodology • Innovation in workforce planning • Focused use of CPD monies to support development	• Service by service workforce planning to strengthen services in the short/medium/long term • Greater focus on the age profile of the workforce and succession planning • Fragile services • Workforce planning with partners • Further roll out of e-Roster • Further reduction in bank and agency spend



New workforce planning approach trialled in UECC

Urgent and Emergency Care Centre – Junior Clinical Fellows case study

By redesigning the rotas in UECC against run rate rather than budgeted establishment the service has been able to attract significant interest in bespoke junior clinical fellow roles, fill the establishment, increase the quality of care, reduce wait times, and deliver an estimated £100K recurrent budget saving.



Approach to nursing recruitment – case study

By over-recruiting to nursing roles and collaborating with South Yorkshire Trusts we have been able to make the optimum number of offers to student nurses. This approach factors in turnover and a predicted dropout rate in order to ensure we can start the right number of nurses and avoid the costs of bank or agency staff.

13. Anchor Role and skills

Skills Street

This initiative provides an immersive and innovative experience designed to widen career aspirations among children, young people and adults in the region. TRFT has collaborated with Rotherham Metropolitan Borough Council (RMBC) and the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) to fund a Health and Care area at Skills Street. Skills Street welcomed the first school visits in 2025 and is playing a critical role in inspiring future generations into jobs and careers into health and care.

Ambassador Programme

TRFT is part of the ambassador programme operating across schools and colleges in Rotherham. It provides students with valuable insights into careers in Health and Social Care. This year, the initiative aims to facilitate over 3,000 meaningful interactions with students interested in pursuing roles in the sector.

Work Experience

Between January and June 2025, TRFT has facilitated 25 work experience placements for young people to gain essential workplace experience. The Trust's approach to work experience is being reviewed to focus it on a targeted approach to ensure these opportunities are accessible to individuals from diverse backgrounds.

Apprentices

TRFT currently has 162 apprentices enrolled. Changes to the funding rules will negatively impact higher level apprenticeships which poses a challenge to supporting people into some roles. The Trust will continue to collaborate with partners e.g. Yorkshire ambulance service to ensure levy funds are maximised for health and care in this region.

Rotherham primary school children learning about the health and social care sector at Skills Street in June 2025

14. Priority Action Areas

No.	Priority action area	Yr1	Yr2	Yr3
1	Review of NHS 10 year plan and subsequent national Workforce plan for opportunities and risks	☑	☑	
2	Fill medical establishment, retain and recruit to secure this	☑	☑	☑
3	Reduce levels of sickness absence	☑	☑	☑
4	Maintain strong grip and control on establishment, reduce bank and agency costs and roll out e-roster further	☑	☑	☑
5	Care groups & corporate teams to produce clear workforce plans to strengthen services taking into account workforce demographics and patient need	☑	☑	
6	Deliver EDI plan	☑	☑	☑
7	Focus on quality appraisals and skills development to grow our own talent	☑	☑	☑
8	Develop succession planning approach focussing on care group leadership and operational management, identify key areas for future years	☑	☑	

No.	Priority action area	Yr1	Yr2	Yr3
9	Implement Nursing and Midwifery national profile work	☑	☑	
10	Carry out Corporate services review	☑		
11	Complete and embed medical job planning to inform capacity and demand work	☑	☑	☑
12	Digital – carry out deep dive analysis of potential impact of AI and further automation on existing roles	☑	☑	
13	Review national developments on organisational forms e.g. FT model and subsidiaries	☑	☑	
14	Develop and apply organisational design principles		☑	
15	Begin to plan for post large waiting list BAU capacity			☑

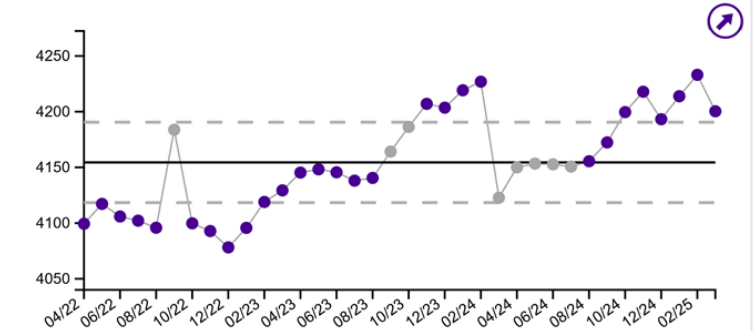
Appendix A

Workforce Profile

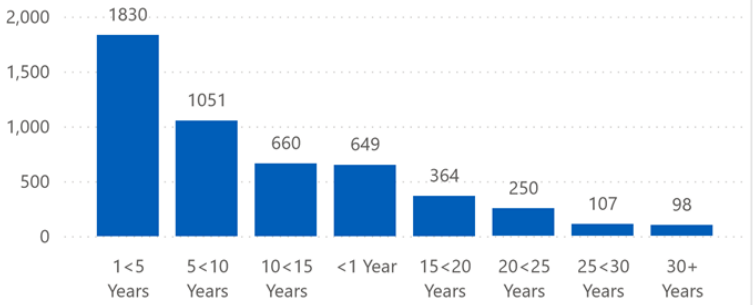
Staff in Post & Eligible Retirees

NHS
The Rotherham
NHS Foundation Trust

Overall FTE By Month



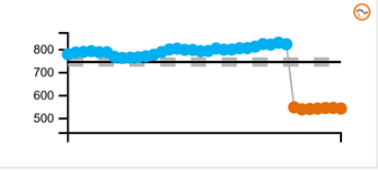
Length Of Service By Headcount



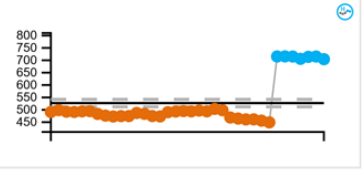
Eligible Retirements Due By Service (Based on the age of 60)

Estates & Facilities	87
Community	47
Anaesthetic & Theatres	33
Children & YP - Acute	28
CSU 2	28
Specialist Surgery	28
Clinical Imaging	23
CSU 4	23
Maternity & Gynae	22
CSU 1	21

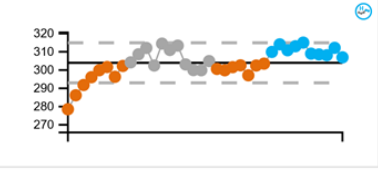
Band 2 FTE (2022 to 2025)



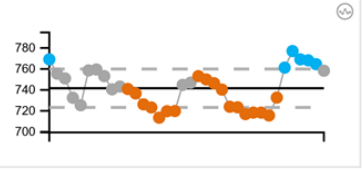
Band 3 FTE



Band 4 FTE



Band 5 FTE



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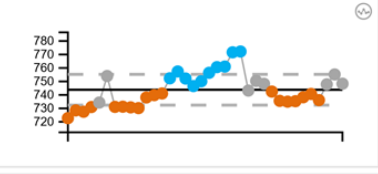
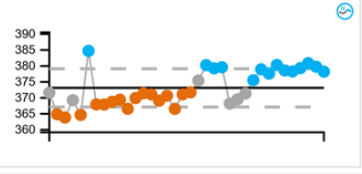
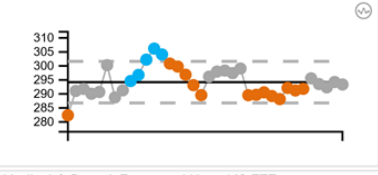


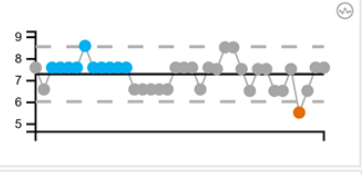
Band 7 FTE



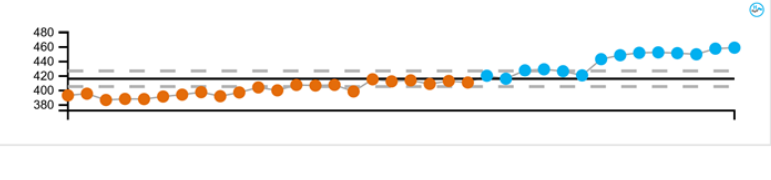
Band 8A TO 8D FTE



Band 9 FTE



Medical & Dental, Execs and Non-AfC FTE

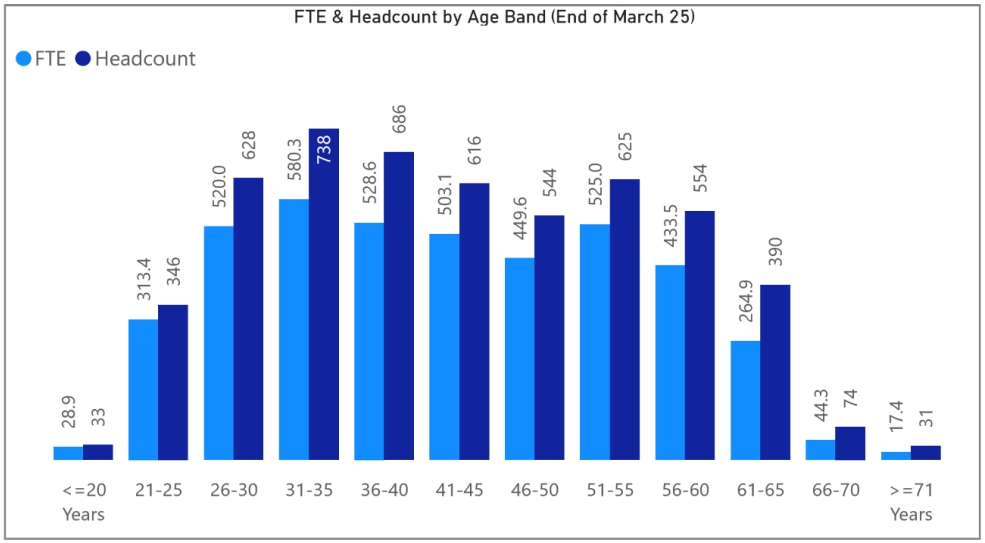


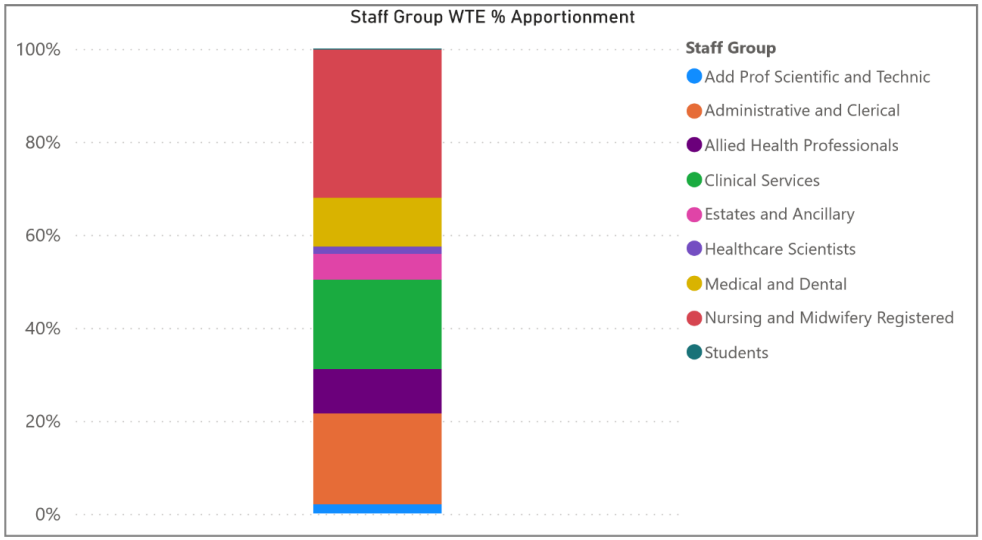
FTE in Post	
Care Group 1	858.7
Care Group 2	822.7
Care Group 3	844.4
Care Group 4	903.4
Corporate	771.3

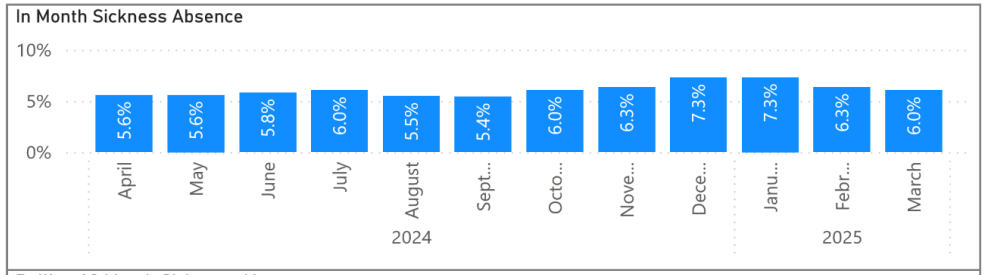
Eligible retirements suggest potential workforce changes, notably within Estates & Facilities with 89 retirements due (based on the age of 60).

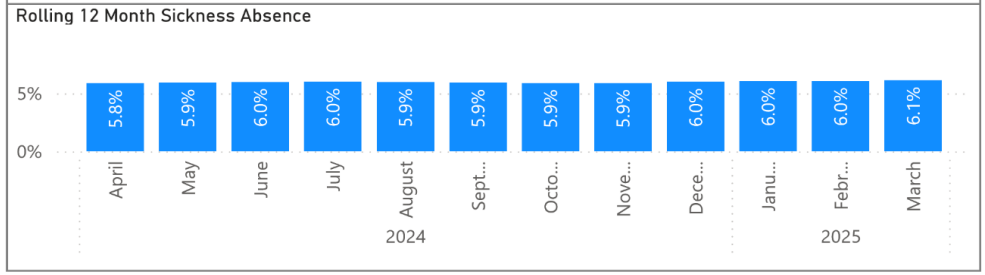
Length of service analysis reveals a workforce with a considerable proportion of newer employees. The band 1-5 years has the highest count at 1,830 employees, while 30+ years has the lowest at 98 employees.

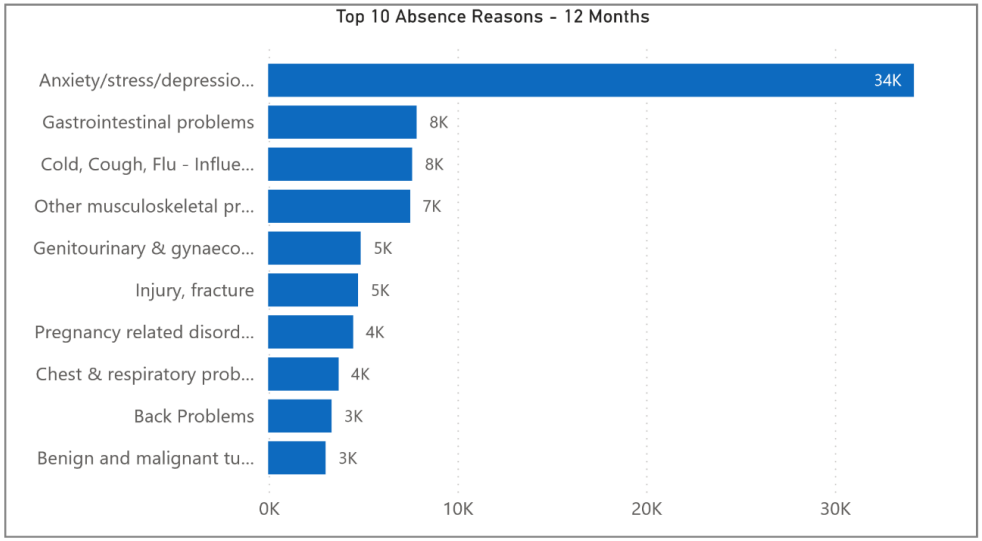
The overall FTE by month shows a relatively stable workforce size, maintaining around 4.2K from April 2022 to March 2025.


FTE & Headcount by Age Band (End of March 25)
FTE
Headcount
28.9
33
313.4
346
520.0
628
580.3
738
528.6
686
503.1
616
449.6
544
525.0
625
433.5
554
264.9
390
44.3
74
17.4
31
<=20 Years
21-25
26-30
31-35
36-40
41-45
46-50
51-55
56-60
61-65
66-70
>=71 Years


Staff Group WTE % Apportionment
100%
80%
60%
40%
20%
0%
Staff Group
Add Prof Scientific and Technic
Administrative and Clerical
Allied Health Professionals
Clinical Services
Estates and Ancillary
Healthcare Scientists
Medical and Dental
Nursing and Midwifery Registered
Students


In Month Sickness Absence
10%
5%
0%
5.6%
5.6%
5.8%
6.0%
5.5%
5.4%
6.0%
6.3%
7.3%
7.3%
6.3%
6.0%
April
May
June
July
August
Sept...
Octo...
Nove...
Dece...
Janu...
Febr...
March
2024
2025


Rolling 12 Month Sickness Absence
5%
0%
5.8%
5.9%
6.0%
6.0%
5.9%
5.9%
5.9%
5.9%
6.0%
6.0%
6.0%
6.1%
April
May
June
July
August
Sept...
Octo...
Nove...
Dece...
Janu...
Febr...
March
2024
2025


Top 10 Absence Reasons - 12 Months
Anxiety/stress/depressio...
34K
Gastrointestinal problems
8K
Cold, Cough, Flu - Influe...
8K
Other musculoskeletal pr...
7K
Genitourinary & gynaeco...
5K
Injury, fracture
5K
Pregnancy related disord...
4K
Chest & respiratory prob...
4K
Back Problems
3K
Benign and malignant tu...
3K
0K
10K
20K
30K

Appendix B

Care Group 1:		Care Group 2:		Care Group 3:		Care Group 4:		Corporate:
Service	**Service area**	**Service**	**Service area**	**Service**	**Service area**	**Service**	**Service area**	**Director area**
CSU 1	A & E Department	***Anaesthetics & Theatres***	Anaesthetics	***Children & YP – Acute***	C&YP Acute Services	***Clinical Imaging***	Medical Photography	Chief Executive
	Alcohol Service		Critical Care		Complex Care		Medical Physics	Managing Director
	Primary Care & Out of Hours		Pain Relief Service		Looked After Children & Care Leavers		Radiology	Medical Director
CSU 2	Acute Medical Unit		Sterile Services		School Nursing Service	***Community***	Adults- Urgent Care and Re-ablement	Chief Nurse
	Elderly Medicine		Theatres	***Children & Young People***	0-19 Childrens Service		Cardiology – Community	Chief Operating Officer
	Stroke	***General surgery & Urology***	General Surgery		Child Health Admin		Community Diabetes Centre	Director of People
CSU 3	Diabetes & Endocrine		Urology		Paediatric Therapy		Community Nursing	Director of Finance
	Endoscopy Service	***Orthopaedics & Rheumatology***	Orthopaedics	***Maternity & Gynae***	Gynaecology		Dental Service	Director of Estates & Facilities
	Gastroenterology		Rheumatology		Maternity		Ear Care & Audiology	Director of Health Informatics
	Respiratory- Acute	***Orthotics & Podiatry***	Orthotic Service	***Patient Access***	Patient Access		Integrated Rapid Response	Director of Communications
CSU 4	Cardiology		Podiatry	***Pharmacy***	Pharmacy		Respiratory- Community	Director of Corporate Affairs
	Clinical Haematology	***Specialist Surgery***	Oral and Maxillofacial surgery	***Rotherham Sexual Health Services***	Rotherham Sexual Health Services	***Therapies***	Planned Care – Community Therapies	Director of Operations
	Dermatology		Ophthalmology	***Vascular & Phlebotomy***	Vascular & Phlebotomy	***Service***	Planned Care – Dietetics	Cancer Services
	Falls and Bone Health					***Clinical Imaging***	Planned Care – Hospital Therapies	
CSU 5	Integrated Medicine Management							

Board of Directors' Meeting
4th July 2025

Agenda item	P/111/25
Report	**TEACHING HOSPITAL STATUS**
Executive Lead	Jo Beahan, Medical Director
Link with the BAF	[insert BAF reference number and brief summary of BAF item]
How does this paper support Trust Values	This paper supports the Trust Value of 'Ambitious'
Purpose	**For decision ☒ For assurance ☐ For information ☐**
Executive Summary	If an NHS trust supports medical or dental training or research and can demonstrate a "significant teaching commitment", it can apply to the Department of Health for an amendment to its Establishment Order to recognise this status. The Trust's current Establishment Order does not include this reference. This report provides an overview of the feasibility of applying for teaching hospital status at The Rotherham NHS Foundation Trust. It examines the potential benefits, challenges and strategic considerations associated with such a significant undertaking. In order to gain a greater understanding of what it entails to achieve Teaching Hospital Status, there have been various discussions and meetings with neighbouring trusts who have been successful in obtaining 'teaching' status. These interactions have been helpful to interpret the national guidance surrounding what constitutes a 'significant commitment to teaching'.
Due Diligence	This paper has been presented to the Trust's Executive Team prior to discussion at Board of Directors.
Board powers to make this decision	The Trust Board of Directors are required to have oversight and support the application to become a Teaching Hospital.

Who, What and When	Once presented, the Medical Director will proceed with the next steps and progress the recommendations. There will be regular reporting to the Board of Directors.
Recommendations	It is recommended that;- 1. Project Management Office to lead on developing of workstream project plan. This would require each workstream to have an Executive Lead and Senior Responsible Officer in each area. 2. Executive Directors are each assigned a workstream to ensure each area is meeting the requirements of obtaining TH status. 3. The Trust Board of Directors is asked to nominate a Non-Executive Director who will be classed as the TH Status "Champion" 4. Executive Team and Trust Board of Directors to sign off Showcase Document.
Appendices	1. TRFT Draft Showcase document.

1. Summary: Becoming a Teaching Hospital

As the Trust embarks on its ambition to be recognised as a Teaching Hospital (TH), this paper outlines the key steps in order to achieve that ambition. This is a decision making paper for the Board to approve the outline plans in order to achieve TH status. In recent years a number of NHS Trusts have become Teaching Hospitals or University Hospitals. Local Trusts who have gained Teaching Hospital Status include;-

- Doncaster and Bassetlaw Teaching NHS Trust
- The Mid Yorkshire Teaching NHS Trust
- United Lincolnshire Teaching Hospitals NHS Trust

In the UK, a teaching hospital:

- Provides undergraduate and/or postgraduate clinical education to medical, nursing, and allied health students.
- Is affiliated with a university medical school.
- May be involved in clinical research and innovation.
- Typically serves as a regional centre for specialist care.

2. What is the process needed to become a Teaching Hospital?

There is little in terms of formal guidance/application to become a Teaching Hospital. We do however need to be able to evidence and demonstrate that as a Trust we have a significant commitment to teaching and we are supported by key stakeholders.

The process is more straightforward for Foundation Trusts (FT) compared to NHS Trusts.

As a foundation trust we would require the approval of more than half of the members of both the foundation trust's council of governors and its board of directors voting in favour of the change (section 37(1) of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012). Foundation trusts are required to adhere to NHS England's NHS identity guidelines and should discuss any proposed name change with NHSE.

3. What have we learnt from neighbouring Trusts?

3.1 Doncaster and Bassetlaw Hospitals (DBTH)

DBTH obtained Teaching Hospital Status in 2017. When discussing their journey to obtain Teaching Hospital Status they described using the University Hospital Status as the principle framework as well as being able to demonstrate that you consistently deliver (above if possible) the NHS Standards for Education and Training. DBTH stated that they did not have any additional investment for achieving teaching hospital status but described common goals and the fact that they have a centralised training hub. The training hub incorporates medical

education, nursing, AHP, OD, Learning and Development, Apprenticeships and Statutory and Mandatory Training all in one central 'hub'. They had autonomy over SIFT funding and HEE funding.

The Trust identified TH Status as a strategic objective and the Board, Chair and Chief Executive were well briefed throughout. Liaison with Sheffield Teaching Hospital (Chief Executive to Chief Executive) was instrumental as well as other key partners including NHSE and Quality Dean.

With having autonomy on educational budgets they were able to ensure that there was sufficient job planned time for clinicians which detailed the objectives/expectations for this remuneration.

Regular briefings to People Committee/Board on GMC NETS, NHSE Educational Standards and self-assessment.

3.2 The Mid Yorkshire Teaching Hospital

In discussions with colleagues Mid Yorkshire regarding their journey to achieving Teaching Hospital Status, they describe the process as a little more challenging given the requirement for ministerial sign off. Similarly to DBTH they also described one of the benefits of TH status as "turbo-charging" the recruitment and retention of employees. They describe a significant uptake in the number of Consultants applying to the Trust owing the recognition of TH status and commitment to teaching.

Mid Yorkshire used the opportunity of achieving TH Status as an opportunity to change the culture at the Trust and with that, changed the reputation.

Liaison with key stakeholders is crucial in order to obtain the necessary support as well as signing off the 'showcase document' which outlines the process and commitment from the Trust.

Once Mid Yorkshire had gained TH status there was an introduction of a new strapline "trusted to teach" which was embedded throughout all of their strategic documentation. The education department had autonomy over the educational budgets to ensure that any educational income was utilised for that exact purpose.

Mid Yorkshire described a change of organisational focus including core research and development and training. Whilst Research is not a specific requirement of gaining TH Status, once achieved Mid Yorkshire stated that there was an increase in trial income and an increase in commercial trials and candidates.

Mid Yorkshire reported that having TH status as a key strategic objective was the biggest driver in achieving TH Status. This meant that the Board were aligned on

culture shift and opportunities that TH Status could bring to the Trust. This meant that positive endorsement and messaging was disseminated from the top and teams recognised the benefits

4. What are the perceived benefits and challenges of becoming a Teaching Hospital?

Some of the benefits of becoming a Teaching Hospital include:-

- Changing culture – enhanced reputation
- Attracting talent to the organisation, Recruitment of top clinicians and students.
- Higher clinical standards
- Funding opportunities and improved patient outcomes through research and training.

Challenges:

- Significant financial and administrative investment.
- Balancing education with clinical efficiency.
- Navigating complex regulatory environments.

Changing Culture for the organisation

When speaking to neighbouring Trusts one of the benefits of pursuing and achieving Teaching Hospital status was the impact on the organisational culture. It was seen as a great opportunity to change culture, perception and reputation certainly in cases whereby Trusts have been burdened with an historical CQC rating which does not reflect the current position, feeling and recognition of improvements made. The three trusts who have gained Teaching Hospital Status are all 'Requires Improvement' Trusts.

Pursuing an ambitious aim of achieving Teaching Hospital status will provide our employees with an assurance that we committed to teaching, development and investment in our teams. This in turns results in the highest quality of care afforded to patients which improves patient outcomes.

Gaining teaching hospital status would be a great way of leading organisational culture change. An opportunity to 'rebrand' and enhance overall performance, satisfaction and long-term sustainability. It provides an opportunity for shared values, beliefs and behaviours within the organisation and will shape how people interact and achieve goals.

5. How to prepare the Trust for Teaching Hospital Status.

Whilst the organisation already meets a significant proportion of the requirements for Teaching Hospital status, we need to be able to evidence this. Our showcase document will detail how we meet the Teaching Hospital principles set out by the University Hospitals Association, however there are a number of areas which we need to provide assurance that we are meeting the necessary requirements, for example,

the Educational Quality Standards. There are ways in which we can ensure that we have adequately prepared for the organisation for TH status prior to the submitting the application for the change of name.

5.1 Build or Strengthen Infrastructure

- **Clinical Training Facilities:** Provide appropriate clinical departments, ward space, simulation facilities, and teaching rooms.
- **Faculty and Mentors:** Experienced clinicians who are qualified to teach. Many will need faculty appointments through the affiliated medical school.
- **Learning Spaces:** Classrooms, simulation labs, libraries, and online learning resources are essential.
- **Quality Assurance:** Implement systems for feedback**,** assessment, and continuous improvement in teaching.
- **Educational quality visits** from HEE/NHS England – Review action plans

5.2 Strengthen partnership working with local medical schools and universities

5.3 Meet GMC and NHS Educational Requirements

- **General Medical Council (GMC):**
  - Ensures hospitals delivering medical education meet the standards set in *Promoting Excellence: standards for medical education and training*.
  - Teaching hospitals must support clinical placements**,** supervision, and educational governance**.**
- **NHS Education Providers:**
  - Work closely with Health Education England (HEE) or its successor bodies under NHS England to provide foundation training and specialty training**.**

5.4 Research and Innovation

TRFT already has a significant investment and recognition for Research and Development and we would be looking to build on this. Teaching hospitals often collaborate with NIHR (National Institute for Health and Care Research) or university research departments. We would look to continue and build on the clinician-led research, hosting clinical trials and developing our research capacity (data governance, ethics approval pathways, research governance).

5.5 Ongoing Responsibilities

Once approved:

- Maintain teaching quality and clinical excellence.
- Submit to regular GMC and HEE reviews.
- Continue staff development in medical education**.**
- Uphold your role as part of the NHS education and training infrastructure**.**

5.6 Liaison with Key stakeholders

- Internal Key Stakeholders, Board of Directors, Council of Governors, Communications, Staff; Education teams, Medical and Dental, Nursing AHP, Apprenticeships, Learning and Development

- External Stakeholders; NHSE, Medical Schools, ICB, Place, MPs, Universities, NHS Trusts (including mental health), Ambulance, Councils, Hospice

5.7 NHS Branding Naming Convention – Key Rules

The NHS has strict branding guidelines to ensure consistency, clarity, and public trust across all its organisations and services. These naming conventions are governed by the NHS Identity guidelines, which are managed by NHS England.

The Director of Communications will advise of the exact formation for naming conventions. Taking into the account the rules governing NHS identities the most appropriate naming convention would suggest us to become Rotherham Teaching Hospital NHS Foundation Trust. Although consideration is to be given on the naming convention and whether there are any other options given we have community arm of the Trust.

6. Recommendations

1. Project Management Office to lead on developing of workstream project plan. This would require each workstream to have an Executive Lead and Senior Responsible Officer in each area.
2. Executive Directors are each assigned a workstream to ensure each area is meeting the requirements of obtaining TH status.
3. The Trust Board of Directors is asked to nominate a Non-Executive Director who will be classed as the TH Status “Champion”
4. Executive Team and Trust Board of Directors to sign off Showcase Document.

Dr Jo Beahan
Medical Director
June 2025

The Rotherham NHS Foundation Trust

Teaching Hospital Status 2025

Ambitious Caring Together

NHS
The Rotherham
NHS Foundation Trust

Contents

Welcome to

The Rotherham NHS Foundation Trust

Welcome from the Chairman

R. Jebb

Overview of Performance: About Us

The Rotherham NHS Foundation Trust provides an outstanding undergraduate education experience for both medical students and physician associate students from the University of Sheffield. Undergraduate teaching is recognised as a particular strength of the Trust, with consistently high performance in annual reviews conducted by NHSE and the University of Sheffield. For consecutive years, Rotherham has exceeded the required standards for clinical placements, reflecting the commitment of the Trust to delivering a supportive, structured, and high-quality learning environment.

The Trust accommodates in excess 330 medical students annually across all core specialties, offering diverse and clinically rich placements. A comprehensive simulation programme enhances students' practical skills and clinical reasoning, delivered through both high-fidelity ward-based scenarios and dedicated simulation suite sessions. The undergraduate team maintains a strong pastoral ethos, operating an open-door policy and providing continuous access to academic and wellbeing support. Students benefit from high-quality study facilities, including an award-winning library and dedicated undergraduate study areas. Teaching is delivered by a dynamic faculty comprising consultant educators, clinical and leadership fellows, a pharmacist educator, and a skilled simulation team, all of whom are committed to delivering an engaging and inclusive educational experience.

Medical Undergraduate Education

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Medical Education

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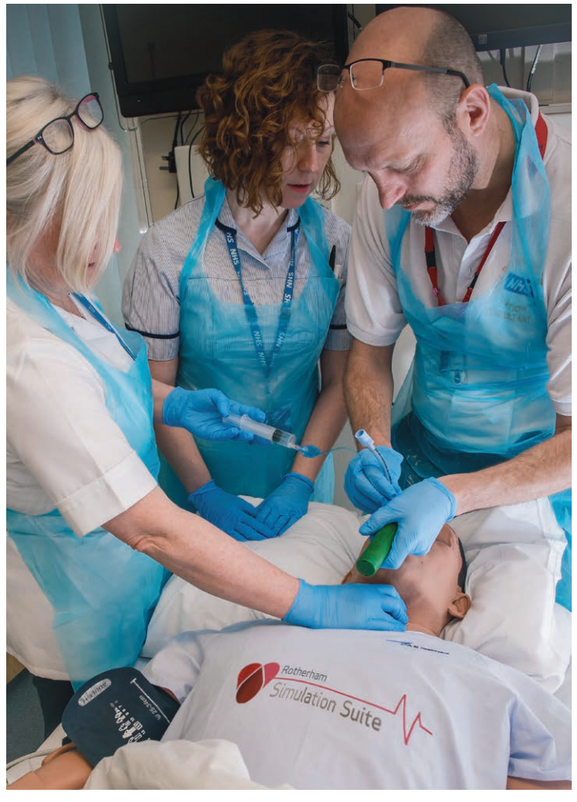


Medical Postgraduate Education

The Trust has built a strong reputation for delivering high-quality postgraduate medical education, underpinned by a supportive, learner-centred environment.

Our Trust hosts trainees across a wide range of specialties, offering a breadth of clinical exposure tailored to the needs of Foundation, Core and Higher Specialty trainees. We are committed to fostering excellence in clinical teaching, with educational supervisors and consultants who are fully engaged in training delivery, mentorship, and continuous professional development. The Trust's Education Centre provides dedicated facilities for simulation, teaching, and collaborative learning, ensuring that postgraduate doctors receive not only clinical training but also leadership development, research opportunities, and pastoral support.

Our educational governance is robust, aligning with GMC standards and NHSE expectations, and we maintain a strong partnership with local medical schools and regional training programmes. Trainees consistently report high levels of satisfaction in national surveys, reflecting the Trust's commitment to safety, learning, and professional growth. As we continue to innovate and expand our educational offer, we believe that teaching hospital designation will formally recognise the high standards already in place and support our ambition to become a leading hub for postgraduate medical education in South Yorkshire and beyond.

The Medical Education Department currently employs a Clinical Teaching Fellow dedicated to supporting undergraduate education and a Future Leader Fellow focused on postgraduate education, both appointed on fixed-term 12-month contracts. These roles provide valuable educational support while also developing the fellows' leadership, teaching, and academic capabilities. The Trust remains committed to identifying, recruiting, and developing clinicians as part of our growing faculty, equipping them with the skills and experience needed to become the clinical educators and leaders of the future.

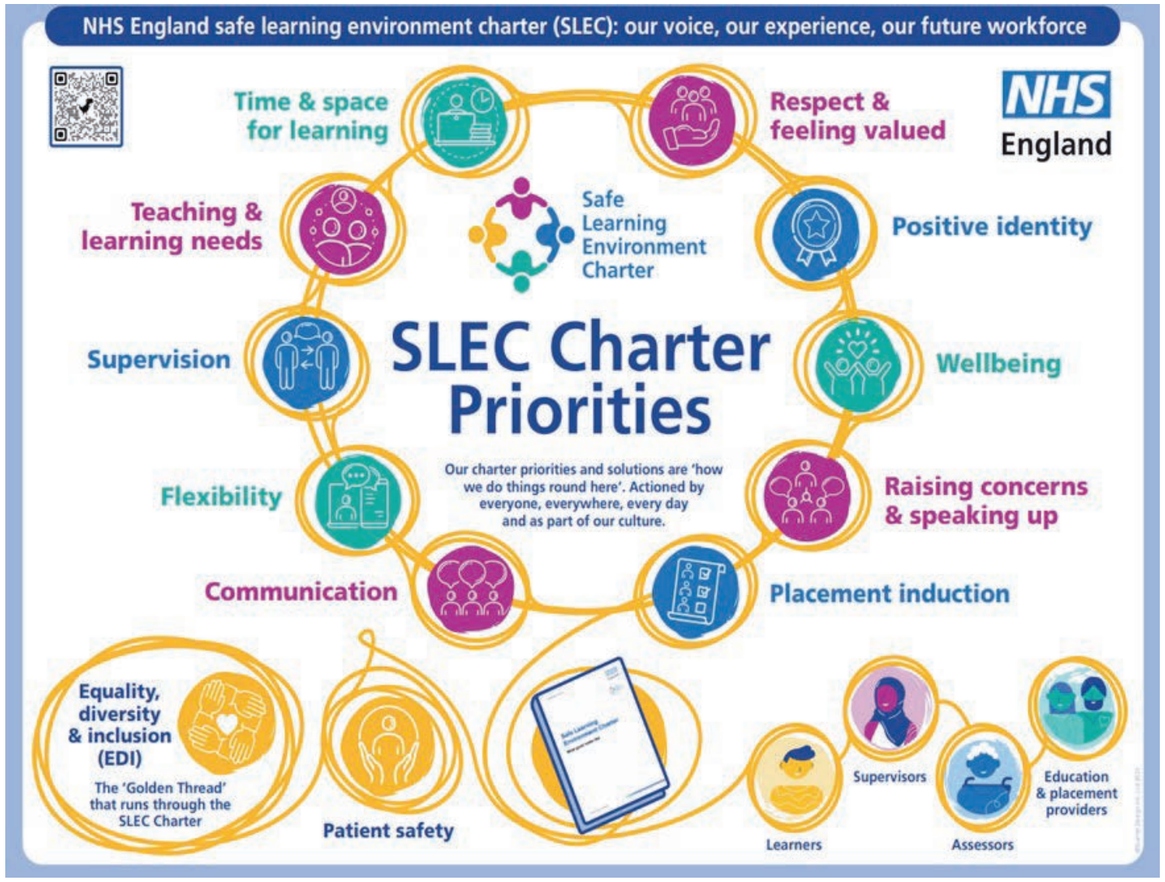
Quality improvement

The Trust is proud to have led the co-design of our Quality Improvement (Qi) offer with 5 other trusts across the South Yorkshire Integrated Care System (ICS). This has means developing an Improvement Learning South Yorkshire Practitioner (ILSY) programme for Qi training and also the Foundations one-day course. The course follows the 9 step roadmap for improvement (below).

Qi is the foundation for early career staff of all disciplines at the Trust as part of the multi-professional preceptorship programme as well as the Foundation Years for medical students and the Graduate Management Trainees. It is the golden thread throughout a number of activities, including the Exemplar Accreditation programme as well as Preceptorship and Clinical Leadership development programmes, Our Qi sharing events provide opportunities for all staff to share their improvement activity.

The NHS Safe Learning Environment Charter (SLEC)

SLEC is a framework designed to promote positive and safe learning cultures within healthcare settings. It aims to ensure that learner's feel supported, valued, and have access to quality learning experiences. The charter addresses key aspects like equality, diversity, inclusion, psychological safety, and the importance of feedback and reflection.
Our student handbook outlines the principles of SLEC and how we have implemented these safe learning cultures within the Trust.

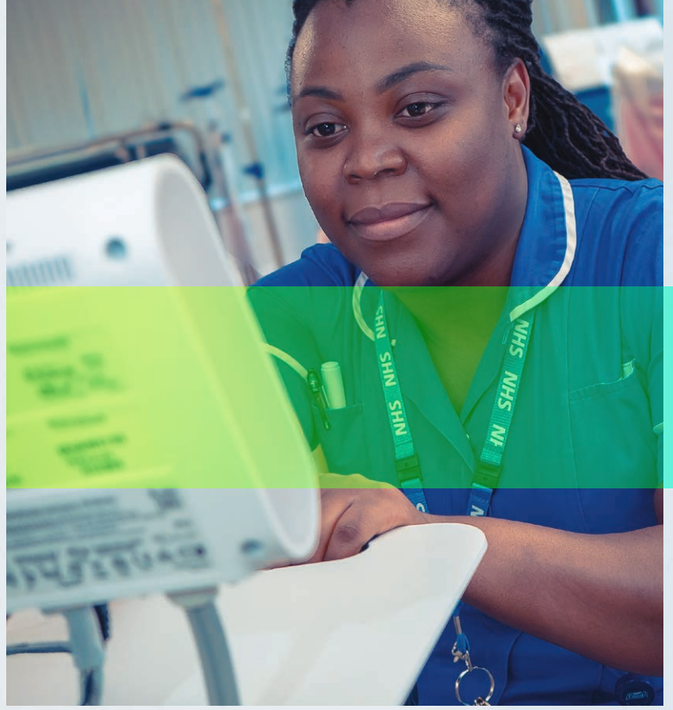


T-Level Students

T Levels are two-year, vocationally-focused courses designed for 16-19 year olds in England, following GCSEs. They are equivalent to three A Levels and offer a combination of classroom learning and a substantial work placement, aiming to equip students with industry-specific skills and knowledge for skilled employment, apprenticeships, or further study.

The Trust has built up a partnership with Rotherham College, part of the RNN group to be able to support T-level students on placement with us and support is offered by the education and development team.

Placements include a structured induction in the fundamentals of care and wide variety of learning opportunities.

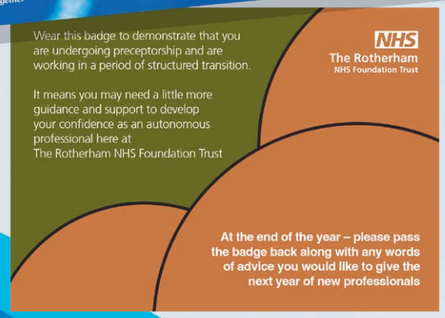


Health Care Support Worker/ Care Support Worker Academy

The Trust has around 700 Healthcare Support Workers (HCSW) and Care Support Workers (CSW). To support their education and development, the Trust runs a HCSW/CSW Academy model.

The Academy supports HCSW/CSW to gain a thorough understanding of the code of conduct and the skills needed to meet the expected standards in your role in the Trust. The academy offers the necessary education to develop skills through various learning methods, including practical steps and activities. These include:

- Care Support Worker: Support to complete the Care Certificate.
- Healthcare Support Worker: Clinical skills such as taking and recording vital signs, point of care testing and assistance with further professional development through career conversations and exploring available options.



Student Nurses and Midwives

We provide high quality clinical placements to over 450 pre-registration student nurses each year and 168 Midwives. Students can study a degree or post graduate qualification in nursing at university or take a 'dual field' degree. We work closely with two local universities:

University of Sheffield

Sheffield Hallam University

Students are supported in studying for undergraduate degrees (3 years), postgraduate degrees (2 years) or as a registered nurse degree apprenticeship (RNDA). This option is through employment and university study (2 to 4 years).

All student nurses on placement are supported and prepared through our induction programme and offered a wide variety of learning opportunities. We offer high-quality, audited practice placement experiences for all learners providing support, guidance, and teaching, one on one working and support for the myepad/pebblepad.

Preceptorship Academy

Preceptorship is a structured period of support for newly registered healthcare professionals, designed to help them transition from student to autonomous practitioner. It's a key part of supporting early careers in nursing, midwifery, and other Allied Health Professions (AHPs).

The National Preceptorship Framework for Nursing sets standards for this process, aiming to improve retention of newly registered nurses and interim accreditation for the Trust work on this was achieved in 2023.

The Trust run a Preceptorship Academy Model, and Model 1 under The National Preceptorship Framework for Midwifery.
This includes:

- Structured Support: Newly registered professionals receive guidance and development from experienced practitioners (preceptors).
- Focus on Confidence and Competence: Preceptorship helps build confidence and develop competence in the new role.
- Transition to Autonomy: It facilitates the transition from student to an autonomous practitioner.
- Quality Improvement: QI (Quality Improvement) training for early career nurses is built into our preceptorship programme, focusing on developing skills and knowledge in quality improvement methodologies and their practical application in nursing practice. This training can empower early career nurses to contribute to improvements in patient care and working conditions.

The Trusts runs an annual ‘Dobson’s Den’ for all preceptee’s to present their Qi work with all the senior nurses, midwives and AHPs in attendance, who vote to invest in the preceptee’s Qi idea.

Preceptor Role

A preceptor is a named, experienced practitioner who provides guidance and support to the preceptee. This is normally an experienced practitioner with sufficient experience in their clinical area and be registered for at least 12 months.

Preceptors offer advice, mentoring, and encouragement to the preceptee. Also helping to apply knowledge, develop skills, and build confidence during an adequate period of supervision and support.

Since 2023, the Trust has trained 350 Preceptors and run a regular learning and support forum to ensure they are up to date.

Practice Assessors and Practice Supervisors

Practice Supervisors (PS) are registered nurses who support who ensure students meet learning outcomes while upholding patient safety and supporting their professional development. Since 2023, the Trust has 75 staff trained as a PS and this is now incorporated into the preceptorship programme.

Practice Assessors (PA) are registered nurses who assesses and support student's to achieve practice learning objectives and will assess and sign them off as competent. Since 2023, the Trust has 505 staff trained as Practice Assessors (PA) to ensure students can be competently signed off achieving placement objectives.

Training for PS and PA lasts for three years and updates for next year are being planned.

Early Careers Nurses

The majority of early career nursing roles fall within the category of clinical practice, characterised by delivering direct care to patients and boasting the widest choice of roles at a variety of different settings and levels. Registered Nurses are advised to gain a few years post-qualifying experience after completing preceptorship, before going on to managerial, specialist (enhanced) or advanced roles.

At TRFT our career tree helps explain the different specialties you can work in. These include:

Community Nursing
Medical Care Nursing
Emergency Care Nursing
Surgical Nursing
Theatre Nursing
Critical Care Nursing
Children's Nursing
Gynaecology and Sexual Health Nursing

Early Career Midwives

The Preceptorship Programme in Midwifery is designed to ensure our Early Career Midwives gain all the experience, exposure, clinical skills, knowledge and support they require to complete their preceptorship and gain the Band 6 uplift within 12-18 months. Our programme gives Early Career Midwives a rotation working on Labour Ward, Wharncliffe Ward (Antenatal/Postnatal), Greenoaks (Outpatient antenatal), and as a part of the Ivy Team (Maternity Triage and Antenatal Day Ward) settings within the hospital setting, and also working in the Community Midwifery Teams. Early Career Midwives are supported with supernumerary time at the start of their experience in each new working area, working alongside Buddy Midwives, an allocated named Preceptor for support and regular review meetings to embed learning and give pastoral support. Early career Midwives are also supported with the study time required to increase and gain their clinical skills in perineal suturing, epidural management, fetal surveillance assessment, Newborn and Infant Screening, Safe Bedside Blood administration and IV access training.

On completion of the programme at 12-18months, Early Career Midwives will gain their Band 6 uplift and become a fully rotational Junior Midwife within Maternity Services.

Ward and Department Managers

Ward and Department Managers help patients by managing the nurses and midwives who care for them, drawing together patient experience and the coordination of the multidisciplinary team. They can also play an important role in providing staff with learning and development opportunities.

It's not only about having line management responsibilities, they act as a role model by exhibiting excellent values and behaviours, inspiring others, leading on change and implementing best practice.

Clinical Nurse Specialists

Many nurses are drawn towards specialist roles because they have a particular interest or passion within a certain area of nursing, and prefer the idea of being a clinical expert within that area. You could specialise:

- Within a clinical remit or area (e.g. school nursing, sexual health, etc.), or
- In relation to a clinical condition (e.g. palliative care, cancer, diabetes, TB, heart failure)

Nurses working within specialist roles will have specialist skills, competencies and experience, and practice at an enhanced level. They will also usually have completed or will be working towards post-registration qualifications relevant to their specialist area such as modules towards a degree pathway, SCPHN courses, or Masters programme.

Although they work within a multidisciplinary team, they have a greater deal of autonomy, and will be responsible for a caseload or group of patients.

Cancer Clinical Nurse Specialist development

The ACCEND (Aspirant Cancer Career and Education Development) programme in the NHS is a national framework designed to support the development of cancer nurses and allied health professionals. It aims to improve the knowledge, skills, and capabilities of the cancer workforce, ultimately enhancing the quality of care for people living with cancer.

ACCEND aims to ensure that nurses and AHPs have the necessary knowledge, skills, and behaviours to provide high-quality cancer care, regardless of their level of experience. The programme seeks to overhaul career pathways, education, training, and learning opportunities for those working in cancer care.

ACCEND addresses the need for a well-trained and skilled cancer workforce, particularly in light of the increasing number of people diagnosed with cancer.

Advanced Practice

Advanced Practice roles are characterised by advanced clinical skills and competences, a higher degree of autonomous decision-making, along with the remit to diagnose, treat and prescribe. They require an education to Master's level, as well as prescribing qualifications. 3 years post registration experience is often required.

Nurses in advanced roles practice in various areas, including the community, emergency medicine, medicine, surgery and orthopaedics.

Research and innovation

Working in research may lead you to become interested in an academic career, and pursue a PhD, or a Professional Doctorate to become an independent nurse researcher. Our research department is led by the Director of Research and the Lead Research Nurse, fostering a high value research-active culture.

Clinical Academic Career

Clinical academics are clinical professionals working across healthcare providers and academic institutions. They have a dual role combining their clinical career with a research career. There are several routes to becoming a clinical academic and various development opportunities to take to pursue this path

To provide a real-life example of clinical academic career development, we have created a poster (available separately for download) showing the career path of community matron, Paula Berridge, from community staff nurse to her current PhD study.

Specialist Midwifery Roles

Midwives working within Specialist roles have a specialist skill set and further training within those areas. They will also usually have completed or will be working towards post-registration qualifications relevant to their specialist area such as modules towards a Masters programme. These roles include –

- Bereavement Specialist Midwife
- Clinical Education Midwife
- Fetal Surveillance Midwife
- Diabetes Specialist Midwife
- Antenatal and Newborn Screening Midwife
- Sonographer Midwife
- Governance Midwife
- Pre-Term Birth Specialist Midwife
- Digital Midwife
- Infant Feeding Midwife
- Named Midwife for Safeguarding
- Vulnerabilities Specialist Midwife
- Birth in Mind (Perinatal Health) Midwife
- Smoking In Pregnancy Specialist Midwife
- Clinical and Pastoral Support Midwife

These roles support the Team with training, development, overseeing safety planning and standards, and they also provide specialist care direct to women and families accessing Maternity Services.

Professional Nurse Advocate (PNA) & Professional Midwifery Advocate (PMA)

PNA & PMA training is a level 7 Masters module, providing those on the programme with skills to facilitate restorative supervision to their colleagues and teams, in nursing, midwifery and beyond. It equips nurses and midwives to listen and to understand challenges and demands of fellow colleagues, and to lead support and deliver quality improvement initiatives in response. The Trust has 50 PNA in post with plans to continue training 5 new PNA each year, and 12 PMA's in post with plans to continue training 2 new PMA's each year.

Continued Professional Development (CPD)

Continuing Professional Development (CPD) for nurses and midwives is a lifelong learning process designed to enhance skills, knowledge, and practice. It ensures nurses and midwives stay updated with the latest advancements in clinical practice and patient care, while also addressing their individual professional development needs.

CPD ensures our nurses and midwives stay informed about the latest evidence-based interventions, best practices, and research findings, supporting nurses and midwives in achieving their career aspirations and demonstrates their commitment to professional excellence.

CPD is a key requirement for revalidation with the Nursing and Midwifery Council (NMC), ensuring registered nurses and midwives maintain their professional registration.

Continued Professional Development funding

The Continuing Professional Development (CPD) funding for nurses in the NHS in England provides registered nurses, nursing associates, midwives, and other allied health professionals with a financial allowance for their personal and professional development. This funding allows for development in areas like clinical skills, career advancement, and maintaining professional registration.

The funding provides a £1,000 allowance per individual over three years, or £333 per year. This is available to registered nurses, nursing associates, midwives, and other allied health professionals working for the Trust.

We support funding bids through a monthly CPD panel. The funding can be used for various activities, including courses, virtual and face-to-face study days, university-level accredited modules, subscriptions to clinical portals, training and associated travel costs, conferences, and practice development programs.

Role Specific Training in Nursing

The Trust reviews the role specific training offer each year as this is dependent on themes and trends identified to drive improvements in patient safety, patient experience and clinical effectiveness. These themes remain around the early recognition and management of seriously unwell ward patients and early recognition and management of patients needing palliative and end of life care.

The following courses are now on offer:

REACT: For registered healthcare professionals in inpatient areas
Aiming to increase knowledge skills and confidence in the recognition and response to a clinically deteriorating patient. Candidates will gain experience in completing a systematic A to E assessment in a simulated environment. NEWS2, sepsis, AKI SBAR will be covered throughout the day.

REACH: For Band 3 Health Care Support Workers
A course to support the recognition of deterioration in patients, staff will be able to undertake a basic A to E assessment, understand sepsis, hypotension and reduced conscious level with practical sessions including fluid balance monitoring.

Tracheostomy Study Day: For registered staff that care for patients with a tracheostomy
Aiming to support competence and confidence in caring for patients with a tracheostomy or laryngectomy, this will include, SALT, nutrition, humidification and dealing with emergencies. Suitable if you work on AMU/ASU/A3/Day Surgery.

Palliative Care Study Day: For the multi-professional team who care for patients needing palliative and end of life care.
Aiming to increase knowledge on early recognition of the need for palliative care, breaking bad news, oncology emergencies, ReSPECT, symptom management, practical, emotional and cultural support, taste for pleasure and care at the end of life. Efficacy of this training is measured through the results of the National Audit for Care at the End of life (NACEL).

Leadership Development

The Trust has commissioned various leadership development opportunities through CPD funding.

These include the Royal College of Nursing Clinical Leadership Programme (CLP). This is aimed at nurses working at B6/7 level who need to develop their leadership skills and abilities. Over 60 nurses have now been through this programme.

We have also commissioned a programme for more senior leaders through the Florence Nightingale Foundation (FNF). This is aimed at nurses in B8A level who wish to stretch their leadership and Qi knowledge further. 40 Nurses have been through the FNF leadership development programme.

NHS Leadership Academy

A variety of programs, tools, and resources are offered by the NHS Leadership Academy and other organizations. The Trust has nominated people to undertake all of these programmes.

- Edward Jenner Programme: A free e-learning resource for those taking their first steps into leadership or wanting to enhance their existing skills.
- Mary Seacole Programme: A program for those in their first leadership role, focusing on developing leadership and management knowledge and skills, according to the NHS Leadership Academy.
- Elizabeth Garrett Programme: A program for mid-level leaders aspiring to lead large and complex areas, says the NHS Leadership Academy.
- Nye Bevan Programme: A program for senior leaders seeking to transition to board-level roles.

Research & Development

Research and Development Mission Statement

The Research and Development Department at The Rotherham NHS Foundation Trust is committed to advancing healthcare through high-quality, ethical, and patient-centered research. Our mission is to foster innovation, support clinical excellence, and collaborate across disciplines to generate evidence that improves patient outcomes and informs best practice. We strive to empower staff, patients, and the community to actively engage in research, ensuring that our work reflects the needs and priorities of those we serve.

Research and Development Strategic Plan

Our strategic plan for clinical research is designed to enhance patient care through innovative, high-quality, and impactful research. The Research and Development Department focuses on developing interventions to meet the current and future health needs of the community.
Key elements of the strategic plan include:

- **Research Integration:** Embedding research into clinical pathways to improve patient outcomes and inform evidence-based practice
- **Diverse Research Portfolio:** Conducting a wide range of studies across various specialties, currently anaesthesia and perioperative medicine, cancer, cardiovascular, children, critical care, dementia and neurodegeneration, dermatology, gastroenterology, infection, mental health, musculoskeletal and orthopaedics, public health, reproductive health and childbirth, respiratory, surgery, trauma and emergency care
- **Research Engagement:** Promoting research participation through initiatives like Red4Research day, which raises awareness about the importance of research and encourages involvement from staff, patients, and the public
- **Research Capacity Building:** Providing training and support to staff to develop research skills and foster a research-active culture within the Trust
- **Collaboration and Partnership:** Strengthening relationships with external partners, including academic institutions and commercial organisations, to expand research opportunities and resources

Through these strategic initiatives, TRFT aims to advance clinical research, improve patient care and ensure our research portfolio aligns to the needs of our local community.

Recent Successes

Research Participation Growth: The R&D team have grown the number of TRFT participants recruited to research trials from under 300 in 2015/16 to over 3200 in 2024/25

Research Performance:

- TRFT was the highest recruiter to the Anaesthesia, Perioperative Medicine and Pain Management (APOMP) portfolio in Yorkshire and Humber in 2024/25
- TRFT was the second highest recruiter to the Critical Care portfolio in Yorkshire and Humber in 2024/25
- TRFT was the third highest recruiter to the Reproductive Health and Childbirth portfolio in Yorkshire and Humber in 2024/25

Research Awards: NIHR CRN Y&H Early Career Researcher/ Associate Principal Investigator of the Year 22/23 Dr Jake McCormick

Nursing Times Awards: Clinical Research Nursing Finalist – Advancing patient care through research in Rotherham

NIHR API Scheme: Ten colleagues have completed the Associate Principal Investigator scheme, including Resident Drs and pharmacists

Colleague Perspectives

''Research is extremely important for people affected by cancer as we know being involved in research gives our patients better outcomes. As the Trust Lead Nurse for Cancer it is my vision that cancer research will be at the heart of the care we deliver ensuring our patients have access to the best possible quality care.''

Michelle Fletcher, Macmillan Lead Nurse for Cancer, Principal Investigator APPROACH Study

''Access to research and clinical trials has allowed our patients to receive newer drugs and the latest diagnostics. This has a positive impact on the care they receive and they do not have to travel away to receive these treatments. Patients also feel that they are contributing to advancement of clinical medicine.''

Dr Arun Alfred, Consultant Haematologist, Principal Investigator

''Research underpins physiotherapy practice. We try to keep up to date with current literature so that we can provide the most relevant and effective management of our patients. In physiotherapy we are happy to support research opportunities wherever we can and promote the great work we do at TRFT.''

Ben Cooper, Senior Physiotherapist, Meteor2 Trial physiotherapist

Page 222 of 421

Patient Feedback

Racer2 participant: a patient in the Clinical and cost-effectiveness of individualised (early) patient-directed rehabilitation versus standard rehabilitation after surgical repair of the rotator cuff of the shoulder trial, said

"How immensely grateful I am to have had the opportunity to participate in research and to be able to contribute to helping others."

Mr Draviaraj, Principal Investigator Racer2 Trial

Access to research and clinical trials has allowed our patients to receive newer drugs and the latest diagnostics. This has a positive impact on the care they receive."

Dr Arun Alfred, Consultant Haematologist, Principal Investigator

Innovation

Professor Anil Hormis and Dr Kim Russon trialled the use of virtual reality (VR) glasses during awake surgical procedures to improve patient experiences and manage anxiety, whilst reducing the need for sedation. Patients and staff provided positive feedback. The potential benefits include quicker recovery for patients, earlier discharge, increased use of regional rather than general anaesthesia, cost benefits in improving theatre efficiency and increasing the throughput of theatre lists.

Clinical research Fellow, Dr Jake Warrington and Phil Smith, Medical Student, supported the work and together achieved the following awards:

Oral Presentation: WRAIG: Wrightington International Regional Anaesthesia Congress 2024

First Prize for Presentation: WRAIG: Wrightington International Regional Anaesthesia Congress 2024

Poster: British Society of Orthopaedic Anaesthetists (BSOA) ASM 2024

Induction and On boarding at The Rotherham NHS Foundation Trust

At The Rotherham NHS Foundation Trust, our Corporate Induction—The Big Welcome—is the starting point for every new colleague's journey. Designed to foster early engagement and a strong sense of belonging, it introduces new employees to our Trust's values, strategic objectives, key services, and leadership, including a personal welcome from a member of the Trust Board.

The Big Welcome is part of a broader on boarding process that integrates staff into the organisation both practically and culturally. It includes orientation on essential systems such as the Electronic Staff Record (ESR), which supports personal data management, training records, and compliance monitoring. New starters are also introduced to critical teams such as Learning and Development, Equality, Diversity and Inclusion (EDI), Freedom to Speak Up (FTSU), Safeguarding, and the Tobacco Treatment team, ensuring early access to support and resources.

Organisational development

Each employee also receives a local induction tailored to their specific role and department from day one. This ensures that both individual and departmental needs are met effectively. The programme highlights key initiatives such as the #Hellomynameis campaign, internal communications, NHS Professionals, our staff networks, and the TRFT Staff App. It also includes insight into our vision, mission, behavioural framework, and the work of the Trust's charity.

Through this comprehensive and structured induction, new employees are equipped not only with the practical knowledge to begin their roles but also with a clear understanding of how they contribute to the Trust's educational, clinical, and research goals. By the end of the process, staff are fully prepared to thrive within a supportive, learning-focused environment—key attributes of a future Teaching Hospital Trust.

Onboarding

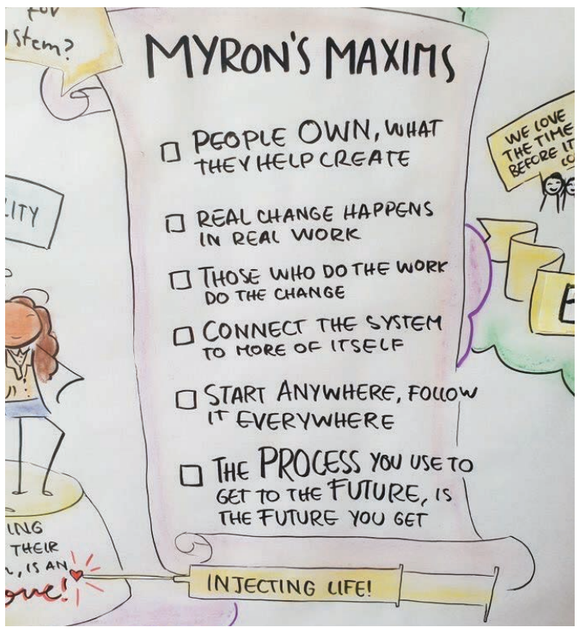
A good on boarding experience for employees involves various factors, including a personalised approach, clear communication, and ongoing support. It aims to make new starters at The Rotherham NHS Foundation Trust feel welcome, have an excellent candidate experience, and feel motivated to contribute to the Trust's success.

Here at The Rotherham NHS Foundation Trust, we have a centralised recruitment team who are proud of their award-winning on boarding processes that meets both local and national time to hire and time to clear KPIs. We use a certified digital identity service, Trust ID to process our right to work and DBS checks. This provides candidates with the choice regarding how they would like to process them. The system has been designed to make identity checks easier, more accessible and falls in line with the excellent candidate experience we offer.

The team follows the NHS Employers pre-employment guidance and uses both NHS Jobs and ESR. Each candidate will have a dedicated recruitment administrator who will guide them through the process and offer support where needed.

Widening Participation

For the last 18 months, The Rotherham NHS Foundation Trust has worked closely with the Rotherham Place Lead, focusing on widening access for those who are underrepresented and those from minority backgrounds. This program allows the Trust to foster a diverse and inclusive workforce by providing various career pathways and opportunities.



Bespoke Organisational Development

Our People Team offer an organisational development service that includes consultative, bespoke design, facilitated interventions, service process mapping, individual coaching, pyschometrics and team development. Our local and regional approach to organisational development is led by a DO OD methodology and underpinned by Myron's Maxims as adopted by NHS Horizons.

Leadership and Management

This is a combination of in-house provision by our People Team whose design and facilitation of management development is underpinned by the 'NHSE Expectations of a Manager' and local leadership aligns to 'Our Leadership Way'.

We also work with regional and national programmes including NHS Leadership programmes, the Coaching & Mentoring Hub and the Healthcare Leadership Model including 360 facilitated feedback.

We provide access to the NHS Leadership Academy Learning Hub with supplementary support available in-house which includes authentic leadership, motivation, emotional intelligence, courageous conversations and systems leadership.

Any other training

- Crucial conversations including active listening, feedback, challenge, compassion, wellbeing, menopause, psychological safety and performance. This development is aimed predominately on how to have a quality appraisal conversation, but also supports with every workplace conversation.
- Interview Skills to support colleagues with confidence as well as competence.
- Recruitment and Selection support for every recruiting manager to gain knowledge and skills for every step of the process.
- Ensuring that all of our development focuses on whether it has delivered improved outcomes and the value that has been added for the patient, ourselves, our colleagues and/or service.

Graduate Management Training Scheme (GMTS)

We also host trainees from the national NHS graduate management training schemes.

[Ask Ben Grey for further information]

Apprenticeships

The Trust has a long history of supporting apprenticeships, for both local residents and existing staff. Since 2022-23, we've increasedd our starts by 70%.
We currently have 160 apprentices enrolled

- Level 2 – 8
- Level 3 – 55
- Level 4 – 15
- Level 5 – 23
- Level 6 – 26
- Level 7 – 33

We utilise our apprenticeship levy in order to support gaps in our workforce. We've struggled to recruit into a number of qualified roles such as Physiotherapists, Occupational Therapists, Advanced Clinical Practitioners and Radiographers. The apprenticeship levy has given existing staff opportunities to progress into these roles ensuring we continue to offer an exceptional service to patients.

We also offer new apprenticeship opportunities in Business Admin, Pharmacy and Healthcare Science which creates our workforce of the future.

Future Plans

- Our plan is to increase apprenticeship starts further in 25/26 for both new and existing staff.
- We aim to work more collaboratively with local Trusts having closed NHS apprenticeship cohorts
- We're strategically working closer with Care Groups identifying further gaps in the workforce where apprenticeships can support

T-Levels

Last year we started our first T-Level placement for Digital. We've continued to support T-Levels moving into 2025 having our first 3 Health T-Level placements. We've planned for a further 8 Health T-Levels in September and are also looking to grow none clinical T-Level placements across the Trust.

Early Careers Teaching

The Trust has a long history of working across organisational boundaries to deliver meaningful a meaningful careers education offer for the people of Rotherham and the surrounding areas. Our careers education staff have links with all 16 secondary schools in the borough, and in 2024-5 had contact with over 2,500 pupils across Rotherham. We have a team of 35 Health and Social Care Careers Ambassadors, drawn from across the local authority, private care providers and the NHS; these ambassadors are trained to teach students and members of the public about the careers they can access in Rotherham.

The Trust has recently worked with local partners to develop a careers education facility for pupils from primary school level; 'Skills Street' is designed to demonstrate careers across different sectors to pupils, and has a curriculum associated with the activities in a teaching room.

The curriculum has been designed by our education experts and teachers at the South Yorkshire Education Hub. Built using Levelling-Up monies, this facility will allow pupils from 90 primary schools in Rotherham and across the region to see what careers are on offer in the sector.

The Trust is working on its careers offer to ensure that is delivers meaningful learning outcomes and tangible results. We are working with Wickersley Partnership Trust to deliver interventions to a specific cohort of students, and will be using pupil destination data to establish what careers they choose and how our interventions influenced this. The Trust will also be offering classroom sessions to groups of pupils, using technology to give them access to real-time patient care, without having to be on the ward. These will complement the departmental open days we are offering across the Trust, and our 'So You Want to be a Doctor' programme for prospective medical students which is in its 10th year and continues to be warmly received. A set of video guides to careers will include pre-and post learning questionnaires to ensure our resources are having the right impact.

It is our ambition as a Trust that we use our teaching ability in the field of careers education to ensure we widen participation and bring varies employment opportunities to the people of Rotherham, regardless of the background they are from.

Board of Directors' Meeting
4 July 2025

The Rotherham NHS Foundation Trust

Agenda item	P112/25
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 • Spending review announcement • Opening of Skills Street
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 – May 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 Patients will receive better, faster and more appropriate emergency care as the government sets out reforms to shorten waiting times and tackle persistently failing trusts. The new package of investment and reforms will improve patients' experiences this year, including by caring for more patients in the community, rather than in hospital which is often worse for patients and more expensive for taxpayers. Backed with a total of nearly £450 million, the plan will deliver:

- Around 40 new Same Day Emergency Care and Urgent Treatment Centres – which treat and discharge patients in the same day, avoiding unnecessary admissions to hospital.
- Up to 15 mental health crisis assessment centres to provide care in the right place for patients and avoid them waiting in A&E for hours for care, which is not the most appropriate setting for people who are experiencing a crisis. These centres will offer people timely access to specialist support and are directed to the right care.
- Almost 500 new ambulances will also be rolled out across the country by March 2026.

The plan's emphasis will be on shifting more patient care into more appropriate care settings as part of the move from hospital to community under the government's Plan for Change to rebuild the NHS, while tackling ambulance handover delays and corridor care.

2.2 The ten 10 year plan white paper is expected to be released in July, laying out a vision for 10 years covering the themes of: Treatment to prevention, hospital to community and analogue to digital.

2.3 Over the spending review period from 2025/26 to 2028/29, the NHS will receive a 3.0% real terms growth in day-to-day spending, amounting to a £29bn increase in annual resource budgets. By the end of the spending review period, the resource departmental expenditure limit (RDEL) for DHSC will peak at £232bn.

DHSC has committed to delivering at least 5% savings and efficiencies over the spending review period, including £17bn in savings over three years by improving productivity by 2%. The NHS will also cut the need for temporary staff by capping agency spending and eliminating agency use for entry-level positions. This builds on the nearly £1bn reduction in agency spending achieved in 2024/25.

3.0 South Yorkshire Integrated Care Board (SYICB)

3.1 An update from the ICB Chief Executive on key matters to members of the Integrated Care Board is attached covering: national changes impacting on South Yorkshire and highlights from each place.

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 Finance and Performance Committee.

4.0 Rotherham Place

4.1 On the 18th June, a number of the team presented alongside partners at the Rotherham Place Annual Review covering quality, performance, finance, team achievements and a look forward including developments around neighbourhoods.

4.2 Skills Street, a new immersive careers and skills experience in Rotherham, has officially opened its doors to schools from across the region. Located at Gulliver's Valley theme park, it's part of a £20 million investment by Rotherham Council to boost skills and leisure. The venue has already welcomed over 600 school-aged visitors, with highlights including the "FlyMe @ Skills Street" aviation experience and exploration of aircraft engines.

Bob Kirton, Managing Director
July 2025

Enclosure 07

Chief Executive Report

Integrated Care Board Meeting

7 May 2025

Author(s)	Gavin Boyle, SY ICB Chief Executive
Sponsor Director	Gavin Boyle, SY ICB Chief Executive
This report provides assurance against the following risk(s) on the ICB's Board Assurance Framework, Risk Register or Issues Log:	N/a

Purpose of Paper

The purpose of the report is to provide an update from the Chief Executive on key matters to members of the Integrated Care Board.

Key Issues / Points to Note

Key issues to note are contained within the attached report from the Chief Executive.

Is your report for Approval / Consideration / Noting

To note

Recommendations / Action Required by the Committee

The Board is asked to note the content of the report

Board Assurance Framework

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

Priority 1 - Improving outcomes in	✓	Priority 2 - Tackling inequalities in	✓

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

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

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

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

Chief Executive Report

Integrated Care Board Meeting

7 May 2025

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for March and April 2025.

2. Integrated Care System Update

2.1 Pathways to Work

One of the key priorities for the SY Integrated Care Partnership is to reduce economic inactivity as a means of improving people's health and wellbeing. There is a strong relationship between good jobs and good health. NHS South Yorkshire is continuing to work with partners to support people with health conditions remain in work or to enter the workplace. This aligns well with the ICBs four core responsibilities of improving health, tackling health inequality, maximising value and contributing to the wider social and economic development of South Yorkshire.

A quarter of all working age adults in South Yorkshire are economically inactive, which is why the Government have committed £18m to South Yorkshire ICB, the SY Mayoral Combined Authority and our four Local Authorities for the Trailblazer/Accelerator programme, which aims to support around 10,000 people into work or to stay in work.

Liz Kendall MP, Secretary of State for Work and Pensions launched our programme in Barnsley in April as part of the Government's Get Britain Working plan. This will see a dedicated new service working with employers to hire those with health conditions, and a new triage system to make it quicker and easier to connect people to employment, health, and skills support. This work will include preventing people falling out of work completely due to ill health through an NHS programme.

2.2 Foundations for reform of the NHS

On 1 April 2025 the Chief Executive of NHS England wrote to NHS trusts and integrated care boards on 'Working together in 2025/26 to lay the foundations for reform'. This followed the Prime Minister's announcement in March 2025 that NHS England will become part of the Department of Health and Social Care (DHSC) over the coming two-year period.

The letter referred to the publication of the 10 Year Health Plan and how the Government's Spending Review, which follows, will support a shift towards a longer-term approach to NHS planning. The letter also set an expectation that the NHS will move to a sustainable financial position to enable the delivery of better quality NHS services, particularly with more timely access, support the development of integrated models of neighbourhood care and improve wider population health.

The letter also noted that integrated care boards (ICBs) will be central to this but working specifically as the strategic commissioners of NHS services. Given this more focussed role, operating costs of ICBs nationally will need to reduce by 50%.

To achieve these reductions NHS England will soon share the core functions ICBs will be expected to retain and functions, which are currently duplicated by partner organisations, that can be shared or removed. In addition, NHS trusts have been asked to reduce corporate costs growth by 50% of the 2019 spend position.

NHS England will shortly be publishing the response to the NHS Standard Contract consultation and the payment rules consultation for 2025/26, which will set out the approach to planning elective activity, and the Urgent and Emergency Care Delivery plan, which will support how we plan for winter this year.

2.3 Financial Plan 2024/25

2024/25 was a challenging year for the NHS from a financial perspective. We fund NHS services in South Yorkshire to the total of £3.7bn each year. This year we exceeded our overall budget by nearly 1%, with a deficit at the end of the year across all service provision of £30.1m. Included in this total was a deficit against the ICB of £38.3m, with local providers generating an overall surplus of £8.2m.

The overall position contains some national deficit support but was better than our mid-year forecast agreed with NHS England. However, we know we have work to do with all our NHS partners to fulfil our collective commitment to become a financially sustainable health system. We are working together to find the right balance between how services are delivered with the funding available and maintaining quality and safety.

2.4 Operational and Financial Plan 2025/26 and NHS Joint Forward Plan for South Yorkshire

NHS South Yorkshire has submitted its plan for 2025/26 which will deliver a balanced financial position at the year-end, inclusive of agreed deficit support, albeit with significant risk. The plan meets most of the major operational standards, including urgent and emergency care and reducing the backlog for planned operations and investigations. However, the cancer 62-day target of 78% will not be met across South Yorkshire. It will met by all trusts except for Sheffield Teaching Hospitals NHS Foundation Trust, who have committed to significant improvement of 10% above their current performance.

In addition, we have published a refresh of our Joint Forward Plan noting the imminent publication of the national 10 Year Health Plan, which will reflect the Government's vision for health focussing on its three shifts of:

- Moving care from hospitals to communities
- Making better use of technology
- Focussing on preventing sickness, not just treating it

The development of the plan has been informed by a national consultation exercise Change NHS, which started in October last year. Health and care staff came together from across South Yorkshire in February 2025 to discuss how we might change locally to reflect these ambitions. NHS organisations and staff, including NHS South Yorkshire itself, have contributed to the Change NHS consultation and we have

encouraged our communities and partners to take part too.

2.5 Integrated Care Partnership (ICP) Board

The ICP last met in January 2025 due to local elections taking place in South Yorkshire and the need to adhere to the nationally mandated pre-election period. The Integrated Care Partnership will next meet in June 2025. However, since January partners have continued to work together to advance the ambitions of the Integrated Care Strategy.

2.6 Mental Health Out of Area Placements investment

South Yorkshire has been awarded £7m of NHS England capital funding to increase capacity in mental health inpatient provision and reduce out of area placements. South Yorkshire has historically, and currently, had to admit patients who needed mental health care into hospitals outside of the area partially due to local infrastructure and bed availability.

This funding will support our three Mental Health, Learning Disability and Autism (MHLDA) trusts to improve our services, so they are delivered closer to home, meeting patient needs, and improving outcomes, including for autistic people, and people with a learning disability. The projects include:

- Rotherham, Doncaster and South Humber NHS Foundation Trust to create a £1.8m 16 bedded adult mental health rehab unit
- Sheffield Health and Social Care NHS Foundation Trust £4.2m to refurbish and reopen a 17-bed ward to create more acute mental health bed capacity
- South West Yorkshire Partnership NHS Foundation Trust to invest £1m in 12 medium secure beds at Cheswold Park

These projects have been supported by the ICB and Mental Health, Learning Disability and Autism (MHLDA) Provider Collaboratives' inpatient quality transformation programme. As part of the next steps in progressing these schemes each provider is required to complete a full Programme of Works for submission in late May 2025, with NHS South Yorkshire providing a letter of support for the submission and approving the full programme of works submissions later, subject to Board approval.

2.7 GP Collective Action

In February the General Practitioners Committee England voted to agree the 2025/26 GMS contract changes, bringing an end to collective action. This followed proposals that include nearly £900m of additional funding, with the expectation that it will improve access to appointments, increase the use of advice and guidance arrangements between secondary and primary care and enable the adoption of new technology.

The contract came into effect on 1 April 2025. The British Medical Association will now work with the Government to negotiate a new substantive contract within this Parliament. Across South Yorkshire partners, including general practice, have worked closely together to support both our patients and communities, and those involved in the collective action.

2.8 UK Supreme Court Ruling regarding gender definition

Last month the UK's Supreme Court ruled that people's sex is defined by biological sex under equalities law. This marked the culmination of long-running legal considerations that will have implications for how sex-based rights apply across the country, and specifically for public sector bodies such as the NHS.

The Equality Act 2010 outlines that UK law prohibits discrimination, harassment, and victimisation based on nine protected characteristics. These are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. NHS South Yorkshire will always seek to ensure the law, and its principles are followed.

We anticipate a full review of services will be required and NHS England is currently reviewing guidance on same sex accommodation, considering all relevant legislation and the recent ruling. As an employer we'll continue to uphold our values of One Team at NHS South Yorkshire and that everyone has a right to be themselves, feel welcome and accepted at work.

3. NHS South Yorkshire

3.1 Eligibility changes to Non-Emergency Patient Transport across South Yorkshire

From 1 April 2025 the updated national eligibility criteria for Non-Emergency Patient Transport Services were implemented across South Yorkshire. NHS England undertook a public consultation between 2 August 2021 and 25 November 2021 on updated 'non-emergency patient transport services (NEPTS) eligibility criteria' to be adopted for all patient transport throughout England. Following feedback, NHS England updated and published the eligibility criteria for Non-Emergency Patient Transport Services (NEPTS).

The implementation of the national criteria was agreed by the NHS South Yorkshire ICB Board in January 2025 following feedback from the public and Joint Health Overview and Scrutiny Committee to help understand any potential impact of the updated criteria in South Yorkshire.

The updated eligibility criteria state most people should travel to and from hospital independently by private or public transport, with the help of relatives or friends if necessary. NHS-funded patient transportation is reserved for when it is considered essential to ensuring an individual's safety, safe mobilisation, condition management or recovery.

The criteria provide clarity on who is eligible for transport and to ensure that where relevant, they have appropriate access to patient transport. Included in the updated eligibility criteria is a universal commitment of transport support for patients attending in-centre haemodialysis.

3.2 Specialised Commissioning

NHS South Yorkshire took formal responsibility for specialised commissioning functions from NHS England on 1 April 2015. This includes responsibility for commissioning 70 specialised services that support people with a range of rare and

complex conditions. The services often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. The change will see NHS South Yorkshire work with six NHS trusts in neighbouring regions who provide specialised services and two independent providers.

NHS South Yorkshire will be hosting a specialised commissioning hub on behalf of the four North East and Yorkshire ICBs. A small number of existing NHS England colleagues will be joining the ICB on 1 July 2015 to work on behalf of the wider region.

3.3 NHS Staff Survey results for NHS South Yorkshire

The response rate from staff at NHS South Yorkshire to the NHS Staff Survey was over 75% for the first time. The scores this year were a significantly improvement on the previous year with nearly all indicators in the survey showing higher scores and above average in comparison compared to other ICBs across the country. Some of the notable improvements included staff engagement and overall morale, and progress had been made in other areas such as whether we are a learning organisation. The survey informs the work we do to support staff through our Inspired Colleagues organisation development plan.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

A landmark study in Sheffield has found 69 previously unidentified genetic determinants of rare disease, including uncommon forms of kidney disease and diabetes. The breakthrough research, involving Sheffield Teaching Hospitals NHS Foundation Trust and the University of Sheffield, uses a new analytical approach for identifying the genetic basis of rare diseases, which could diagnose more cases and help develop new treatments for patients.

Rare diseases collectively affect between 4% and 6% of individuals worldwide. Despite advances in genetic testing, most genetic variants that lead to disease remain unknown resulting in around 80% of people with a rare disease being undiagnosed even after genomic sequencing.

4.2 Doncaster

NHS providers are exploring the possibility of offering services in the heart of Doncaster city centre following approval for plans to convert empty retail space in the Waterdale area of the city centre. City of Doncaster Council has approved plans to lease the vacant St Modwen retail unit on Kingsgate in Waterdale. It is proposed that the 25,000 sq. ft. space could be sub-let to Doncaster and Bassetlaw Teaching Hospitals (DBTH) and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH), with a view to providing health services from the premises.

In addition, the City Council’s children's services have been praised by Ofsted in its first inspection since returning to Council control. Ofsted inspectors say the service has significantly improved and is now rated as "Good".

4.3 Rotherham

The Rotherham NHS Foundation Trust is continuing to make progress on the upgrade to the Urgent and Emergency Care Centre (UECC). The Trust secured £7m from the national Additional Capacity Targeted Investment Fund to expand urgent and emergency care capacity. The expanded centre, which is due to open in June 2025, will provide additional capacity for urgent primary care, minor injuries and the medical same day emergency care (SDEC) unit. This additional capacity will support the Trust's improvement journey working towards achieving the national four-hour emergency care standard. The centre will also include a new purpose-built fracture clinic with its own x-ray facility.

4.4 Barnsley

Work is underway on the relocation of hospital outpatient services as part of Barnsley's Health on the High Street programme, which will bring more accessible and convenient health and wellbeing services to the community. NHS South Yorkshire is working with Barnsley Metropolitan Borough Council, Barnsley Hospital NHS Foundation Trust and partners to transform the first floor of the Alhambra Shopping Centre into a health and wellbeing hub, which will see its first outpatient appointments transfer to Barnsley Hospital's new satellite centre in the heart of town later this year. The Alhambra programme follows the creation of the Community Diagnostic Centre (CDC) in The Glass Works three years ago, which is seen as an exemplar in improving healthcare access and patient satisfaction.

5. General Updates

5.1 Autism Acceptance Month

The NHS took part in Autism Acceptance month, with a focus on individuals reaching a genuine understanding of acceptance and how the NHS and wider society support our autistic colleagues, services users and communities. In addition, Sheffield held a first Autism Friendly Festival in April 2025. The festival's aim was to empower, support and celebrate autistic people, improve others' understanding of autism, and inspire action to make Sheffield a more autism friendly city.

5.2 Awards

South Yorkshire was recognised in the shortlist for the 2025 HSJ Digital Awards. The Rotherham NHS Foundation Trust's GP Connect in Meditech: Streamlining Medication and Allergy Data Project has been shortlisted in two categories including the Digital Clinical Safety Award and the Improving Medicines Management and Pharmacy Through Digital Award. Sheffield Children's Hospital NHS Foundation Trust has been shortlisted for the Reducing Health Inequalities through Digital Award for their Roma Video Reminder Project. In addition, Liz Leggott from the South Yorkshire Primary Care Workforce and Training Hub has been shortlisted for Digital Innovator of the Year.

The NHS South Yorkshire Star Awards recent winners were:

- March: March's Star Awards winners were Alex Watchorn and Megan Seymour. Alex and Megan were recognised for the work they have done on the impact of inhalers to the environment. Through their research they identified a

certain asthma inhaler that, whilst as clinically effective as other more common brands, had a much lower carbon footprint.

- April: April's star awards winner was Jill Auty. Jill, an administrator at the ICB is a valued member of staff always known to be willing to help other members of her team and plays a key part in organising the team ensuring reports are completed and provided in a timely manner.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 7 May 2025

Board of Directors Meeting
4th July 2025

Agenda item	P/113/25
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 May 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 – May 2025

Board of Directors Meeting

Integrated Performance Report - May 2025

Performance Matrix Summary

NHS The Rotherham NHS Foundation Trust

Assurance

Variation	Pass	Hit or Miss	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	-	-			C
Number of 52+ Weeks	200	678	Feb-24					VC
Number of 65+ Weeks	37	74	Feb-24					S

Performance Matrix Summary - Quality

NHS The Rotherham NHS Foundation Trust

		Assurance		
		Pass	Hit or Miss	Fail
Variation	Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE**	**GOOD: CELEBRATE AND UNDERSTAND** • 1:1 Care in Labour • Moderate and Above Harms - Acute	**CONCERNING: CELEBRATE BUT TAKE ACTION**
	Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • SHMI • Fill Rate (%) – Registered/Un-Registered combined	**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) – Acute • Pressure Ulcers (Cat 3 and above) – Community • C. diff infections • Patient Falls (Moderate and above) – Acute • VTE Risk Assessments • Breast milk first feed • Pressure Ulcers (Cat 3 and above) – Acute • Combined Positivity Score • UECC Positivity Score • Fill Rate (%) – Registered • Moderate and above Harms – Community • 3rd and 4th degree tears • Massive PPH • Moderate and above maternal harms	**CONCERNING: INVESTIGATE & TAKE ACTION** • Stillbirth rate
	Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**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" (105.6)	Jan-25	N/A	P		-	G
Readmissions (%)	-	6.1	Apr-25	-	-			S
VTE Risk Assessments (%)	95.0	95.0	May-25	☑	?			S
Combined Positivity Score (%) – excl UECC	95.0	95.1	May-25	☑	?		-	S
UECC Positivity Score (%)	95.0	82.8	May-25	☒	?		-	S
Complaints (per 10k Contacts)	8.0	12.4	May-25	☒	?		-	S
Patient Safety Incident Investigations	3	3	May-25	☑	?			S
Moderate Harms and above per 1000 bed days – Acute	-	0.2	May-25	-		L		S
Moderate Harms and above per 1000 bed days – Community	-	0.3	May-25	-				S
Medication Incidents - Moderate and Above per 1000 bed days – Acute	0.1	0.0	May-25	☑	?		-	S
Pressure Ulcers Cat per 100 contacts - Community	0.1	0.05	May-25	☑	?			S
Pressure Ulcers per 1000 bed days - Acute	0.8	0.8	May-25	☑	?		-	S
Patients Falls (Moderate and Above per 1000 bed days)	0.2	0.0	May-25	☑	?			S
C. difficile Infections	4	6	May-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 May 2025

Data, Context and Explanation

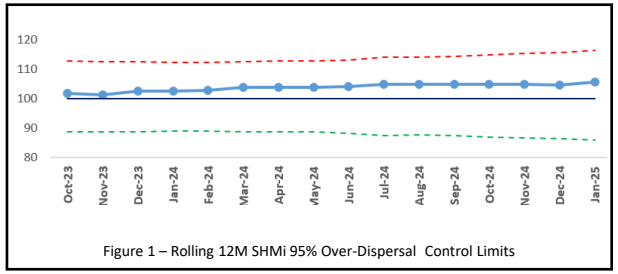


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

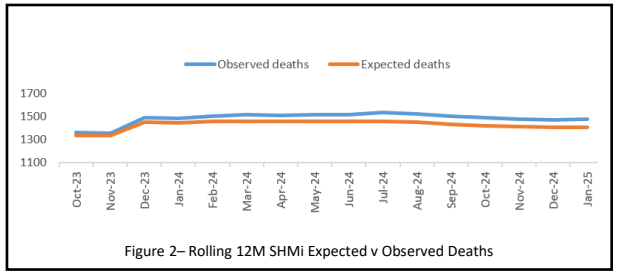


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

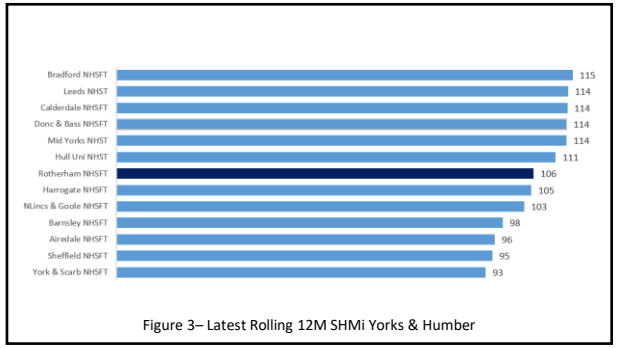


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

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 - Jan 25	105.6	-	Jo Beahan	John Taylor
Expected Deaths	1405	-		
Observed Deaths	1480	-		
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?

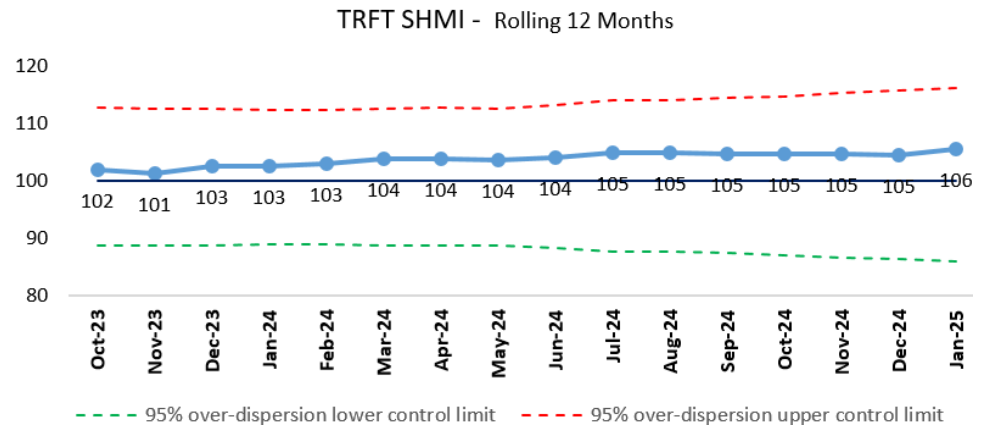
- Investigations or reviews resulting from SHMI investigations will give the Trust Assurance when there are significantly more deaths observed than expected
- Intelligence from SHMI investigations/reviews may lead to changes/improvements in practice

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

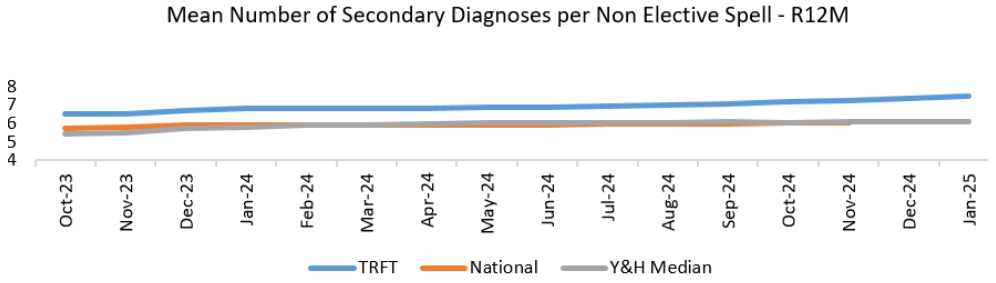
SHMI Update



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

A run of more deaths than expected between Nov 2024 & Jan 2025, in the Septicaemia diagnosis group, has triggered a VLAD Alert.

A coding review has been requested and completed SJRs will be reviewed for patients in this group.

Theses review reports and the background SHMI data will be discussed at the July Trust Mortality Group. Decisions will be made with regards to any further required investigation/reviews.

Diagnosis Group	SHMI Banding	VLAD Alert (Accumulated Risk)
Septicaemia (except in labour), Shock	As Expected	**Yes**
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
Acute bronchitis	As Expected	No
Urinary tract infections	As Expected	No

SHMI Changes – Methodology, Process or Specification

No new changes

SHMI Coding Metrics –

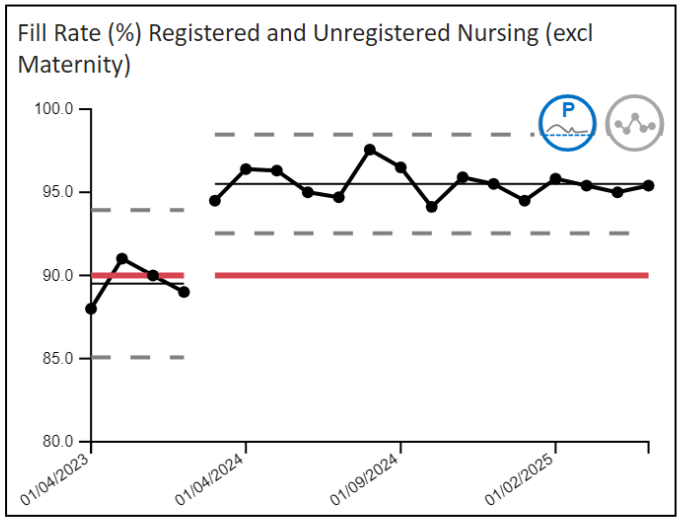
TRFT continue to have a high rate of spells with an Invalid Primary Diagnosis Code and where the code is a Sign or Symptom.

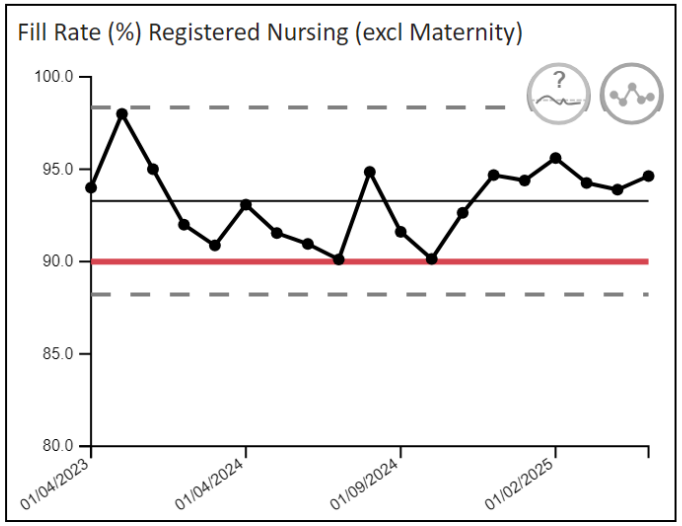
TRFT continue to have a high depth of comorbidity coding for its non elective spells.

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	25.1	4.2	1.7	29
Rotherham NHSFT	15.8	3.2	7.4	2.1	45
Bradford NHSFT	8.5	1.4	4.0	1.4	43
Mid Yorks NHST	8.7	0.5	6.7	2.3	44
NLincs & Goole NHSFT	17.5	0.1	4.7	1.3	27
Donc & Bass NHSFT	13.0	0.1	5.1	2.2	52
Airedale NHSFT	14.9	*	4.7	1.2	24
Calderdale NHSFT	6.6	*	7.2	3.3	51
Barnsley NHSFT	14.6	0.0	7.7	2.7	52
York & Scarb NHSFT	13.5	0.0	6.1	1.2	27
Sheffield NHSFT	10.0	0.0	5.2	1.8	39
Hull Uni NHST	8.4	0.0	6.2	2.3	37
Leeds NHST	5.5	0.0	6.6	2.2	36
England	14.8	2.7	6.1	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 May was 7.3.
- All actions to maintain Safe Staffing continue as business as usual.
- Review of all Inpatient, Assessment areas and UECC has been undertaken using the Safer Nursing Care Tool. A recommendation to increase establishments in some CG1 areas has been made.
- A paper was taken to ETM to support over offering of posts to support anticipated turnover and winter pressures 25/26.

Metric	Target	Value	Exec Lead	Ops Lead
Fill Rate (%) Registered Nursing (excl Maternity)	90.0	94.6	Helen Dobson	Cindy Storer
Fill Rate (%) Registered and Unregistered Nursing (excl Maternity)	90.0	95.4	Helen Dobson	Cindy Storer

What actions are planned?

- Continued roll out of the Exemplar Accreditation programme to triangulate CHPPD with patient outcomes.
- Offer letters have been sent for September NRN/NRM Recruitment. To date 84 have accepted.
- Bed reconfiguration paper for CG1 to be discussed at ETM.
- Nurse Establishment review to board in July recommending an increase in establishment for some CG1 areas.

What is the expected impact?

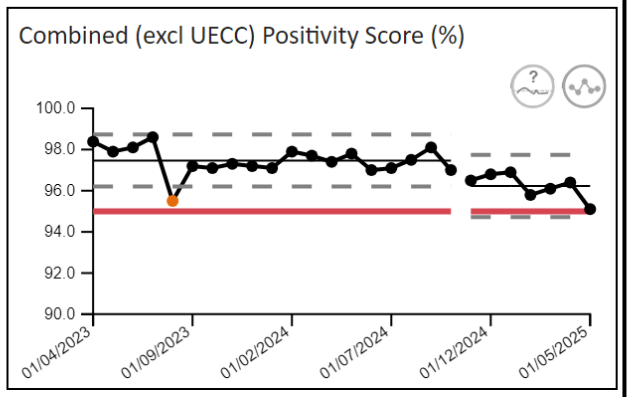
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.
- Ensure funded establishments match levels of acuity and activity.

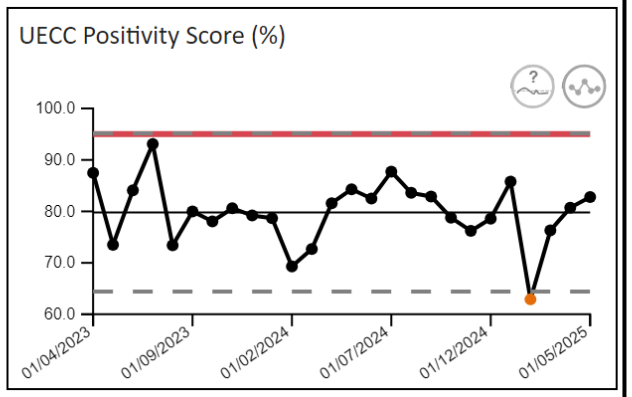
Potential risks to improvement?

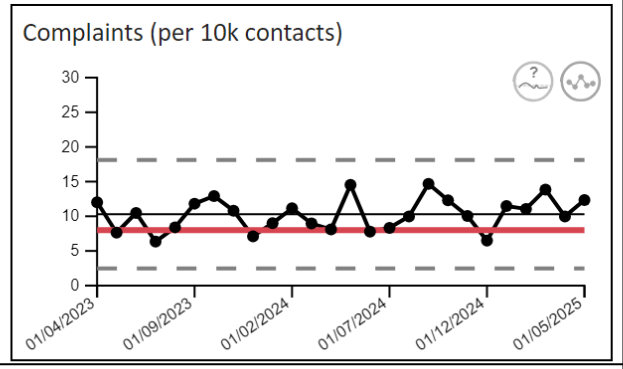
- Additional winter beds not yet fully closed.
- Roster KPI not being met.
- High rates of sickness absence in some areas.

Subtheme: Patient Experience

Data, Context and Explanation







- The Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
- The FFT asks people if they would recommend the services they have used. Our Combined Positivity Score (excl UECC) has shown a slight decrease in month but remains over 95% at 95.1%. 1136 responses were positive
- UECC position is now reported separately to allow focused intervention to improve the score.
- The number of complaints has been a consistent rate of written complaints per month over the last three years, despite the rising numbers of patients being seen.
- The number of PALS contacts from September 2024 to date are resulting in a 50% reduction in concerns being raised.
- Inpatient Survey results have been received but are currently embargoed.

Metric	Target	Value	Exec Lead	Ops Lead
Combined (excl UECC) Positivity Score (%)	95.0	95.1	Helen Dobson	Cindy Storer
UECC Positivity Score (%)	95.0	82.8	Helen Dobson	Cindy Storer
Complaints (per 10k contacts)	8.0	12.4	Helen Dobson	Cindy Storer

What actions are planned?

- Work to reduce waiting time in UECC continues against a picture of rising numbers of attendees
- New SDEC opens July 2025 to support patients being treated in the correct area which should improve patient experience.
- Patient experience improvement plan for 2025/6 now approved and aligned with new quality strategy.

What is the expected impact?

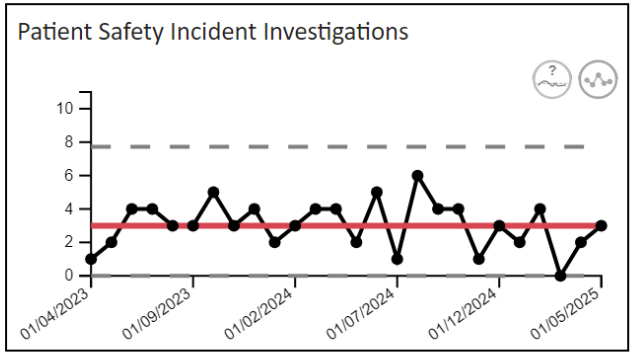
- FFT Positivity score above 95.
- Reduction of the number of formal complaints/concerns due to the PALS service.
- Patient flow through the hospital improves to reduce waiting time in UECC.

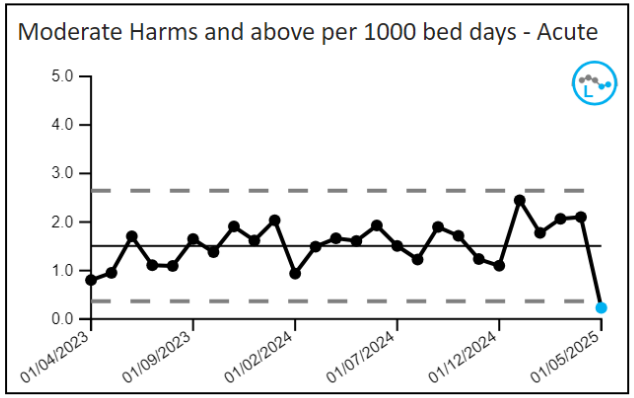
Potential risks to improvement?

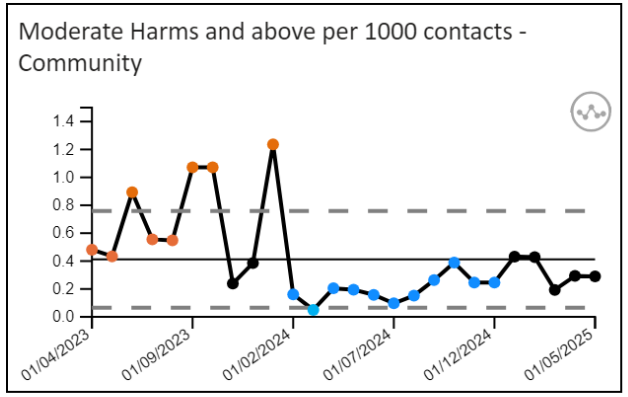
- Increasing numbers of patients attending UECC leading to longer waits.

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 remain consistent per month.
- 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.
- There were 2 nationally mandated PSII and 1 locally mandated PSII for May 2025.
- All moderate harm and above incidents are discussed at the Incident Review Group to determine what level of investigation is required and what immediate actions need to be taken. There has been a general reduction in moderate and above harms over the last 2 months.
- Within community all moderate harms are directly attributed to pressure ulcers.

Metric	Target	Value	Exec Lead	Ops Lead
Patient Safety Incident Investigations	3	3	Helen Dobson	Victoria Hazeldine
Moderate Harms and above per 1000 bed days - Acute	-	0.2	Helen Dobson	Victoria Hazeldine
Moderate Harms and above per 1000 contacts - Community	-	0.3	Helen Dobson	Victoria Hazeldine

What actions are planned?

- Thematic analysis underway to identify if there are any improvements to be made to prevent delayed or missed diagnosis of cancer patients requiring endoscopy care.
- Quality Governance and Assurance Team to commence co-ordination and investigation of all PSIIs (with the exception of CG3) from July 2025.

What is the expected impact?

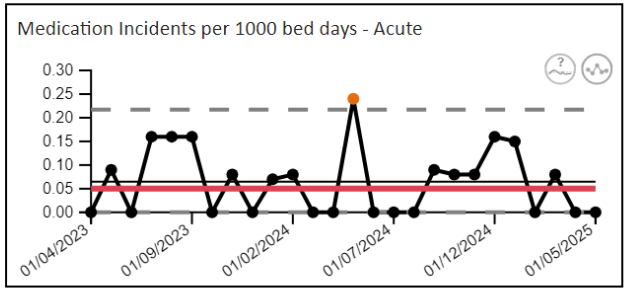
- Stabilisation of PSII's with adequate evidence of shared learning.
- An established working group will identify any key actions and potential risks.

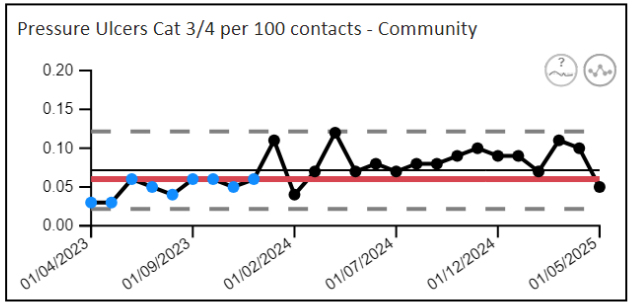
Potential risks to improvement?

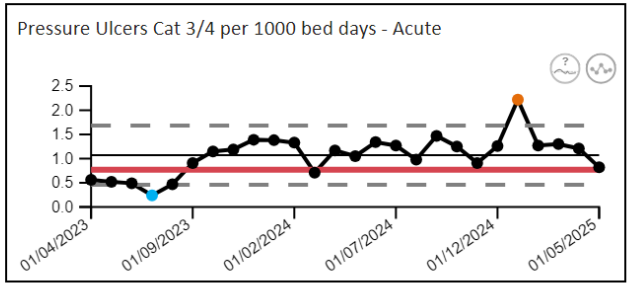
- Accurate data collection for all patients that are in and out of scope for endoscopy procedures.

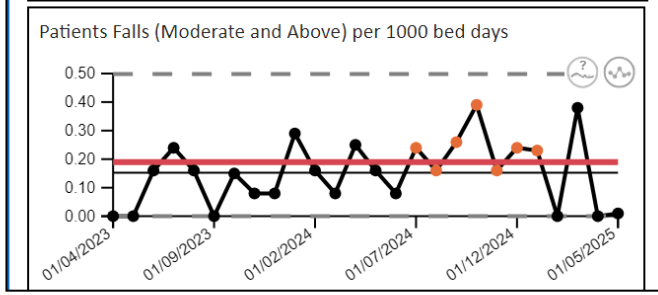
Subtheme: Care Incidents (2)

Data, Context and Explanation









- Medication incidents in Acute remain in common cause.
- Pressure ulcers (PU) remain a concern and are considered, the main, an avoidable harm associated with healthcare delivery. The rate of PU in Acute remains in common cause, however in Community the PU rate has shown a deterioration with an increased rate of PU.
- The reported Cat 3 and 4 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.
- Pressure Ulcer Identification Tool audit has demonstrated improved compliance.
- The number of patient falls at moderate harm has now declined over the past two months.
- The patients who suffered a moderate harm due to a fall were all reviewed and discussed at incident review group.

Metric	Target	Value	Exec Lead	Ops Lead
Medication Incidents per 1000 bed days - Acute	0.1	0.0	Jo Beahan	Victoria Hazeldine
Pressure Ulcers Cat 3/4 per 100 contacts - Community	0.1	0.05	Helen Dobson	Victoria Hazeldine
Pressure Ulcers Cat 3/4 per 1000 bed days - Acute	0.8	0.8	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.2	0.0	Helen Dobson	Victoria Hazeldine

What actions are planned?

- Medication incidents at moderate harm and above remain low, incidents related to critical medication have been identified and will be presented at the next Medication Safety Committee.
- The trust has completed the implementation plan to come into line with the National Guidance of having only Category 1, 2, 3 and 4.
- Business case currently being completed for a full mattress replacement program.
- The newly recruited Falls Prevention Lead will contribute to QI projects and falls prevention education to help reduce the total number of all falls and moderate harm falls

What is the expected impact?

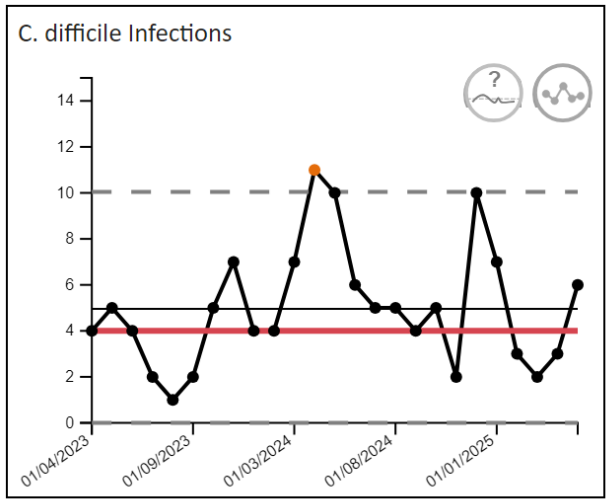
- Reduction in the number of critical medication incidents.
- Converting to hybrid mattresses will mean that patients requiring pressure relieving equipment will have it immediately and reduce the incidence of PU's.
- Reduction in the total number of falls.
- Key themes identified from moderate harm 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

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.
- The 25/26 trajectory has been set at 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.
- Action are in place to address (see planned action box).

Metric	Target	Value	Exec Lead	Ops Lead
C. difficile Infections	4	6	Helen Dobson	Jen Hilton

What actions are planned?

- Microbiology support through ward rounds on AMU to advise on prescribing.
- New process 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
- Antimicrobial prescribing Quality Priority for 25/26 will develop in year.

What is the expected impact?

- A reduction 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

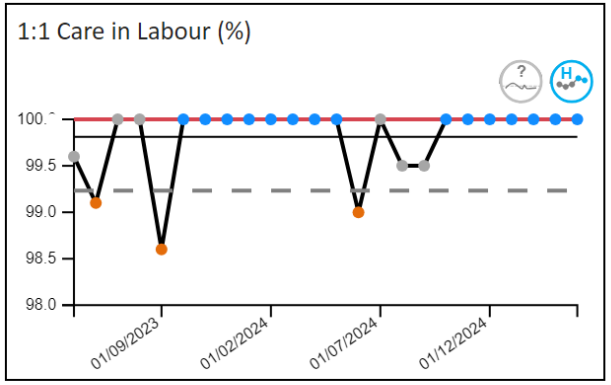
Maternity

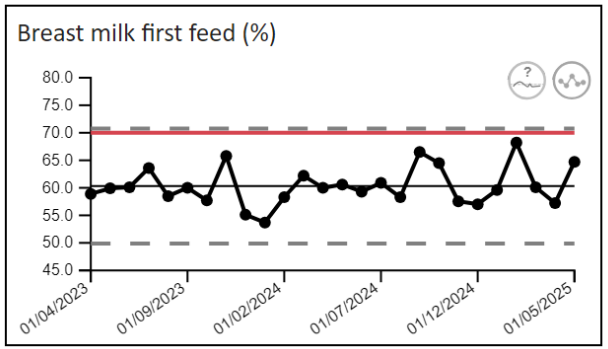
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	100.0	Apr-25	☑	?	H	-	G
Breast milk first feed (%)	70.0	64.7	May-25	☒	?			S
Stillbirth rate (per 1000 births)	3.29	1	May-25	☒	?		-	S
3rd and 4th degree tears - All	-	5	May-25					S
Massive PPH	-	3	May-25					S
Maternal Harm - Moderate and above Incidents (Harm Free)	-	1	May-25					S

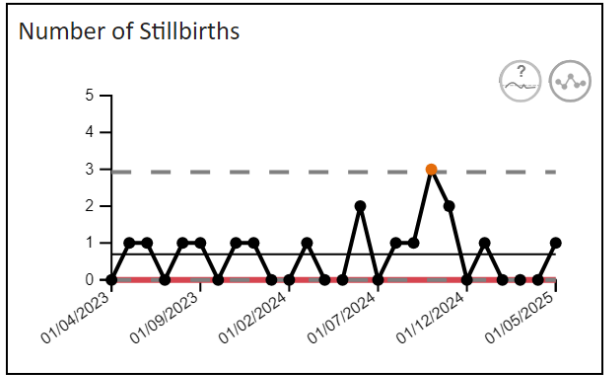
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

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 64.7% against a Trust target of 70% in the month of May. Slight increase from last month but mean measurement remains 60.4%.
- In May 2025 1 stillbirth occurred in this month.
- National rates (Stabilised and adjusted) were:
  - 2022: 3.33/1000 births
  - 2023: 3.9/1000 births
  - 2024 data not yet available.
- Our Local stillbirth rates (Stabilised and adjusted) have also seen an increase from 2022 to 2024:
  - 2022: 2.68/1000 births MBRRACE data
  - 2023: 2.88/1000 births MBRRACE data
  - 2024: 3.66/100 births MBRRACE data

Metric	Target	Value	Exec Lead	Ops Lead
Number of Stillbirths	0	1	Helen Dobson	Sarah Petty
Breast milk first feed (%)	70.0	64.7	Helen Dobson	Sarah Petty
1:1 Care in Labour (%)	100.0	100.0	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.

What is the expected impact?

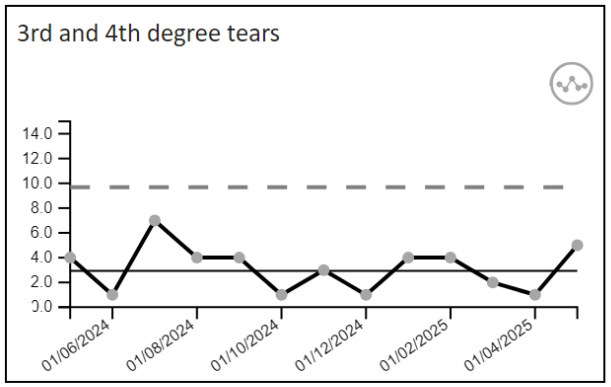
- Safety of women and babies will be maintained on labour ward
- Rates of first feed breastmilk will increase for all women who are cared for at TRFT.
- Learning from recently released reports and pending national recommendations will inform the work undertaken at TRFT to monitor, learn and improve services for woman at risk of suffering a stillbirth.

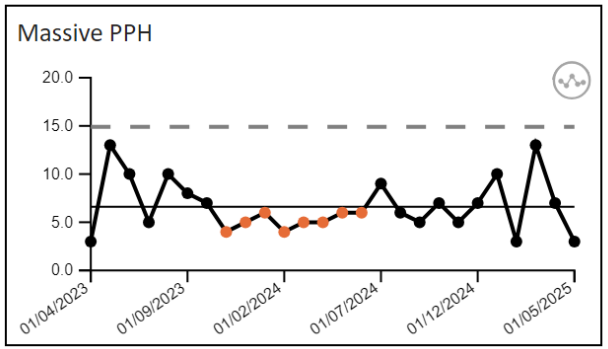
Potential risks to improvement?

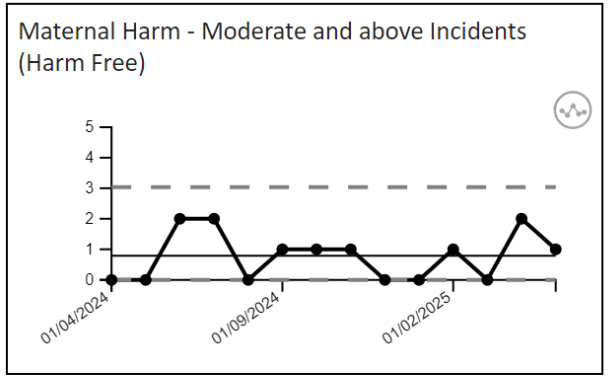
- If staffing levels were not maintained, 1 to 1 care in labour may be impacted.
- Lack of focus on public health work streams for pregnant women. Women are often disadvantage within the Rotherham's birthing population. TRFT maternity need to maintain focus on the health promotional needs of all women to inform of the benefits of breastfeeding.
- Stillbirth national targets need to be re-set so that trusts have clear trajectories.

Subtheme: Maternity - Maternal Harms

Data, Context and Explanation







3rd and 4th degree tears have an MDT review to ensure that all care was appropriate. In the month of May, the 5 cases were 2 from vaginal births and 3 from assisted births. This information is shared at the labour ward forum for monitoring and sharing learning.

Post Partum Haemorrhage (PPH) over 1500mls – May's data shows a rate of 1.3% (3 cases) against a Target of 2% of all births. TRFT mean is 3.2%. A thematic review is underway and is showing promising highlights for learning that were not apparent prior to implementing the PSIRF model of reviewing cases. The learning is shared via Safety Champion meetings and labour ward forum.

In May, 1 case remained moderate following MDT review. Whilst it was agreed at the Trust Panel meeting that the care the woman received was good, due to the amount of blood loss of 3.4 litres, DoC threshold was met and that the case should remain moderate.

Metric	Target	Value	Exec Lead	Ops Lead
Maternal Harm - Moderate and above Incidents (Harm Free)	-	1	Helen Dobson	Sarah Petty
Massive PPH	-	3	Helen Dobson	Sarah Petty
3rd and 4th degree tears	-	5	Helen Dobson	Sarah Petty

What actions are planned?

- Dashboards with the trends and themes are shared via governance meetings, safety champion meetings and labour ward forums for discussion.
- Actions identified for any learning from the MDT review of moderate harms is added to datix.
- Learning from the review of any cases and good care identified is shared via the maternity newsletter and learning points in each areas.

What is the expected impact?

- That by utilising the PSIRF model the teams will have an awareness of any commonalities, trends or themes. Actions will then be proportionate to the problem.

Potential risks to improvement?

- Maintaining safe staffing levels to ensure that women get the most appropriate care with the most appropriate staff member.
- Ensure that learning from any case reviews is shared via maternity mast sessions.
- Number of staff trained in PSIRF.

Performance Matrix Summary – Finance and Performance

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** • RTT • Patients waiting < 18wks for 1st OP Apt	**CONCERNING: CELEBRATE BUT TAKE ACTION** • Capped Theatres Utilisation
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • Clinic Utilisation – Elective and 2ww • Mean LoS (Non-Elective)	**STATIC: INVESTIGATE AND UNDERSTAND** • Waiting List Size • 52+ weeks – CYP • 52+ weeks • OP to PIFU • DM01 • 31 Day Treatment • 62 Day Treatment • FDS • 4hr Performance • Avg Amb Handover Time • >12 hours in A&E • 12hr Trolley Waits • Bed Occupancy • LoS >21 Days • Discharge Ready Date • Patients on VW • DNA (%) • *LOS > 7 Days • *Overdue Reviews • *Mean LOS (elective) • *A&E Attendances from Care Homes • *Admissions from Care Homes	**CONCERNING: INVESTIGATE & TAKE ACTION** • Criteria to Reside is No • Average time to be Seen • Discharges before 5pm
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

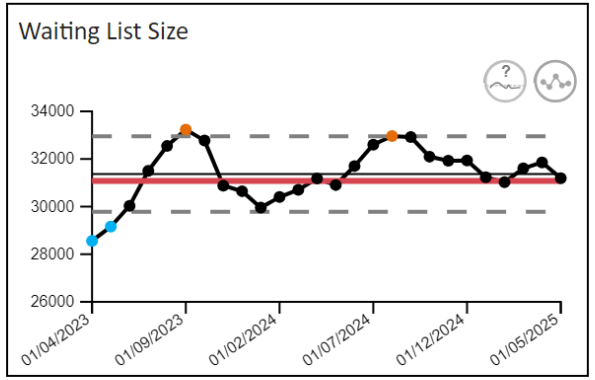
Elective Care and Cancer

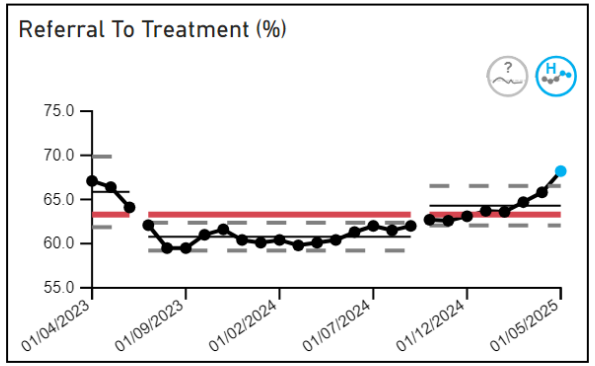
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	31,074	31,192	May-25	✗	?			S
Referral To Treatment (%)	64	68.2	May-25	✓	?	H		G
Number of 52+ Weeks	812	703	May-25	✓	?			S
Number of 52+ Weeks - CYP	65	49	May-25	✓	?			S
% Patients Waiting < 18 Wks for 1st OP	74	78	May-25	✓	?	H	-	S
OP Activity moved or Discharged to PIFU (%)	2.6	2.8	May-25	✓	?			G
DM01 (%)	1.0	0.6	May-25	✓	?			S
Faster Diagnosis Standard (%)	80.0	80.1	Apr-25	✓	?			S
31 Day Treatment Standard (%)	96.0	98.1	Apr-25	✓	?			S
62 Day Treatment Standard (%)	77.0	72.0	Apr-25	✗	?			S

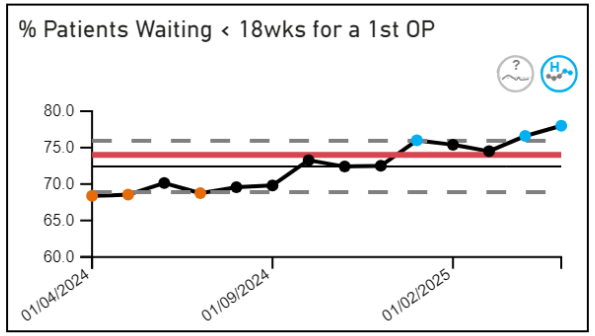
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Waitlist & RTT

Data, Context and Explanation







- Due to significant operational pressures over winter, which impacted on our ability to increase activity, we have seen growth in the waiting list over the past year. Despite these challenges, we have seen an 5.3% improvement from 32,920 in August 2024 where the waiting list peaked, to 31,192 in May 2025.
- We have increased performance by 7.7% against the RTT Standard with the Trust achieving 68.2% in May 2025 compared to 60.5% in May 2024. This is achieving trajectory, and we will now look to sustain this improvement and go further.
- The RTT standard was achieved across several specialties, including General Medicine, Geriatric Medicine, Respiratory, Clinical Haematology, Ophthalmology, Paediatrics, and Paediatric Cardiology, as well as sub-specialties such as Diabetes & Endocrine, and Stroke.

Metric	Target	Value	Exec Lead	Ops Lead
Waiting List Size	31,074	31,192	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	63.3	68.2	Sally Kilgariff	Andrea Squires
% Patients Waiting < 18wks for a 1st OP	74.0	78.0	Sally Kilgariff	Andrea Squires

What actions are planned?

- Clinic Template Reviews – Specialties to submit updates by 20th June to inform capacity planning and balance NEW/FU appointments.
- Finalise process for non-responders to move to PIFU and enhance oversight via new dashboard.
- Incorporate feedback from GIRFT follow-up review and Further Faster gap analysis into programme actions.
- Continue rollout of Virtual Fracture Clinic and start PIFU by default trial in ENT and Gastro (kick-off 18th June).

What is the expected impact?

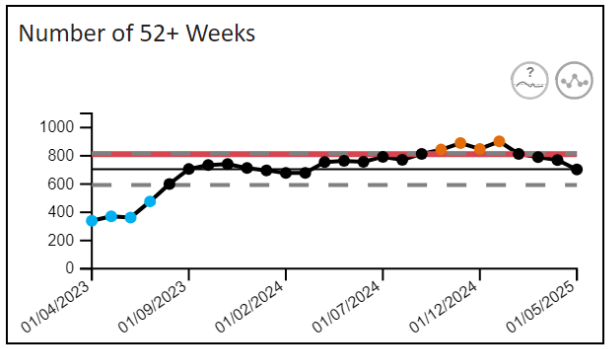
- Improved alignment of capacity to demand, supporting increased access to first appointments and reduced follow-up backlog
- Better management of follow-up lists, reduced unnecessary appointments, and improved visibility of waiting list risks
- Targeted improvements through best practice adoption, to streamline pathways and reduce RTT delays
- More efficient patient pathways and reduced face-to-face demand, freeing up clinical capacity for priority cases.

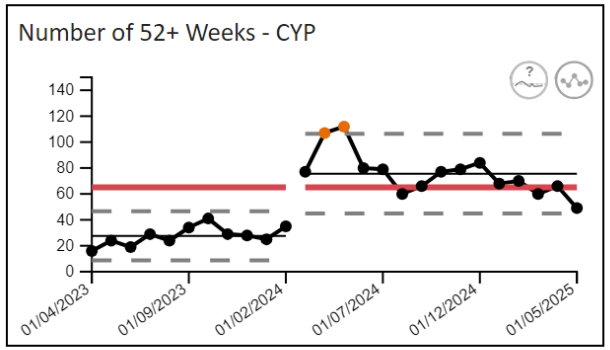
Potential risks to improvement?

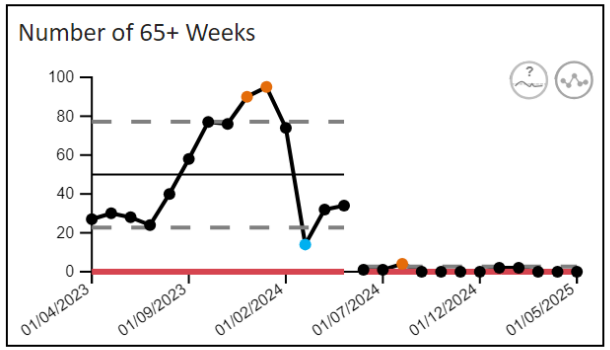
- Operational pressures (e.g. HDU capacity, elective demand) may delay planned actions
- Waiting list additions continue to exceed removals
- Limited financial resources may restrict delivery of additional activity
- Enhanced validation may uncover further long waits
- Potential impact of increased validation may adversely impact RTT due to removals below 18 weeks.

Subtheme: Long Waiters

Data, Context and Explanation







- The Trust had committed to reducing the number of patients waiting over 52 weeks to 812 in May 2025. We achieved this ambition, with 703 patients waiting for treatment over 52 weeks. The Trust remains in second quartile nationally.
- Particular growth in patients waiting over 52 weeks has been noted in OMFS, Gynaecology, T&O, and General Surgery. Insourcing and outsourcing options continue to be prioritised for these specialties.
- The Trust had committed to reducing the number of children and young people waiting over 52 weeks to 65 in May 2025. We achieved this ambition, with 49 CYP waiting.
- 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 successfully achieved 0 patients waiting more than 65 weeks in April and May 2025.

Metric	Target	Value	Exec Lead	Ops Lead
Number of 52+ Weeks	812	703	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks - CYP	65	49	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	0	0	Sally Kilgariff	Andrea Squires

What actions are planned?

- Implement GIRFT Actions – Progress agreed changes to improve scheduling and reduce long waits.
- Improve Day Case Flow – Continue ENT e-triage pilot and trial Urology high-flow/Super TURP lists.
- Enhance Pre-Assessment – Focus on right patient selection and attend GIRFT workshop to improve processes.
- Strengthen Workforce & Planning – Review succession planning and Band 3 HCA roles to boost efficiency.

What is the expected impact?

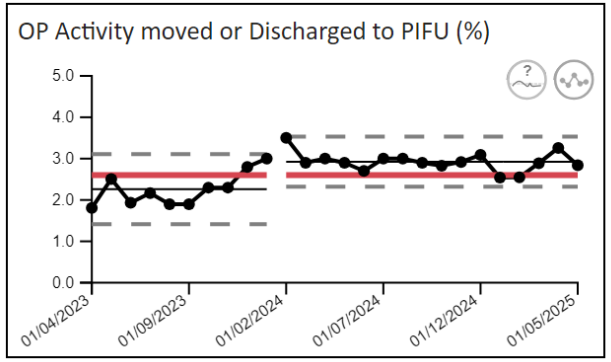
- More effective scheduling, better use of theatre capacity, and reduced delays for long waiting patients.
- Increased throughput and utilisation in key specialties, helping to reduce the day case backlog.
- Improved booking accuracy and reduced last-minute cancellations, creating more reliable theatre lists.
- Improved team resilience and productivity, supporting sustainable delivery of elective activity.

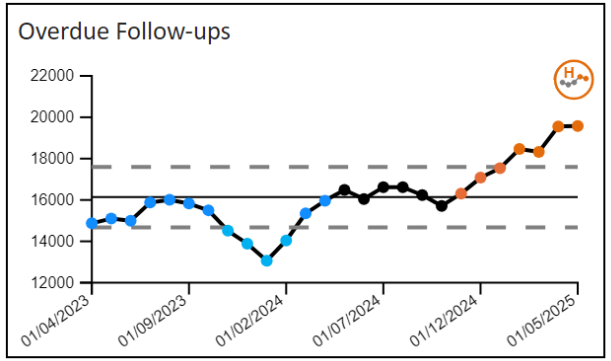
Potential risks to improvement?

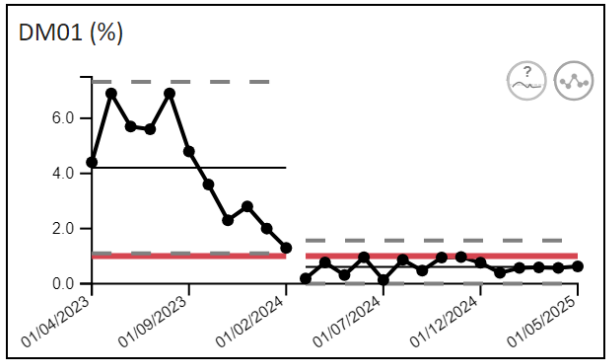
- Operational pressures (e.g. HDU capacity, elective demand) may delay implementation of planned actions.
- Limited staff availability, high sickness rates, and change fatigue may affect uptake of new processes and technologies.
- Financial constraints may limit delivery of additional activity.
- Enhanced validation may identify further long-wait patients.

Subtheme: Diagnostics & Follow-ups

Data, Context and Explanation







- The Trust has a trajectory to increase the uptake of PIFU in line with the national ask to ensure that PIFU is offered as a standard in all pathways by March 2026.
- 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 May 2025.

Metric	Target	Value	Exec Lead	Ops Lead
OP Activity moved or Discharged to PIFU (%)	2.6	2.8	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	-	19,575	Sally Kilgariff	Andrea Squires
DM01 (%)	1.0	0.6	Sally Kilgariff	Andrea Squires

What actions are planned?

- Specialties to complete national template by 20th June, supporting improved balance of NEW vs FU appointments
- Finalise plan to move non-responders to PIFU and improve tracking via the new dashboard
- Kick-off trial in Gastro and ENT (18th June), aiming to reduce unnecessary follow-ups.
- Conduct administrative validation of all follow-up waiting lists, and merge into one follow-up waiting list to reduce the risk of delays and improve oversight and management following GIRFT feedback

What is the expected impact?

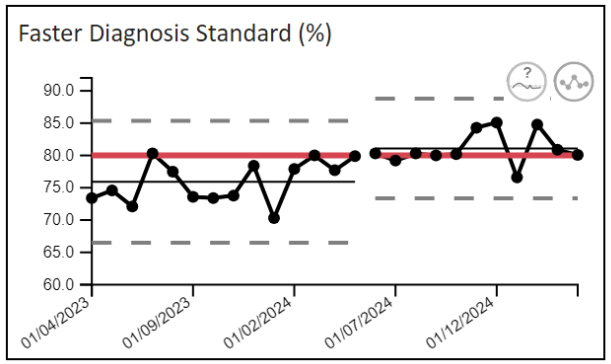
- More efficient follow-up management, reduced overdue appointments, and increased use of appropriate PIFU pathways
- Reduction in routine follow-up demand, freeing up capacity and supporting sustainable outpatient care models
- Targeted improvements in high-volume areas, reducing backlog and supporting delivery of DM01 and RTT standards.

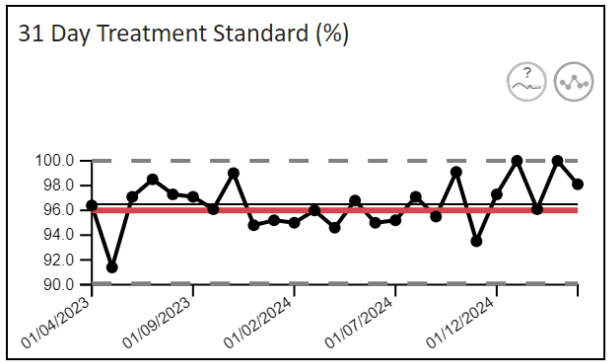
Potential risks to improvement?

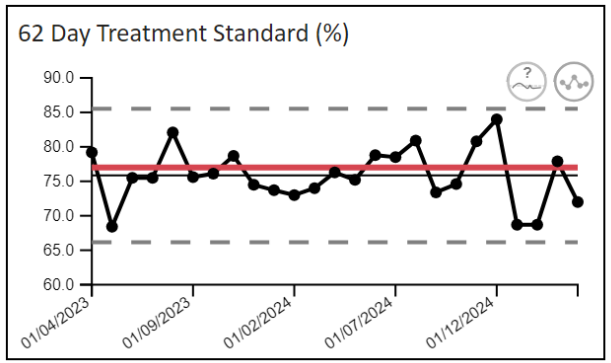
- Inclusion of overdue surveillance patients inDM01 for Audiology patients from July 2025 may impact performance due to additional capacity requirements
- Financial constraints may limit delivery of additional activity
- Transfer of long-wait DM01 patients under mutual aid agreements may affect local performance.
- Limited staffing, high sickness rates, and change fatigue may hinder adoption of new processes and technologies.

Subtheme: Cancer

Data, Context and Explanation







- In April 2025, the Trust target was to achieve 80% against the 28-day Faster Diagnosis Standard. We achieved this ambition with performance of 80.1%.
- The 31-day standard was also achieved and delivery of the 96% target has been sustained for 6 consecutive months now.
- The 2025/26 national planning guidance has set the objective to improve the 62-day performance to 75%, and the Trust has a system target of 77%. Unfortunately, we did not achieve this standard in April due to delays in the LGI Gynaecology and Urology pathways.
- A full review is currently being undertaken, and we are working with the General Surgeons to ensure we have robust plans to bring the LGI pathway forwards and ensure patients receive timely access to cancer treatment.

Metric	Target	Value	Exec Lead	Ops Lead
Faster Diagnosis Standard (%)	80.0	80.1	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	96.0	98.1	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	77.0	72.0	Sally Kilgariff	Andrea Squires

What actions are planned?

- Progress recruitment nurses and admin staff to support improved endoscopy pathway coordination and booking efficiency
- Trial of navigator-led single point-of-contact messaging to improve patient engagement and reduce delays
- Reinstate GP-Direct Access Flexi-sigmoidoscopy pathway to improve flow
- Complete 62-day pathway analysis for Haematology and LGI to identify delays and implement improvements

What is the expected impact?

- Improved pathway coordination, reduced booking delays, and increased capacity to support timely diagnostics and treatment
- Enhanced patient engagement, reduced DNAs, and improved compliance with diagnostic appointments
- Increased diagnostic throughput and earlier identification of cancers, supporting improved FDS and 62-day performance
- Identification of key bottlenecks, enabling targeted actions to reduce delays

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

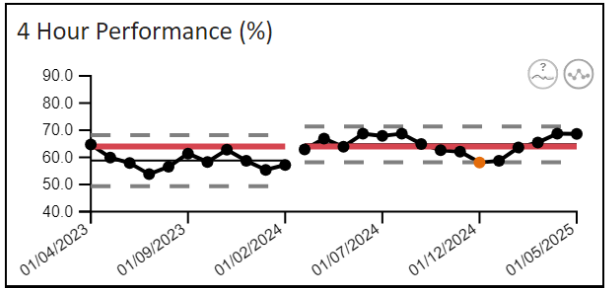
Non-elective and Flow

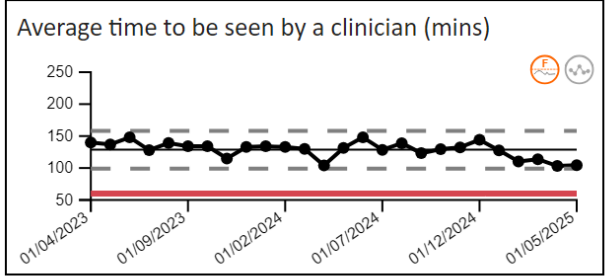
Metric	Trust Target	Latest Data	Period	Achieved (in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	64.0	68.6	May-25	☑	?			S
Average Ambulance Handover Time (Mins)	21:00	17:36	May-25	☑	?		-	S
Average time to be seen by a clinician (mins)	60.0	104.5	May-25	☒	F		-	C
Patients spending >12 hours in A&E from time of arrival (%)	6.5	1.6	May-25	☑	?			S
12hr Trolley Waits	0	1	May-25	☒	?			S
Bed Occupancy (%)	92.0	90.0	May-25	☑	?			S
Length of Stay over 21 Days	64	40	May-25	☑	?		-	S
Patients where Date of Discharge = Discharge Ready Date (%)	82.0	84.1	Mar-25	☑	?		-	S
Criteria to Reside is No (%)	10.0	18.7	May-25	☒	F		-	C

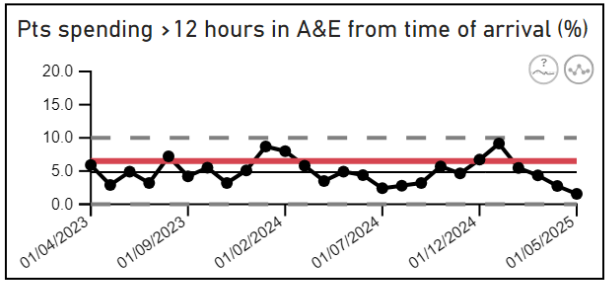
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

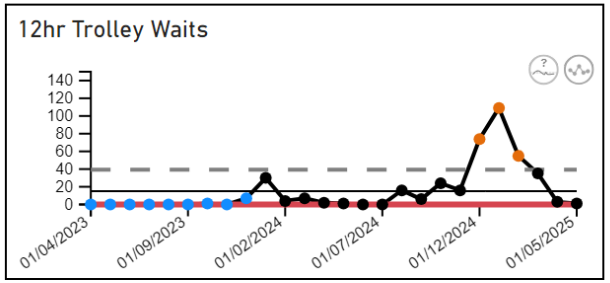
Subtheme: Emergency Care - Waiting Times

Data, Context and Explanation









- National guidance for 25/26 sets an objective for all Trusts to achieve the 4 hour performance standard of 78%. The trust has a trajectory to deliver this by March 26. and is currently achieving. There has been sustained improvement in this area, which is now performing at a stable average of 68%.
- Average time to see a clinician remains in a natural variation pattern. Recent months are showing signing of improvement bit not yet showing a consistent reduction.
- 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 hrs 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 (%)	64.0	68.6	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	60.0	104.5	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	6.5	1.6	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	0	1	Sally Kilgariff	Lesley Hammond

What actions are planned?

- New build of Green area and SDEC opening early July
- The Community ready unit will support this is pulling patients early and wards highlighting patients over night that can be moved.
- 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.
- Workforce – An additional 4 clinical fellows have been recruited to in this years cohort. This will leave a fully staffed rota from August which is an incredible achievement.

What is the expected impact?

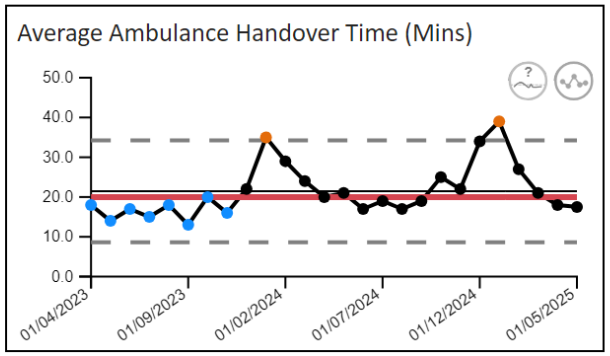
- Reduce delays waiting for admission to wards
- Reducing patients spend over 12 hours in the department
- Reduce the average time spent in the department by admitted patients
- Improvement in 4 hour performance
- Reduction in over crowding
- Empowerment of ward managers to support flow and patients home in a timely fashion

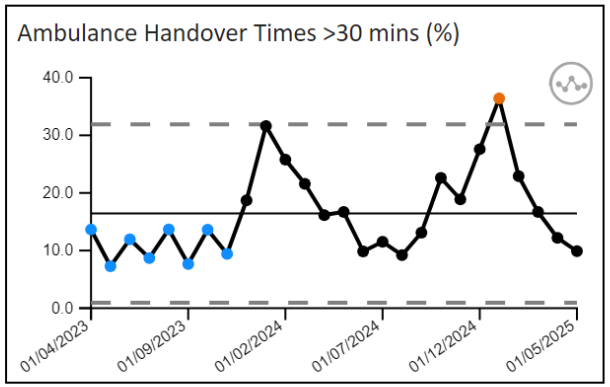
Potential risks to improvement?

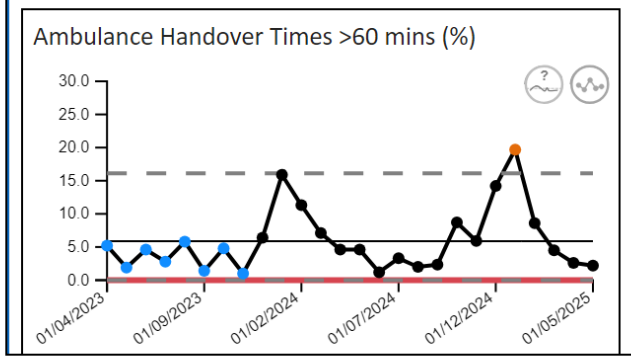
- Increase in demand will impact the Trust ability to achieve the 4 hour performance standards.
- Medical workforce staffing availability
- Sickness across medical and nursing workforce
- Infection control challenges in relation to bed occupancy

Subtheme: Emergency Care - Ambulance

Data, Context and Explanation







- The Operational Planning Guidance set an objective improving average ambulance handover times. The trust trajectory is to meet 22 mins by March 26.
- The Trust is currently performing at around 20 mins.
- The Trust compliance with Ambulance handover times >30 minutes and > 60 minutes has significantly improved with consistent reduction seen since January 2025.
- Current performance trends for Handover times >60 mins 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
Average Ambulance Handover Time (Mins)	21	18	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times <15 mins (%)	65.0	54.1	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >30 mins (%)	-	9.9	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	0.0	2.2	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?

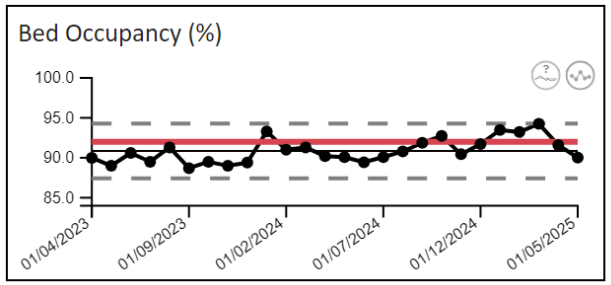
•There will be an improvement in ambulance handover times and TRFT sustained high levels of performance.
•Pilots will support reduction in conveyance to ensure all pathways in and out of hospital are utilised
•Patients seen by the right clinician at the right time in the right place first time

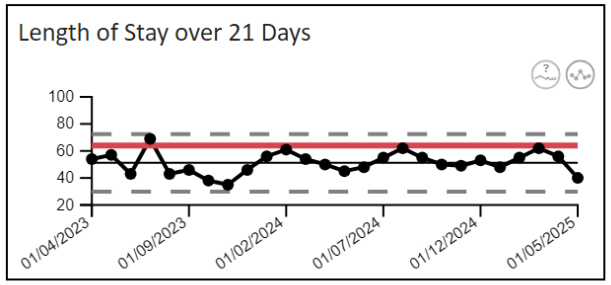
Potential risks to improvement?

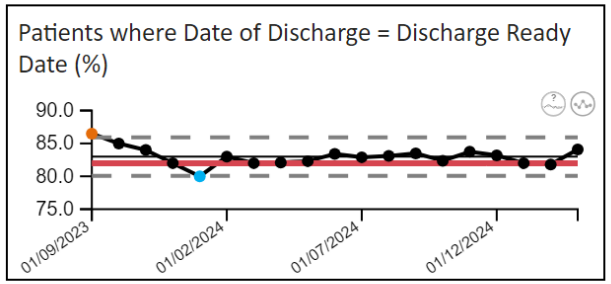
•High demand resulting in possible increase in ambulance attendances or batching of ambulances
•Ongoing demands for UEC services
•Peaks in demands for services
•Flow within the Trust/organisation and Place
• IPC challenges in relation to bed occupancy

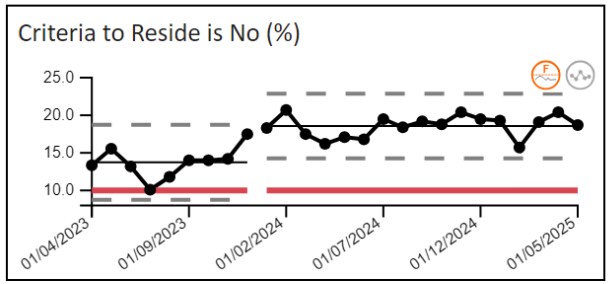
Subtheme: Inpatient Flow

Data, Context and Explanation









- Bed occupancy for May is 90.02% 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 92.51%. (B5 131.82% and SU 106.5%).
- 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.
- Length of stay >21 days remains in line with natural variation and achieving the target for the month
- Date of Discharge = Discharge Ready has shown a slight increase in May to 84.1%
- 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	90.0	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	64	40	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	82.0	84.1	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	10.0	18.7	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Length of Stay meetings – Actions discussed in operational meeting with ward managers
- Focus on criteria to reside (C2R) and internal delays – Deep dive completed and learning taken
- Every minute matters week in July around C2R to focus on recording
- Board round standardisation across medical wards with support from Ward managers and Clinical Nursing lead for patient flow
- Pilot of 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 May
- Reduction in those patients that have been an inpatient over 7 days in May
- Reduction in delays of paper work to IDT from wards
- 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

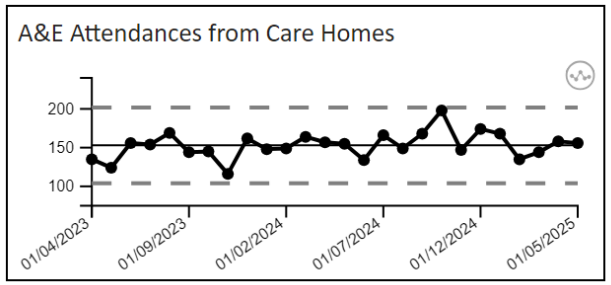
Community

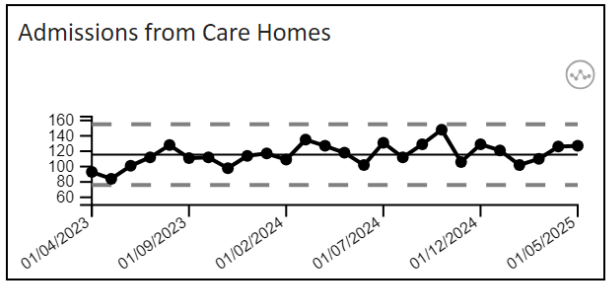
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	-	156	May-25		-		-	S
Admissions from Care Homes	-	127	May-25		-		-	S
Number of Patients on Virtual Ward	80	54	May-25				-	S
Urgent 2 Hour Community Response (%)	70.0	86	Mar-25				-	G

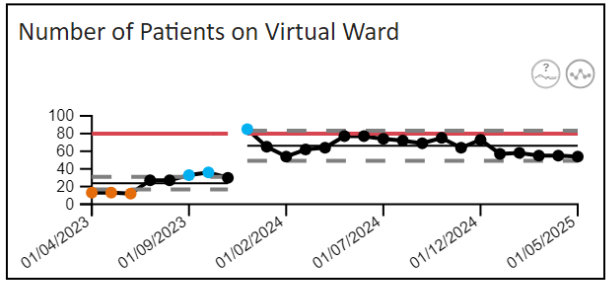
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

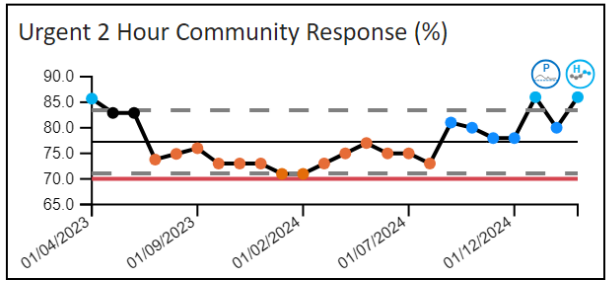
Subtheme: Community

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 joined the TOCH early January, IDT are following.
- All care homes attendances and admissions are analysis each month. The average number of inpatients from care homes throughout May was 21.
- The number of patients on Virtual Wards has decreased in month. The average occupancy in May was 53 against a Trust standard of 80. Occupancy reached a peak of 60 on 27th May. 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	-	156	Sally Kilgariff	Lesley Hammond
Admissions from Care Homes	-	127	Sally Kilgariff	Lesley Hammond
Number of Patients on Virtual Ward	80	54	Sally Kilgariff	Lesley Hammond
Urgent 2 Hour Community Response (%)	70.0	86.0	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
- Go Live with Community Mobile X-Ray Pilot

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

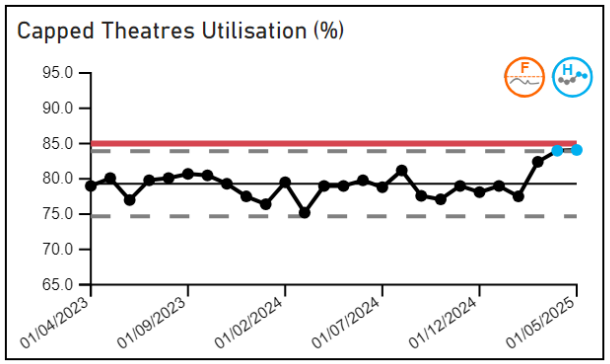
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%) – Elective and 2WW	85.0	94.2	May-25	☑	P		-	G
Capped Theatres Utilisation (%)	85.0	84.1	May-25	☒	F	H		C
Did Not Attend (%)	7.0	7.6	May-25	☒	?			S
First Outpatients (% of Plan)	TBC	TBC			?			S
Inpatients (% of Plan)	TBC	TBC			?		-	S
Daycases (% of Plan)	TBC	TBC			?		-	S
Length of Stay over 7 days	-	162	May-25	-	-		-	S
Mean Length of Stay (Non-elective)	6.9	5.1	May-25	☑	P			G
Mean Length of Stay (Elective excluding Daycases)	-	2.0	May-25	-	-			S
Discharged before 5pm (%)	70.0	65.2	May-25	☒	F			C

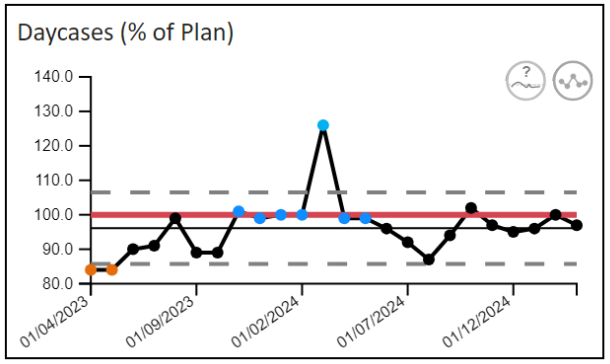
Plan is 19/20 + 3% i.e. *103% of 19/20*, therefore 100% achievement against Plan is 103% of 19/20

*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 84.1% against the 85% standard. Orthopaedics and Gen Surgery theatre utilisation has improved with increases cases from Jan.
- Model hospital data shows TRFT in the top quartile for utilisation.
- Anaesthetic and theatre staffing sickness has continued through May 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	84.1	Sally Kilgariff	Darren Howlett
Daycases (% of Plan)			Sally Kilgariff	Darren Howlett

What actions are planned?

- Staffing paper to be produced to look at long term planning.
- Increased anaesthetic SAS additional session payments for a 6 month period for uncovered theatre sessions
- Improved utilisation of MEOC for simple cases / MEOC doing elements of triage for us
- Continue to increase cases per list in Ophthalmology
- Theatre Manager to visit other trusts to look at numbers in theatre
- More robust on scheduling, lists being removed from specialties if non compliant

What is the expected impact?

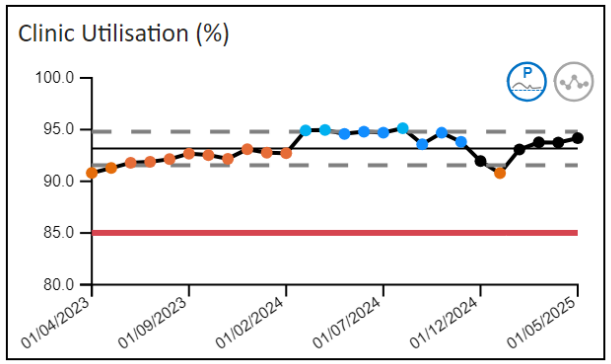
- Reduced gaps in emergency theatre will lead to less cancellations of extended trauma
- Reduced elective and extended trauma theatre session cancellations
- Improved overall utilisation and avoidance of 65 week breaches
- Increased day case rate in Ophthalmology
- Avoidance of 65 week breaches, challenges in scheduling
- More cohesive on the day theatre co-ordination and management of sickness

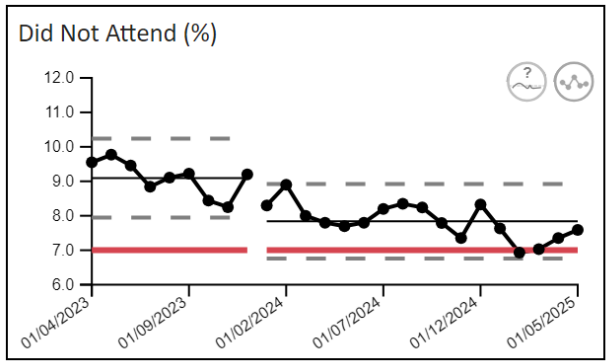
Potential risks to improvement?

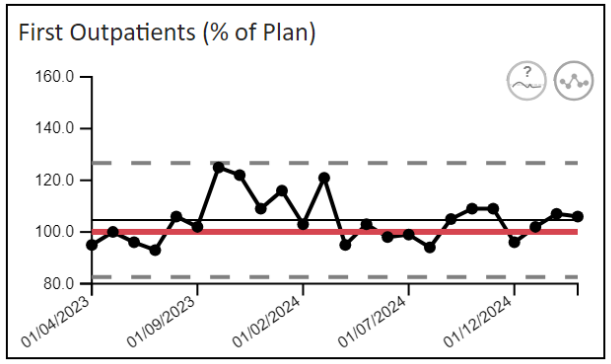
- Anaesthetic rotas may continue to impact on the ability to run theatre activity which significantly impacts on T&O in particular, expected to have up to 8wte missing In August 2025
- Capacity to deliver pre-op assessment may impact on patients available and fit for surgery
- Theatre staffing remains a concern

Subtheme: Outpatients

Data, Context and Explanation







- Clinic Utilisation is key to productivity and underutilised clinics and continues as a key focus for the Trust this year. The utilisation figures reported for 25-26 relate to Elective and 2ww wait clinics, that should be fully utilised, this utilisation is 94.2% in May.
- Trust DNA rates have shown sustained improvement. 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.
- 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. The Trust has just received the initial feedback report from GIRFT on its outpatient improvement programme.

Metric	Target	Value	Exec Lead	Ops Lead
Clinic Utilisation (%)	85.0	94.2	Sally Kilgariff	Kevin Wilkinson
Did Not Attend (%)	7.0	7.6	Sally Kilgariff	Kevin Wilkinson
First Outpatients (% of Plan)			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 1st 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
- DNA AI tool being tested in ENT. Plan to roll out wider upon completion of trial.

What is the expected impact?

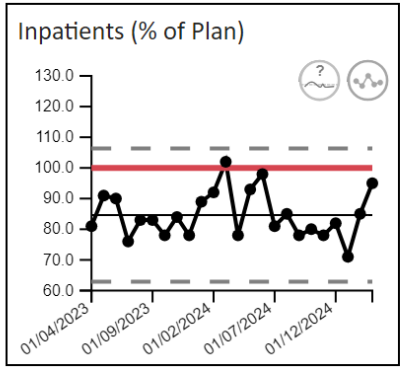
- Continued improvement of clinic utilisation into 2025/26.
- Sustained reduction in patients that DNA to 7% into 2025/26
- Sustained outpatient delivery at 100% into 2025/26.

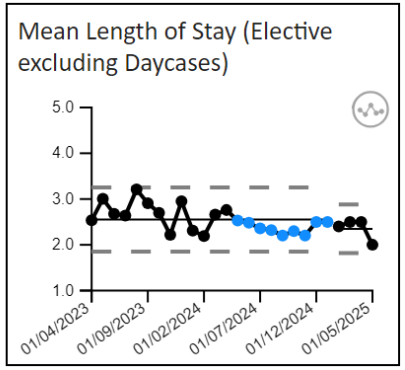
Potential risks to improvement?

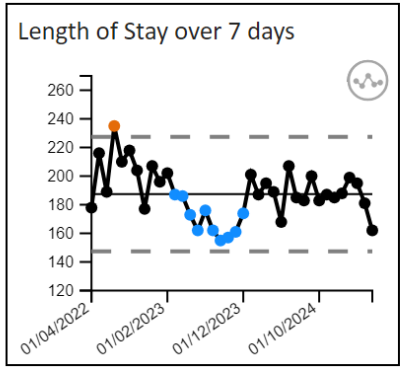
- Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
- Patient availability may impact on the ability to improve clinic utilisation, particularly short notice backfilled appointments.
- GP collective action and impact on referrals to specialities and use of advice and guidance

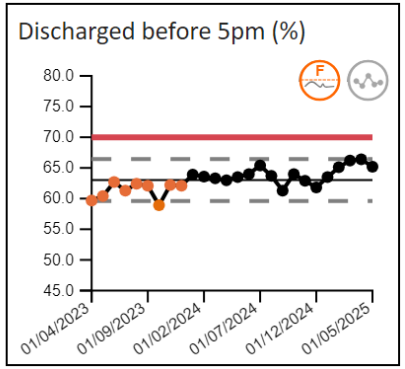
Subtheme: Inpatients

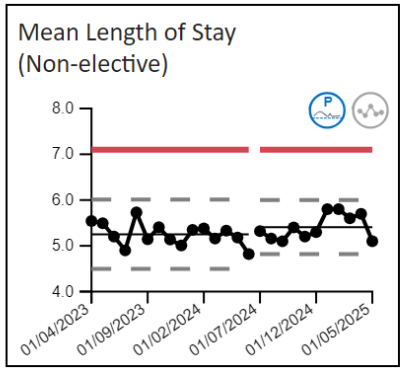
Data, Context and Explanation











- At present the % against plan charts are paused at March 25 and data is expected to be updated as of next month once the plan is embedded.
- Mean length of stay for **elective in**patients has shown an in month reduction.
- The number of patients with a LoS of 7+ days has seen some reduction of over the last two months and work continues to focus on getting patients to the right place and follow the home first approach.
- Patients discharged before 5pm has showed further improvement in the last 5 months, as the Trust continues to focus on improving discharge rates earlier in the day.
- Mean length of stay for **Non-elective** patients has remained stable under 5.5 days over the last 12-18 months

Metric	Target	Value	Exec Lead	Ops Lead
Inpatients (% of Plan)			Sally Kilgariff	Jodie Roberts
Length of Stay over 7 days	-	162	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	6.9	5.1	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	-	2.0	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	70.0	65.2	Sally Kilgariff	Jodie Roberts

What actions are planned?

- 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 particularly elective patients
- Focus from PLACE partners to reduce number of 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
- Bed reconfiguration
- Earlier transport at weekends

What is the expected impact?

- Increase number of patients discharged before 5pm to 70%
- Reduction of 7 day LOS patients
- Continued reduction in average LOS for elective inpatients
- Increased number of discharges before 5pm

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)

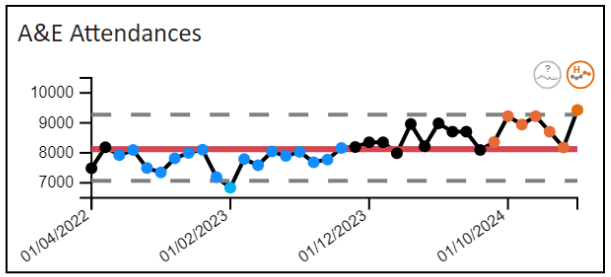
Activity

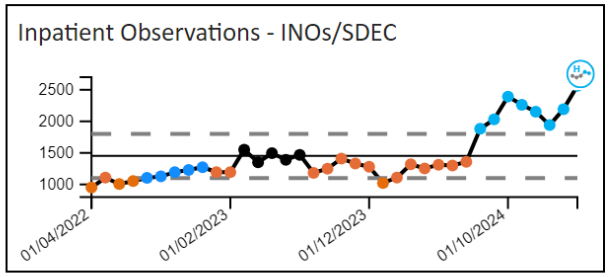
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances [Block]	TBC	9,429	Apr-25	-	?	H	-	S
Inpatient Observations – INOs/SDEC [Block]		2,460	Apr-25	-	-	H	-	G
Non-Elective Inpatients [Block]	-	2,512	Apr-25	-	-	H	-	C
Outpatients Follow Up - Attendances [Block]		15,280	Apr-25	-	?		-	S
Daycases [ERF]	TBC	1,983	Apr-25	-	?		-	S
Inpatients - Electives [ERF]	TBC	286	Apr-25	-	?		-	S
Outpatients New - Attendances [ERF]	TBC	5,783	Apr-25	-	?		-	S
Outpatient Procedures - New and Follow Up [ERF]	TBC	4,848	Apr-25	-	?	H	-	S
Referrals [Outpatient Demand]	-	8,543	Apr-25	-	-		-	S
2ww Referrals [Outpatient Demand]	-	1,259	Apr-25	-	-		-	S

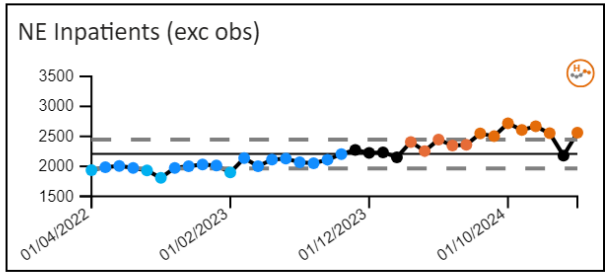
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

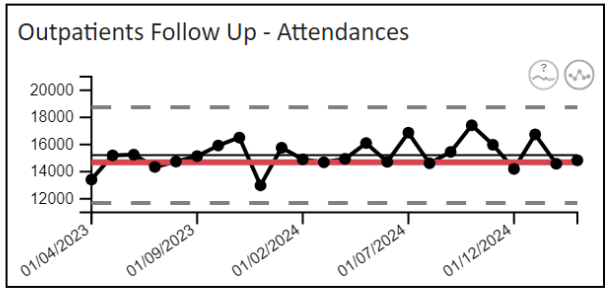
Subtheme: Block

Data, Context and Explanation









- Activity is based on M10 forecast outturn
- Plans will be updated in the report for M2
- NEL activity plans have been adjusted to take account of the full-year-effect of introduction of SDEC
- National focus remains on reducing follow-up attendances
- In line with the national direction of travel we will review any digital options within the market to aid follow-up reductions
- A joint costing exercise of the block lines is underway involving South Yorkshire Commissioners and Providers to understand the costs now versus 19/20 uplifted to today's prices
- There are no guarantees of additional funding being made available as a consequence of the above exercise

Metric	Target	Value	Exec Lead	Ops Lead
A&E Attendances		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		14,836	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?

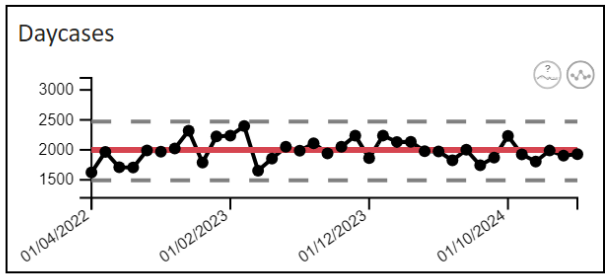
- Ensure accurate record keeping for A&E attendances
- Identify areas of above national/peer average new to follow-up ratios and initiate further review to understand why

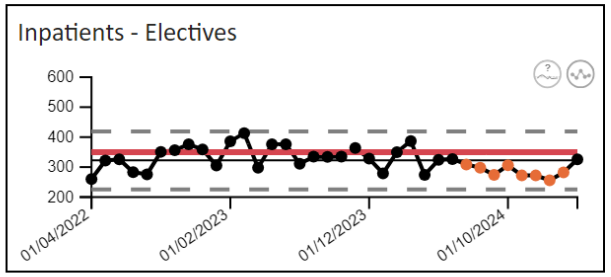
Potential risks to improvement?

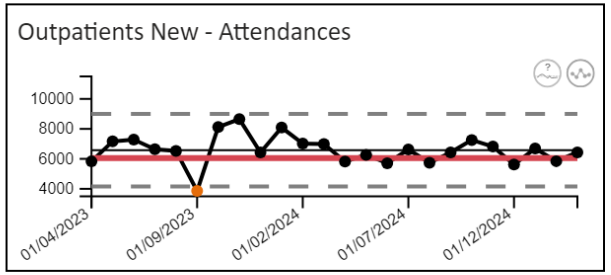
- Despite being on block, all key lines require scrutiny to ensure the Trust a) understands how this is impacting on financial performance b) we maintain an accurate position to safeguard changes to future contracting models
- Continuing increase in non elective demand, which is unfunded due to block contract.
- Switches of activity to SDEC could impact on any future re-basing (contract team aware)

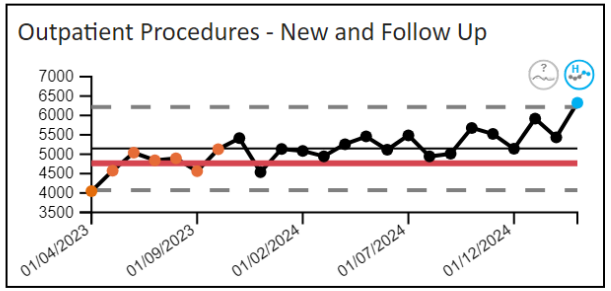
Subtheme: ERF

Data, Context and Explanation









- ERF activity targets are based on month 12 actuals
- Activity plans will be updated for month 2
- ERF lines operate on a cost and volume basis as per National Planning Guidance
- ERF over performance could result in Commissioners issuing Activity Management Plans with the potential to restrict further activity exceeding allocated ERF financial envelopes
- Key activity recording issues were resolved in 24/25 and included in the month 12 actuals

Metric	Target	Value	Exec Lead	Ops Lead
Daycases		1,928	Sally Kilgariff	Jodie Roberts
Inpatients - Electives		326	Sally Kilgariff	Jodie Roberts
Outpatients New - Attendances		6,433	Sally Kilgariff	Jodie Roberts
Outpatient Procedures - New and Follow Up		6,328	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Oversight of amended activity recording due to data mapping issues will continue to be monitored
- Any newly identified recording issues will be managed through the correct governance process in-year
- Increased scrutiny of Contract Monitoring to identify trends in variances
- 25/26 activity schemes have been agreed with some already being delivered
- Alignment of capacity and demand linked to contracted activity will be transacted

What is the expected impact?

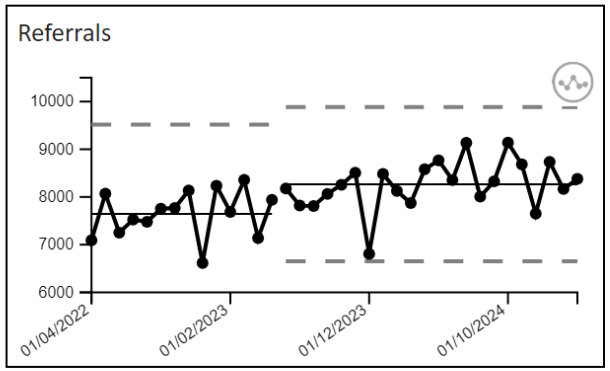
- Ensure corrected activity recording continues to be transacted in Contract Monitoring to attract the correct level of income for the work delivered
- Any significant deviations in activity can be addressed early to ensure no loss of income for work delivered
- Early commencement of 25/26 additional activity to support delivery of performance targets
- Aligning capacity/demand and targets will demonstrate areas requiring further support in 25/26

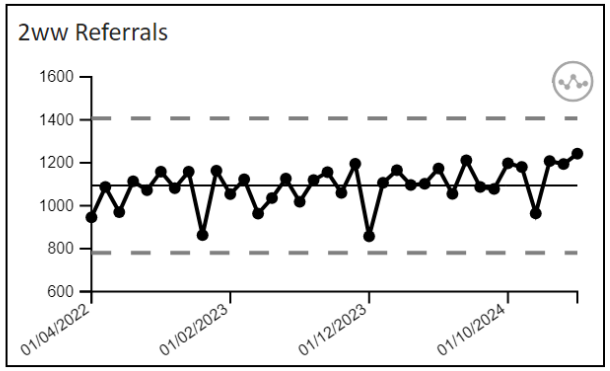
Potential risks to improvement?

- 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
- Recommencement of the Rotherham Commissioner/Provider Clinical Referrals Management Committee (CRMC) will support discussions regarding referral patterns and actions will be agreed to agree management plans

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
- Increasing use of pre and post referral Advice & Guidance
- Ensure Advice & Guidance activity is correctly reported and the associated income generated
- 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

May-25

Key Headlines	Month			YTD			Forecast Variance £000s	Prior Month Forecast variance £000s
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s		
I&E Performance (Actual)	(288)	(287)	1	(576)	(815)	(239)		
I&E Performance (Control Total)	(224)	(224)	0	(448)	(690)	(242)		
Efficiency Programme (CIP)	1,028	522	(506)	2,055	523	(1,532)		
Capital Expenditure	1,675	83	1,592	3,769	347	3,422		
Cash Balance	(2,303)	(3,331)	(1,028)	7,320	11,854	4,534		

Performance Matrix Summary – People and Culture

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**EXCELLENT: LEARN AND CELEBRATE** • Turnover (12 month rolling)	**GOOD: CELEBRATE AND UNDERSTAND**	**CONCERNING: CELEBRATE BUT TAKE ACTION**
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • MAST - Core • MAST – Job Specific	**STATIC: INVESTIGATE AND UNDERSTAND** • Vacancy Rate (total) • Appraisal Rates • Appraisal Rates (12 month rolling) • Sickness Rates	**CONCERNING: INVESTIGATE & TAKE ACTION** • Sickness Rates (12 month rolling)
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

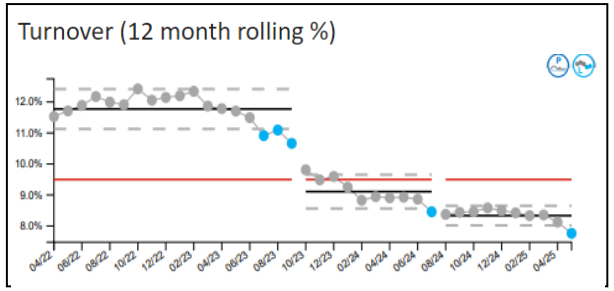
People and Culture

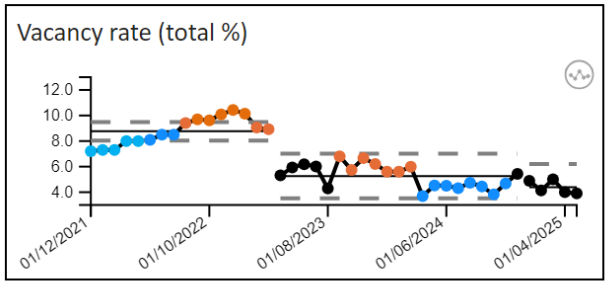
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	7.8	May-25	☑	P	L		VG
Vacancy Rate (total %)	-	3.96	May-25	-	-		-	S
Sickness Rates (12 month rolling %)	5.0	6.1	May-25	☒	F		-	C
Sickness Rates (%)	5.0	5.2	May-25	☒	?			S
Appraisal Rates (12 month rolling %)	90.0	58.9	May-25	☒	?		-	S
Appraisals Season Rates (%)	90.0	18.3	May-25	☒	?		-	S
MAST – Core (%)	85.0	91.2	May-25	☑	P		-	G
MAST – Job Specific (%)	85.0	86.1	May-25	☑	P		-	G

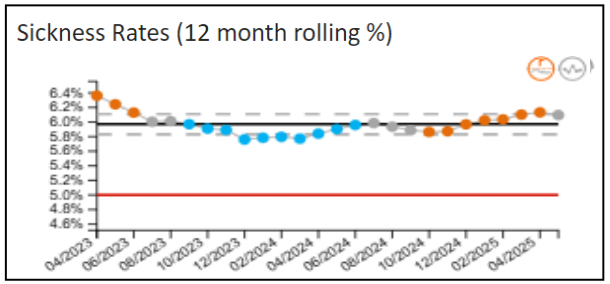
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

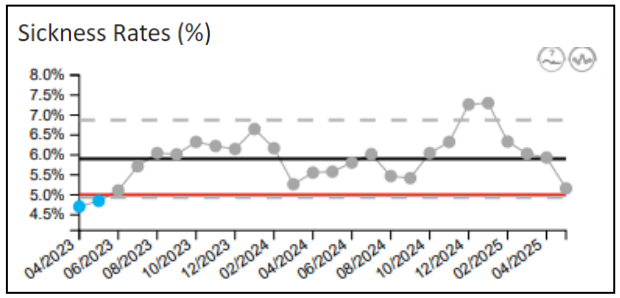
Subtheme: People (1)

Data, Context and Explanation









- Retention performance continues to be strong and has now gone below our target range of 8-9.5%. Detailed breakdowns are provided by Care group and service.
- 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 is static at 6.1% although the in month performance is improved and is driven by a reduction in long term sickness absence.

Metric	Target	Value	Exec Lead	Ops Lead
Turnover (12 month rolling %)	9.5	7.8	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	-	3.9	Daniel Hartley	Paul Ferrie
Sickness Rates (12 month rolling %)	5.0	6.1	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	5.0	5.2	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
- Launch of new Welcome back to work form and Supporting attendance policy and increased senior leader and manager accountability
- Mobilisation of new OH contract

What is the expected impact?

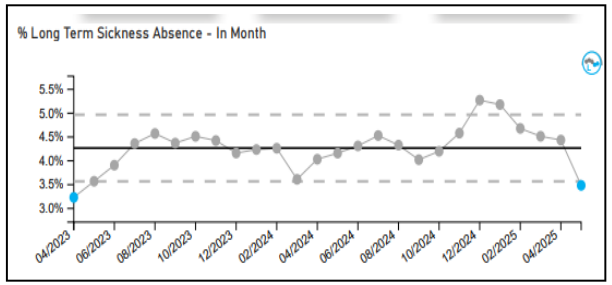
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

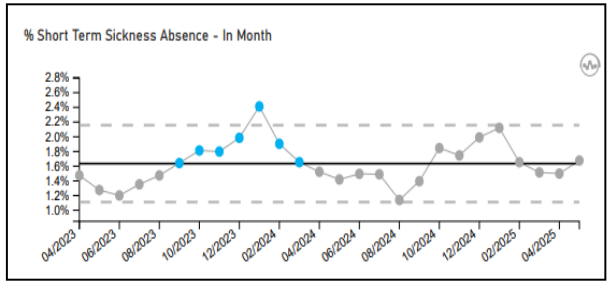
Potential risks to improvement?

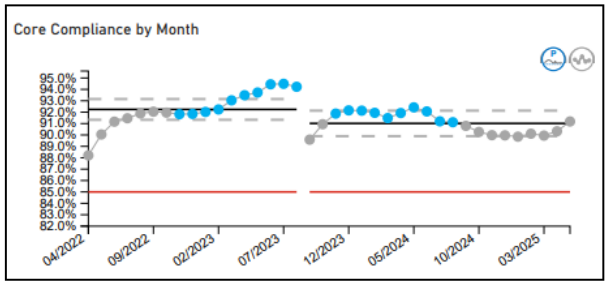
- Continued impact of ill-health of staff on attendance
- Lack of manager compliance with return to work and policy application
- Areas of poor levels of engagement and low morale make insufficient progress

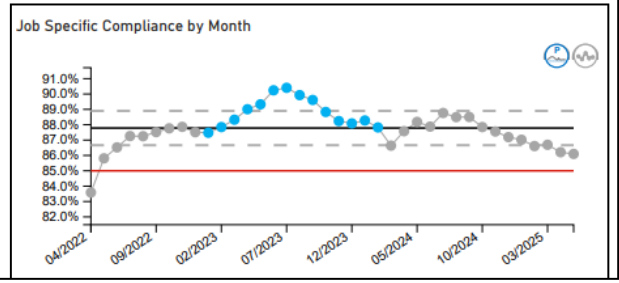
Subtheme: People (2)

Data, Context and Explanation









- 90% of the 3156 respondents to the NHS staff survey stated they have had an appraisal, suggesting not every appraisal is recorded effectively. Appraisal season is showing a similar pattern to last year and a big push on Quality Appraisals is taking place as part of We said we did.
- 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	58.9	Daniel Hartley	Paul Ferrie
Appraisals Season Rates (%)	90.0	18.3	Daniel Hartley	Paul Ferrie
MAST - Core (%)	85.0	91.2	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	85.0	86.1	Daniel Hartley	Paul Ferrie
Long Term Sickness Absence - In Month (%)	-	3.5	Daniel Hartley	Paul Ferrie
Short Term Sickness Absence - In Month (%)	-	1.7	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 MAST as part of We said we did

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

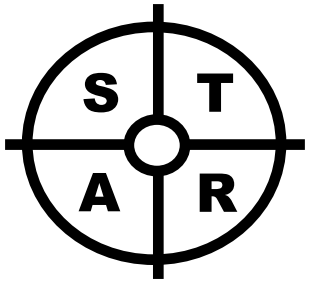
Assurance Icons

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	

Board of Directors' Meeting
4 July 2025

Agenda item	P/114/25
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D9: We will not be able to sustain services in line with national and system requirements because of a potential deficit in 2025/26 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 May 2025 (Month 2 2025/26):
	
	  ○ A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management.
	
	• Section 2 – Income & Expenditure Account for May 2025 (Month 2 2025/26:
	
	  ○ Financial results for May 2025.

	- The Trust is on plan in-month to the control total deficit of £224K and year to date it is £242K adverse to the planned deficit of £448K. - 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 – (total of £126K). • Section 3 – Capital Expenditure for May 2025 (Month 2 2025/26) o Year to date capital expenditure is £347K against a plan of £3,769K an under-spend of £3,422K. o Final budget allocations for 2025/26 are being considered at the Capital Monitoring Group, chaired by the Director of Finance. The split of budgets is dependent on confirmation of funding from NHSE for Estates Safety and Return to Constitutional Standards' schemes. These schemes were included in the 2025/26 capital financial plan and will have an impact on the prioritisation of internal capital funds. Financial budgets and monthly profiles will be revised and updated in line with budget holder expectations. • Section 4 – Cash Flow 2025/26 o A cash flow graph showing actual cash movements between April 2024 and May 2025. A month-end cash value as at 31st May 2025 of £11,854K, which is £4,534K better than plan due to the timing of income receipts and an underspend on capital expenditure.
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 held on 24 June 2025. • CIP performance was discussed at the Efficiency Board meeting held on 11 June 2025. • Capital expenditure was reviewed at the Capital Monitoring Group held on 16 June 2025. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 25 June 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		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
I&E Performance (Actual)	(288)	(287)	1	(576)	(815)	(239)
I&E Performance (Control Total)	(224)	(224)	(0)	(448)	(690)	(242)
Capital Expenditure	1,675	83	1,592	3,769	347	3,422
Cash Balance	(2,303)	(3,331)	(1,028)	7,320	11,854	4,534

1.2 In May 2025, the Trust was on plan against the control total performance. Year to date there is an over-spend of £242K against its I&E control total deficit. 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. These figures do not include any adjustment for under or over-performance on elective recovery activity, which by default is assumed to be covered within the current level of reserves.

1.3 Capital expenditure is behind plan year to date having spent £347K of the £3,769K plan. The capital programme is continuing to be monitored by the Capital Monitoring Group chaired by the Director of Finance. The split of capital budgets is still to be determined as this is dependent on confirmation from NHSE as to whether funding is secured for the targeted, Estates Safety and Return to Constitutional Standards, schemes which were included in the Trust's 2025/26 financial plan.

1.4 The cash position at the end of May 2025 is £11,854K this is better than plan by £4,534K due to the timing of income receipts and under-spend on capital expenditure.

2. Income & Expenditure Account for May 2025 (Month 2 2025/26)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered a control total on plan in month for May 2025 and a deficit to plan year to date of £242K.

Summary Income and Expenditure Position	Annual Plan £000s	Month			Year to Date			2025/2026
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Monthly Trend / Variance
Clinical Income	364,224	30,386	30,501	115	60,892	60,978	86	
Other Operating Income	22,854	2,135	2,482	348	4,006	4,625	619	
Pay	(240,473)	(20,825)	(22,473)	(1,648)	(40,868)	(44,541)	(3,672)	
Non Pay	(95,097)	(9,512)	(10,038)	(526)	(18,512)	(20,098)	(1,587)	
Non Operating Costs	(4,606)	(365)	(296)	69	(731)	(588)	142	
Reserves	(47,894)	(2,107)	(464)	1,643	(5,362)	(1,191)	4,172	
Retained Surplus/ (Deficit)	(992)	(288)	(287)	1	(576)	(815)	(239)	
Adjustments	992	64	63	(1)	128	126	(3)	
Control Total Surplus/ (Deficit)	0	(224)	(224)	(0)	(448)	(690)	(242)	

2.2 Clinical Income is above plan in month, however, these figures do not include any adjustment for under or over-performance on elective recovery activity, which by default

is assumed to be covered within the current level of reserves. At Month 2, the detailed elective recovery targets have not been confirmed with South Yorkshire ICB.

2.3 Other Operating Income is ahead of plan year to date with increased income from staff recharges (£209K), which will be an offset to the pay over-spend, and increased research, education and training income (£311K).

2.4 Pay costs are over-spending by £3,672K. Bank and agency expenditure is not currently being maintained within the gross establishment budget, and contributing to this is £1,101K under-delivery against the planned cost improvements.

2.5 Non Pay costs are over-spending by £1,587K year to date. The overspend is largely related to Drugs and Clinical Supplies £942k, and under-delivery against cost improvement plans of £431K.

2.6 The positive performance in Non-Operating Costs is due to interest receivable on cash balances being better than planned.

2.7 £4,172K has already been released from Reserves in month, this is to cover the under-delivery of CIP, overspends referred to above, and additional capacity over and above funded bed capacity.

3. Capital Programme

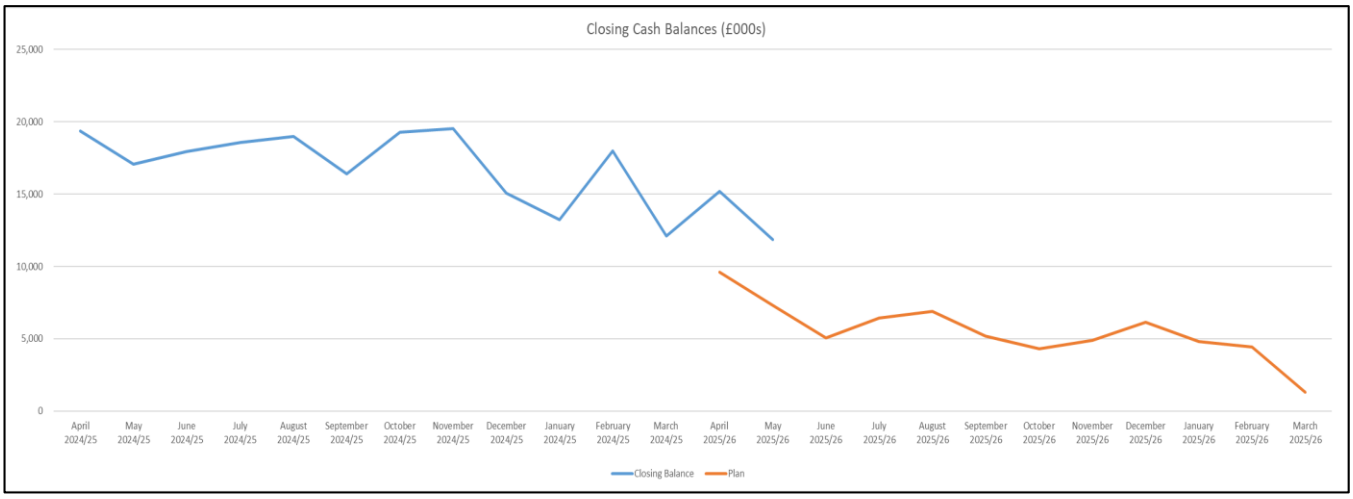
3.1 During May 2025 the Trust incurred capital expenditure of £83K against a plan of £1,675K. Year to date capital spend is £347K against a plan of £3,769K, an underspend of £3,422K. Most of the spend year to date is due to the outstanding commitments from 2024/25.

Capital Expenditure	Month			Year to Date		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Estates Strategy	750	23	727	1,750	94	1,656
Estates Maintenance	750	2	748	1,500	42	1,458
Information Technology	75	39	36	150	152	(2)
Medical & Other Equipment	100	19	81	200	58	142
Other	0	0	0	169	0	169
TOTAL	1,675	83	1,592	3,769	347	3,422

3.2 Final plans for 2025/26 are being considered at the Capital Monitoring Group, chaired by the Director of Finance. Financial plans and monthly profiles will be revised and updated in line with budget holder expectations once confirmation is received from NHSE regarding which Estates Safety and Return to Constitutional Standards schemes will be funded as these will have an impact on the prioritisation of internal capital funds.

5. Cash Management

5.1 Compared to plan, there is an in-month adverse variance on cash of £1,028K. The closing cash balance at 31st May 2025 is £11,854K compared to a plan of £7,320K, the favourable variance to plan of £4,534K is due to the timing of income receipts and the underspend on capital expenditure.



Steve Hackett
Director of Finance
10 June 2025

Board of Directors' Meeting
4 July 2025

The Rotherham NHS Foundation Trust

Agenda item	P/115/25
Report	**Safe Staffing and Establishment**
Executive Lead	Helen Dobson – Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	Ambitious – aiming to achieve full compliance against national standards for safe staffing Caring - supporting health and wellbeing of staff to improve retention and providing a set of metrics to ensure patients are safe and have a positive experience Together – the actions and recommendations are Trust wide to support all areas employing clinical staff
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The National Quality Board (NQB) publication: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, Sustainable and Productive Staffing (2016) outlines expectations and the framework. In addition improvement resources have been published to support and underpin this approach in 2018 for adult inpatient wards in an acute hospital, community nursing services, children and young people, neonatal units and maternity services. This paper has used the SNCT tool to thoroughly review the acuity and dependency of adult inpatients, adult assessment areas, children's wards and emergency departments. Due to a National Pause in the use of the Community Nursing Safe Staffing Tool (CNSST) to review the acuity and dependency of community nursing services, this paper has not been able to provide any updated guidance for Community Nursing Teams. The tool was relaunched in January 2025 and following comprehensive training of all community nursing staff the tool has been used in May 2025 with the data analysis to be included in the next paper. There has been some historical management of establishment changes in Care Groups, without understanding of the risks to RN skill mix. The risks of this are reiterated at the establishment reviews. All the ward managers applied professional judgement to their establishments and confirmed when planned staffing met actual staffing the areas were safe.

	The Surgical and Medical Assessment units had SNCT data with a deficit of 4.27 WTE. Surgical Assessment Unit establishment still includes the SDEC team whose patients aren't inpatients so aren't included in the data sets for these areas. No recommendations were made to make changes to the Assessment Unit establishments The Medical Wards (excluding the assessment unit) have the largest amount of inpatient beds and had SNCT data with a variance of –6.09 WTE. Wards A3, A4 and the Stroke Unit have had significant increases of acuity and dependency and a recommendation is made to increase the RN establishment on these 3 wards. A Recommendation is also made for a review of the Stroke Specialist Nurse Roles and responsibilities and Working patterns. A final recommendation in Medicine is to review the Stroke Unit and B4 surge beds and consider these being funded formally. All of these issues are addressed within a Bed Reconfiguration Business Case that will be reviewed by the Executive Team in June 2025. The Surgical Wards (excluding the assessment unit) funded establishments and SNCT average data show a variance of 0.28 WTE but after adding professional judgement, there are no recommended changes. These wards have smaller bed bases and are therefore more expensive to run. For Children's ward and Children's UECC, there is opportunity to consider dropping the funded establishment on Children's ward and increasing the funded establishment on Paediatric UECC. Children's Ward has a SNCT positive variance of 7.7 WTE and Paediatrics UECC has a SNCT negative variance of -2.06 WTE (22% headroom) and -2.66WTE (25% headroom). However the Care Group have a preference for redeployment dependant on acuity rather than moving the establishment. Opportunities to use the workforce more flexibly to meet seasonal demand will be explored with the Care Group. Adult UECC has a SNCT deficit of 0.54 WTE (22% headroom) and 3.17 WTE (25% headroom) but after adding professional judgement, considering the layout of the department, the increasing number of patients attending and the increasing acuity of these patients a recommendation is made for consideration of increasing the RN establishment in UECC. A Business Case will be required to support this recommendation. Community establishment reviews used Professional judgement only as the CNSST has only just had the first data collection since relaunch and the data is not available currently. No recommended changes are suggested at this current time. The Trust Board are asked to support the recommendations of the establishment reviews as led by the Deputy Chief Nurse (nursing workforce) and agreed with the Chief Nurse.

Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	The Chief Nurse has reviewed the proposed establishments and supports the recommendations in the paper. This paper was presented to People Committee in June 2025.
Powers to make this decision	The Board of Directors are authorised to approve any changes to nursing establishments in line with national guidance, subject to appropriate business cases.
Who, What and When (what action is required, who is the lead and when should it be completed?)	If reductions to establishments are proposed the Board are required to ensure a Quality Impact Assessment has been undertaken. This will be undertaken if a decision is made to reduce the paediatric establishments. The Chief Nurse will ensure that the establishment review is published on the external website in accordance with NHSE requirements.
Recommendations	It is recommended that: The Board of Directors are assured by the process of collecting the SNCT data and using professional judgement to collate proposed establishments The Board of Directors are asked to consider the recommended changes to establishments in Wards A3, A4 and Stroke Unit. This will include the reduction by 0.2WTE on all other medical inpatient wards. This will be addressed within the Care Group 1 Bed Reconfiguration business case. The Board of Directors are asked to support a full review of the roles and responsibilities of the Stroke Specialist nurses specifically the expectations and responsibilities over the full 24 hour period The Board of Directors are asked to consider the recommendations to increase the establishment in Adult UECC which will enable the RAT to remain open 24 hours per day and ensure the ability to meet the National Guidance on Registered Nursing numbers required for the Resuscitation area and to ensure that all Registered and Unregistered Nursing Staff are able to undertake all Essential to role Mandatory Training which is higher than that of inpatient wards. This will require a business case to be completed by Care Group 1. The Board of Directors are asked to maintain all other existing establishments whilst further data is collected, particularly in Community where sufficient data is not yet available.
Appendices	Appendix 1 – SNCT for assessment areas Appendix 2 – SNCT for Surgical Wards (excluding ASU) Appendix 3 – SNCT for Medical Wards (excluding AMU) Appendix 4 – SNCT for Paediatrics Appendix 5- SNCT for UECC Appendix 6 – SNCT Forward Plan

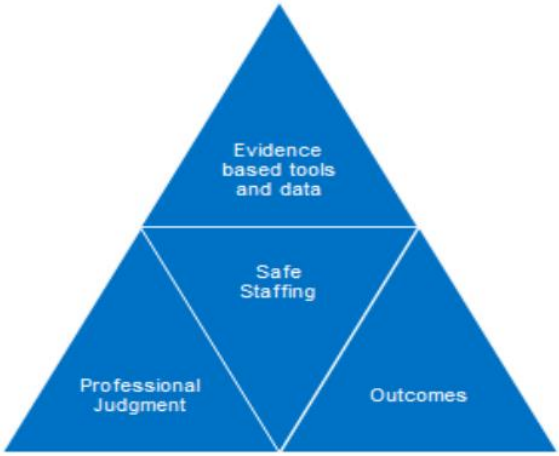
1. Introduction

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

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

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

Figure 1: Principles of safe staffing



1.4 Four cycles of acuity and dependency data collection using SNCT were completed in 2023, two cycles took place in 2024, and one cycle has taken place in 2025 with a second cycle planned for June 2025 the results from the last 4 cycles of data collection are included in this report.

1.5 Neonatal Unit and the Critical Care were excluded from the use of SNCT as staffing is in line with the National Guidelines for these specialist areas. Guidelines on Provision of Intensive Care Services (GPICS v2.1, 2022) and Badgernet Healthcare system for Establishment review of Neonatal Units.

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

1.7 In order to assure the People and Culture Committee of safe staffing on our wards, this paper sets out the outcome of the strategic staffing review which has been undertaken in line with national guidance. The review has been a comprehensive assessment of each

ward, with the ward manager, matron, head of nursing and management accountant, to take into account the following;

- Ensuring professional judgement is applied to staffing and is representative of activity requirements whilst ensuring the appropriate skill mix of staff.
- Benchmarking ward level CHPPD data from peer organisations is incorporated into each review.
- Nurse/midwifery sensitive indicators are aligned to each review such as pressure ulcers, falls, medication incidents and complaints relating to nursing care.
- The financial impact to setting of budgets is considered.

1.8 With each staffing review our compliance against the SNCT guidelines is reviewed to ensure validity of the data. The data analysis overview can be found in appendix 1 (adult assessment areas, appendix 2 and 3 (surgical and medical adult wards), appendix 4 (Children's ward) and appendix 5 (UECC).

2. Compliance against national standards

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

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

- All inpatient wards have the maximum 3 senior staff trained in the use of the Safer Nursing Care Tool (SNCT) using an inter-reliability assessment. This training is ongoing as new staff come into post and is completed by the Matron (Safe Staffing)
- All Band 7 Registered Nurses have received the training using an inter-reliability assessment, in the use of the Emergency Department SNCT Tool.
- The roll out of the community nursing safe staffing tool (CNSST), has included training all Registered Nurses and Nursing Support Workers. Following the National relaunch of the CNSST in January 2025, the Clinical Practice Educators in Community attended "Train the Trainer" training to allow them to provide all community nursing staff with either an update or full training using an inter-reliability assessment to prepare for the use of the new tool which commenced in May 2025.
- Formal reporting of safe staffing and quality to the People and Culture Committee.
- Progression of a Trust wide safety and quality dashboard.
- Implementation of a clear Retention of Nurses plan across TRFT

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

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

- NHS improvement – developing workforce safeguards, supporting providers to deliver high quality care through safe and effective staffing, October 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for Urgent and Emergency Care, 2018

- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for adult inpatient wards in acute hospitals Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for neonatal care, Edition 1, June 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for children and young people's inpatient wards in acute hospitals, Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for Maternity, Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing (SSPS). An improvement resource for adult inpatient wards in acute hospitals 2016 (2017 approved).
- Hard Truths – The Journey to Putting Patients First 'Hear the patient, speak the truth and act with compassion'. Published by the Department of Health 2014.
- National Quality Board report – How to ensure the right people, with the right skills, are in the right place at the right time. Published by NHS England 2013.
- The Model Hospital Portal - a new digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities; key nursing information is contained within the portal. https://improvement.nhs.uk/news-alerts/updates-model-hospital/

3. Feedback to Care Groups

3.1 The Heads of Nursing and Midwifery received their SNCT data, once collected and verified. A detailed feedback session was then arranged with every ward manager, matron, head of nursing/ midwifery and management accountant in April and May 2025.

3.2 The Deputy Chief Nurse (Nursing Workforce) and Matron for Safe Staffing led the feedback. During the session, the funded establishment was confirmed, the current funded skill mix, the average of the latest four SNCT data collections and ward manager supervisory time of 0.8 wte per inpatient ward also confirmed.

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

4. Analysis

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

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

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

4.4 Assessment Units

	Funded Bed Number	Funded Establishment updated April 2024	Funded Establishment updated April 2025	SNCT Average April 2025	Establishment Variance	RN skill mix (planned actual)
AMU	27	64.42 (inc SDEC)	51.8 (AMU only)	52.76	-0.96	67%
ASU	23+10	48.93 (inc SDEC)	47.28 (inc SDEC)	50.59	-3.31	56%
Totals	52 +10	113.35	99.08	103.35	-4.27	61.5%

4.4.1 The current funded establishment for medical and surgical assessment units including the ward managers is 99.08 WTE this includes SDEC on ASU but Medical SDEC has been separated from AMU. The recommended establishments from the last four SNCT data collections is 103.35 WTE. This includes a 22% headroom on average across all the areas as the SNCT tool will not allow a recommended establishment below this head room. This is a variable of 4.27 WTE nursing staff.

4.4.2 The recommended WTE doesn't include SDEC as it is not an inpatient area, therefore the SNCT data collection does not cover this area. But because at the time of completing the establishment reviews, the establishment for SDEC and the Surgical Assessment Unit is combined the SDEC establishment cannot be fully separated from funded establishment.

4.4.3 The current funded Registered Nurse (RN) and Registered Nursing Associate (RNA) skill mix is variable with an average of 61.5% across the assessment areas. The evidence base for assessment areas is 70% RN skill mix.

4.4.4 At the establishment reviews with ward managers, matrons, heads of nursing and management accountants, medicine and surgery confirmed their funded establishments (where the planned staffing matches the actual) on the Assessment Units is safe. Work is being undertaken to consider separating the establishments for ASU and surgical SDEC.

4.4.5 At the establishment review for ASU it was noted that ASU funded establishment has reduced since last April, as shown on the table above. But the SNCT data suggests that the acuity and dependence of patients has increased and an increase in funded establishment is suggested. There was no reason offered as to why this has occurred and last year's establishment reviews had recommended no changes needed to the Nursing establishment.

4.5 Medical wards

Medicine	Funded Bed Number	Funded Establishment updated April 2025	SNCT Average	Establishment Variance	RN skill mix (planned actual)
A1	33	41.6	41.1	0.5	52%
A2	24	37.6	35.5	2.1	54%
A3	33	42.6	46.3	-3.7	51%
A4	33	43.3	46.5	-3.2	50%
A5	33	41.5	42.2	-0.7	48%
A7	12	20.9	13.95	6.95	64%
CCU	8	20.91	14.3	6.61	88%
Stroke Unit	24	33.83	42.2	-8.37	59%
Short Stay	27	38.4	39.13	-0.73	54%
B5	24	36.2	41.75	-5.55	52%
Totals	278	356.84	362.93	-6.09	57.2%
B4 (escalation)	27	0	40.48		53%

4.5.1 The current funded establishment for medicine including the ward managers is 356.84 WTE for the inpatient wards. The recommended establishments from the last four SNCT data collections is 362.93WTE. This includes a 22% headroom on average across all the areas as the SNCT tool will not allow a recommended establishment below this head room. This is a variable of -6.09 WTE nursing staff.
This does not include the escalation beds on B4 as they are not funded recurrently and are only open temporarily but the data collection took place on B4 and shows the funded establishment recommended.

4.5.2 The current funded Registered Nurse (RN) and Registered Nursing Associate (RNA) skill mix is variable with an average of 57.2% across all areas. The evidence base for Inpatient wards should be a 65% RN skill mix

4.5.3 At the establishment reviews with ward managers, matrons, heads of nursing and management accountant, Professional judgement was applied in addition to the data. Wards A1, A2, A5, B5 and Short Stay Unit confirmed their funded establishments (where the planned staffing matches the actual) are safe. . No changes to the establishments of these wards were proposed when professional judgement applied

4.5.4 Coronary Care Unit and Ward A7 are smaller than the other medical wards but safety still needs to be maintained and as such the SNCT average on these wards would not give the minimum of 2 Registered Nurses per shift as is needed to maintain patient safety. Coronary Care Unit also have an average of 8.9 patients who are monitored using telemetry that aren't patients on coronary care but the Coronary Care Registered nurses monitor this remotely and action any problems that may occur with this monitoring. No changes to the establishments of these wards were proposed when professional judgement applied

4.5.5 At the establishment reviews it was discussed that the recommended establishments had increased over the last four SNCT data collections in particular the acuity and dependency has increased significantly on Wards A3, A4 and Stroke Unit. It is recommended that these wards required an increase in Registered nurse establishment

to increase the current 9-5 RN shift to a Long Day (7am-7.30pm) increasing the skill mix and staffing numbers to support the increase in dependency of the patient groups on these wards. This could be partially funded by using the 0.2WTE saved on each medical ward by the Ward Manager working 1 day per week clinically as requested last year by the Chief Nurse, these could be put together to partially fund the extra 4 hours daily on these 3 wards. The costs of this after the move of 9 ward manager hours would be £41,105

4.5.6 The Stroke Unit is currently funded for 24 beds but has had 27 beds occupied consistently for over a year so it is felt that the establishment requires an increase in Registered Nurses to enable the ward to be fully funded formally to 27 beds. The Stroke Unit has the largest deficit of all inpatient wards between planned establishment and SNCT recommended establishment of 8.37 WTE.

At the establishment review for the stroke unit it was discussed that the service is established for 4.88WTE Band 6 Stroke Specialist Nurses who work over a 24 hour period 7 days a week. It is recommended that a review of the roles and responsibilities of the Stroke Specialist Nurses takes place to include a review of working hours required, the expectations of the role overnight and at weekends should be explored as this was not clear during the establishment review and if full 24 hour cover is not required it would release funding to increase the bed base formally to 27 beds and increase the number of Registered nurses to meet the needs of the patient group and to reduce the deficit in recommended funded establishment.

4.5.7 Ward B5 is currently funded for 24 beds but has had 33 beds occupied consistently over the last year, it is felt that this needs to be fully funded formally to 33 beds as currently NHSP is being used to increase staffing levels to ensure patient safety for 33 patients. Action agreed for Care Group 1 to review the funding for the escalation beds on B5.

4.5.8 Care Group one are reviewing the inpatient beds across the care group and are considering options to reconfigure beds but the review has not concluded so no recommendations are available to review as part of the bi-annual establishment review.

4.6 <u>Surgical wards</u>

Surgery (Excluding ASU)	Funded Bed Number	Funded Establishment updated April 2024	Funded Establishment updated April 2025	SNCT Average	Establishment Variance	RN skill mix
Sitwell	14	20.94	19.28	19.53	-0.25	55%
B10	22	29.73	28.17	27.2	0.97	56%
Rockingham	22+6flex	31.61	31.61	33.25	-1.64	57%
Fitzwilliam	27+PBR	39.68	38.94	41.77	-2.83	50%
B11	14	18.63	18.63	14.6	4.03	65%
Totals	99+7	140.59	136.63	136.35	0.28	56.6%

4.6.1 The current funded establishment for Surgery is 136.63 WTE for the inpatient wards which is a reduction of 3.96 WTE in the funded establishments since April 2024. The recommended establishments from the last four SNCT data collections is 136.35 WTE. This would give a 22% headroom on average across all the areas but is only an average. This is a variance of + 0.28 WTE nursing staff.

4.6.2 Professional judgement was applied in addition to the data. As the surgical wards are smaller than the medical wards but safety still needs to be maintained and as such some wards with smaller bed base have an SNCT average which would not give the minimum of 2 Registered Nurses per shift as is needed to maintain patient safety. No changes to the establishments were proposed when professional judgement applied.

4.6.3 The acuity and Dependency on Fitzwilliam Ward has increased over the last four SNCT data collections, currently no changes to establishment is recommended but this will be monitored over the next data collections and if it continues to increase an increase in RN establishment will be recommended.

4.6.4 The current funded Registered Nurse (RN) skill mix is variable with an average of 56.6% across all areas. The evidence base for Inpatient wards should be a 65% RN skill mix. Current establishments won't allow the changes needed to work towards the 65% skill mix, but as the Trust agreed to an over recruitment of Newly Registered Nurses from September 2025 this will allow some establishment restructuring to take place and enable a change to increase the skill mix

4.6.5 At the establishment reviews with ward managers, matrons, heads of nursing and deputy heads of nursing, surgery confirmed their funded establishments (where the planned staffing matches the actual) is safe. However the SNCT average recommended establishment for Surgery has reduced since April 2024 from 140.59 WTE to 136.63 WTE which is a reduction of 3.96 WTE in the last year with no reason provided for the reduction and last year's establishment reviews had not recommended any reduction in establishments.

4.7 <u>Paediatrics</u>

	Funded Bed Number	Funded Establishment April 2025	SNCT Average	Establishment Variance	RN skill mix
Childrens wards	22-25	39.4	31.7	7.7	74%
Childrens Ward 25%	22	39.4	32.2	6.8	

4.7.1 The current funded establishment for Children's wards is 39.4 WTE, the recommended establishment from the last four SNCT data collections is 31.7 WTE. This would give a 22% headroom. This is a variance of + 7.7 WTE nursing staff. Professional judgement was applied in addition to the data and it was agreed due to the flexible number of beds and variable acuity, including assessment beds no changes to establishment is proposed

4.7.2 The current funded Registered Nurse (RN) skill mix is 74% for Children's ward. The evidence base for Children's wards should be a 67% RN skill mix but this area is also an assessment area so the 74% funded skill mix is appropriate.
The Head of Nursing also covers Paediatric UECC and Neonatal Unit so daily redeployment takes place across these areas dependant on acuity in each area

4.7.3 At the establishment reviews with ward manager, matron and head of nursing, children's ward confirmed their funded establishments (where the planned staffing matches the actual) is safe.

4.7.4 When using professional judgement with the Childrens Wards, there are no proposed changes to the funded establishments.

4.8 UECC

UECC Acuity and Dependence data Adults	Average attendees 01.04.2024 – 31.03.2025	Funded Establishment	SNCT Average	Establishment Variance	RN skill mix
UECC Adults 22% headroom	82328	84.08	84.62	-0.54	68%
UECC Adults 25% headroom	82328	84.08	87.25	-3.17	
UECC Adults 27% headroom	82328	84.08	91.5	-7.42	

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UECC Acuity and Dependence data Paediatrics	Average attendees 01.04.2024 – 31.03.2025	Funded Establishment	SNCT average	Establishment variance	RN skill mix
UECC Paediatrics 22% headroom	21088	19.49	21.55	-2.06	73%
UECC Paediatrics 25% headroom	21088	19.49	22.15	-2.66	

4.8.1 A headroom of 25% is recommended in the NQB 2018 guidance (safe, sustainable and productive staffing: An improvement resource for urgent and emergency care). This supports the amount of regulatory training for Registered Nurses within the UECC. The Nursing Workforce Standards for Type 1 Emergency Departments developed by the Royal College of Emergency Medicine (RCEM) and Royal College of Nursing (RCN) (2020) recommends 27% to cover mandated and job specific training The Trust headroom is currently 21% but the SNCT tool does not allow for below 22% headroom, therefore the establishment review included 22%, 25% and 27% headroom percentages for the adult UECC.
This is highlighted in the risk on the Trusts risk register number 6728 recording the inability to ensure MAST and job specific training is provided to all nursing staff in UECC.

4.8.2 For adult UECC, adding professional judgement – there remains concerns that nurse staffing numbers are not meeting patient needs. This is because of the layout of the department as well as the increasing number of patients attending and the increasing acuity and dependency of these patients.
Daily attendances have increased from an average of 218 per day in 2023 to an average of 243 per day in 2025 with number of attendances almost reaching 400 per day on occasion.
Concerns are raised that the resuscitation area of the department is not staffed in line with the national guidance. The Nursing Workforce Standards for Type 1 Emergency Departments developed by the RCEM and RCN (2020) recommended ‘a minimum of 1 registered nurse to each patient in the resuscitation area. This ratio will be at least 2 registered nurses to 1 patient during the resuscitative phase of illness or injury, such as cardiac arrest and the initial assessment of major trauma. Where patients do not require resuscitation, but are nursed in that area due to a crowded ED, or have been stabilised

and are awaiting further investigations or transfer to a ward, 1 Registered Nurse may be able to care for 2 patients.'

The Rapid Assessment and Treatment (RAT) is only funded between the hours of 8am-7pm and the Nursing staff reduce overnight to reflect this. The department is unable to close this area overnight due to lack of flow and the ongoing demand from the ambulance service along with the national key performance indicator to off load ambulances within 15 minutes. The Head of Nursing and Matron continue to have significant concerns regarding increasing attendances, demand and acuity arriving on the department with little to no scope to flex support from the registered nursing workforce to address it. Feedback from the UECC teams is to move back to the original model of closing RAT overnight however, this would have a detrimental impact on ambulance offload times and ultimately patient care.

4.8.3 Concerns are also raised that there is no supervisory time built in for the Band 7 Sisters/Charge Nurses as there is for Band 7 Ward Managers which makes the non-clinical aspects of the role difficult to complete due to the acuity and dependency of the patients. To support professional development, line management responsibilities, quality improvement work and the ability to provide further assurance to manage the current headcount of emergency department nursing staff, a request of 0.2WTE each per week for each band 7 to be protected. As UECC has an establishment of 4.52 WTE at Band 7 then this would be 1 WTE Band 7 at a cost of £63,910 (midpoint)

4.8.4 The current planned establishment for adult UECC is lower than the recommended establishment by either 0.54 WTE (22% headroom), 3.17 WTE (25% headroom) or 7.42 WTE (27% headroom). Considering the recommended establishment alongside Professional Judgement an increase in Registered Nursing numbers to allow 14 RNs on day shift and 12 RNs on the night shifts be a RN establishment of 69.47WTE an increase of 8.22WTE from the current RN establishment of 61.25 WTE and this would be the recommendation of the UECC Adults establishment review.

Changes have been made to the skill mix in the establishment for Adult UECC since the establishment review meeting took place and the difference would now be 9.74 WTE, the cost of this would be £509,746 if the increased Registered Nurses were all Band 5

The Nursing Workforce Standards for Type 1 Emergency Departments developed by the Royal College of Emergency Medicine and Royal College of Nursing (2020) there will be a minimum of 1 registered nurse to 3 cubicles where moderate and high dependency patients are nursed

4.8.5 Paediatric UECC has demonstrated a gap in funded establishment in SNCT recommended data of 2.06 WTE or 2.66 WTE when considering the headroom's of 22% and 25%. Adding in Professional Judgement there are no proposed changes to the funded establishment.

The Head of Nursing also covers Paediatric UECC and Neonatal Unit so daily redeployment takes place across these areas dependant on acuity in each area

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4.8.6 Previous reports have used national average data based in the Trust's annual attendance only and uses the national average percentage distribution of patients at each level of acuity and dependency.

4.8.7 To assess the local distribution of patient acuity and dependency, alongside the annual attendances is a more precise method of identifying the nurse staffing resource for the Trust's ED. This is the way that has been used to inform this report

4.9. Community Nursing

4.9.1 Following the National relaunch of the Community Nurse Safe Staffing Tool (CNSST) in January 2025, all Community Registered Nurses and Support Workers have received further training using the inter-reliability assessment and commenced data collection on 16th May 2025 for 2 weeks. The data isn't yet available from this data collection but it will be reported in the next paper along with the data collection planned for July 2025.

4.9.2 Establishment Reviews did take place for both the Planned and Unplanned community teams using Professional Judgement only, and no changes to establishments were recommended

4.10 Neonatal Unit

4.10.1 The Neonatal Unit isn't included in Safer Nursing Care Data collection as Badger-net is the national tool for the unit.

4.10.2 BAPM (British Association of Perinatal Medicine) provide National Guidance on Nurse Staffing levels for Neonatal Units.

- Intensive Care – 1 Registered Nurse to 1 baby
- High Dependency Care- 1 Registered Nurse to 2 babies
- Special Care – 1 Registered Nurse to 4 babies

4.10.3 The Neonatal unit establishment is 34.40 WTE and the average Badger-Net recommended establishment for the year 2024-2025 is 31.30 WTE which is a positive difference of 3.1 WTE

4.10.4 No establishment Review took place for Neonatal Unit and there are no recommended changes currently to the establishment. However establishment reviews will take place at the same time as the other in patient areas twice yearly from October 2025.

4.11 Critical Care Unit

4.11.1 The Critical Care Unit is not included in Safer Nursing care Tool data collection as this is set following the National GPICS (Guidelines for the Provision of Intensive Care Services)

- Level 3 patients require 1 Nurse to 1 Patient
- Level 2 Patients require 1 Nurse to 2 Patients

4.11.2 GPICS provide guidelines only and do not use data to recommend establishment levels this needs to be completed by the trust.
The current Critical Care Unit establishment is 60.7 WTE and an establishment review is planned to take place in October when the next establishment reviews take place for all inpatient areas

5. Recommendations

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

5.2 There has been some historical management of establishment changes in care groups, without understanding of the risks to RN skill mix and without a clear rationale as to the

changes that take place. The risks of this are reiterated at the establishment reviews. In surgery there appears to be an obvious reduction in overall Budgets over the last year and the reason for this is unclear.
At the establishment reviews a reminder was given that Establishment reviews and changes to establishments are agreed as part of this bi-annual establishment review process, or as a separate request to Trust board for consideration of changes to ensure that a governance process is in place and followed that maintains skill mix and patient safety.

5.3 The Assessment Units for Medical and Surgical Wards had SNCT data with a variance of -4.27. The Surgical Assessment Unit establishment includes the SDEC unit which isn't part of the data collection so it isn't possible to make suggested changes until the establishments are separated and no change to AMU establishment is recommended.

5.4 The Medical Wards, who carry the largest amount of inpatient beds had SNCT data with a variance of -6.09 WTE between funded establishments and SNCT average data.
A recommendation is made that the medical in-patient wards use the 0.2 WTE saving of Ward Manager time and use this to increase the establishment of A3, A4 and Stroke Unit as these wards have a significant increase in acuity and dependency. This is considered within the Care Group 1 Bed Reconfiguration Business Case that is being presented to the Executive Team in June 2025.

5.5 A further recommendation is that the Stroke Nurse Specialist Role is reviewed formally and roles and responsibilities are clear with consideration of the need to provide a 24 hour cover or if some of this funding can provide funding to increase the Registered nurse establishment on the Stroke unit to reduce the deficit of the SNCT recommended establishment and increase the Registered Nurses working clinical to improve the skill mix

5.6 The Surgical Wards had SNCT data with a variance of 0.29 WTE between funded establishments and SNCT average data, but after adding professional judgement, there are no recommended changes. These wards are smaller areas and cannot safely be staffed on less than 2 RNs per shift therefore more expensive to run in relation to patient numbers.
Critical Care will be included in the next establishment reviews following the GPICS guidelines and patient acuity

5.7 For Children's ward and Children's UECC, there is opportunity to consider dropping the funded establishment on Children's ward and increasing the funded establishment on Paediatric UECC. When applying professional judgement, there was a concern that reducing Children's ward establishment would not be safe but an acknowledgement that Paediatric UECC needed a bigger establishment. This is currently reviewed daily dependant on acuity within each area and deployments take place and it was felt by the care group that this gives more flexibly to daily acuity and staffing than moving the establishments.
The Neonatal Unit will be included in the next establishment reviews using the Badgernet data

5.8 It is recommended that the Adult UECC RN establishment is increased by 9.74wte. A separate business case will be developed by Care Group 1 to support this recommendation.

5.9 Data is not available to be provided in this paper from the planned or unplanned nursing teams this is following the national pause in the use of CNSST. The tool was relaunched

by the National Team in January 2025 and the community Nursing teams across TRFT have all been trained to use the CNSST, the first data collection took place in May 2025. The data of this and the July data collection will be included in the next paper.

5.10 A National request to Review all Nursing roles at Band 4-9 is due to commence in June 2025. This review will ensure that generic Job descriptions are in place where possible and to ensure that all Nursing Staff are working within role and Band expectations. Prior to this commencing work is taking place to review all establishment skill mix to ensure the establishment and rosters have this correct for the Hands per shift agreed at the establishment reviews.

5.11 An incidental finding of the establishment reviews and preparation for the National 4-9 review was the variance in break times across the care groups and clinical teams, a Task and Finish Group has commenced looking at the standardisation of these to ensure equity across the trust led by one of the Trusts Heads of Nursing.

5.12 The People and Culture Committee are asked to support the recommendations of the establishment review as led by the Deputy Chief Nurse (nursing workforce) and agreed with the Chief Nurse.

APPENDIX 1

Assessment Units	Funded Bed Number	Funded Establishment	SNCT – Oct 23	SNCT Feb 24	SNCT Jul.Aug 2024	SNCT Feb.mar 2025	SNCT Average plus 0.4WM	Variance WTE
AMU	27	51.8	46.9	60.76	53.25	48.53	52.76	-0.96
ASU	23+10	47.28	39.2	55.06	50.87	55.66	50.59	-3.31
SDEC		Included in ASU						
	52+10	113.35					98.08	-4.27

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

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

SNCT Multiplier's	**Assessment units**
0	1.27
1a	1.66
1b	2.08
1c	4.2
1d	8.38
2	2.26
3	5.96

APPENDIX 2

Surgical Wards (Excluding ASU)	Funded Bed Number	Funded Establishment	SNCT – Oct 23	SNCT Feb 24	SNCT Jul.Aug 2024	SNCT Feb.mar 2025	SNCT Average Plus 0.4 WM	SNCT variance
Sitwell	14	19.28	16.6	20.28	20.04	19.59	19.53	-0.25
B10	22	28.17	25.1	29.06	25.92	27.1	27.2	0.97
Rockingham	22+6flex	31.61	22.5	34.57	35.91	38.44	33.25	-1.64
Fitzwilliam	27+PBR	38.94	36.6	40.82	42.85	45.23	41.77	-2.83
B11	14	18.63	12.9	13.89	13.75	17.95	14.6	4.03
	99+7	136.63					136.35	0.28

SNCT and establishments are reflective of the total staff time spent on direct patient care. This excludes student (nurses and midwives), specialist nurses, housekeepers, discharge liaison, ward clerks and play leaders.
The suggested SNCT establishment includes the Ward Manager. Minimum supervisory time for ward manager is 0.4 wte but this will be confirmed at the check and adjust meeting after the data collection.

SNCT Multiplier's	**Adult Inpatient**
0	0.99
1a	1.38
1b	1.72
1c	4.2
1d	8.38
2	1.97
3	5.96

APPENDIX 3

Medical Wards	Funded Bed Number	Funded Establishment	SNCT – Oct 23	SNCT Feb 24	SNCT Jul.Aug 2024	SNCT Feb.mar 2025	SNCT Average plus 0.4WM	Variance WTE
A1	33	41.6	36.9	41.21	44.54	40.26	41.1	0.5
A2	24	37.6	32	36.18	35.58	36.45	35.5	2.1
A3	33	42.6	43.5	49.74	48.52	43.5	46.3	-3.7
A4	33	43.3	43.1	48.26	47.01	46.04	46.5	-3.2
A5	33	41.5	38.6	39.78	45.07	43.77	42.2	-0.7
A7	12	20.9	14.1	16.96	11.52	11.64	13.95	6.95
CCU	8	20.91	15.1	11.47	13.63	16.5	14.3	6.61
Stroke Unit	24	33.83	37.6	39.91	43.05	46.75	42.2	-8.37
Short Stay	27	38.4	37.3	33.63	39.18	39.19	39.13	-0.73
B5	24	36.2	33.2	48.2	39.18	46.44	41.75	-5.55
Totals	278	356.84					362.93	-6.09
B4	27	0				40.48	40.48	

SNCT and establishments are reflective of the total staff time spent on direct patient care. This excludes student (nurses and midwives), specialist nurses, housekeepers, discharge liaison, ward clerks and play leaders. The suggested SNCT establishment includes the Ward Manager. Minimum supervisory time for ward manager is 0.4 wte but this will be confirmed at the check and adjust meeting after the data collection.

SNCT Multiplier's	**Adult Inpatient**
0	0.99
1a	1.38
1b	1.72
1c	4.2
1d	8.38
2	1.97
3	5.96

APPENDIX 4

Paediatrics	Funded Bed Number	Funded Establishment Jan 2023	SNCT – Oct 23	Feb.Mar 2024	July.Aug 2024	March April 2025	SNCT Average plus 0.4 WM	Variance
Childrens ward 22%	22	39.4 inc B7	38	32.6	26.3	28.4	31.7	7.7
Childrens Ward 25%	22	39.4 inc B7	39	33.5	27.1	29.2	32.2	6.8

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

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

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

APPENDIX 5

UECC Acuity and Dependence data	Attendees 01.04.24-31.03.25	Funded Establishment	SNCT – Oct 23	SNCT March 24	SNCT Jul.Aug 24	SNCT March April 25	SNCT Average	Variance
UECC Paediatrics 21%	20322	19.49	21.1	22	20.5	22.6	21.55	-2.06
UECC Paediatrics 25%		19.49	21.6	22.5	21.1	23.4	22.15	-2.66

UECC Acuity and Dependence data	Attendees 01.04.24-31.03.25	Funded Establishment	SNCT – Oct 23	SNCT – March 24	SNCT – July 2024	SNCT- April 2025	SNCT Average 24- 25	Variance
UECC Adults 21%	82328	84.08	76.77	82.2	88.1	91.4	84.62	-0.54
UECC Adults 25%	82328	84.08	77.7	84.4	92.1	94.8	87.25	-3.17
UECC Adults 27%	82328	84.08	81.4	90.3	98	96.4	91.5	-7.42

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

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

Appendix 6 – Safer Nursing Care Tool Forward Plan 2025-2026

- **SNCT June to July 2025 (all areas)**
- **July 2025 (2 weeks) CNSST data collection**
- **Board paper July 2025**
- **Data analysis, feedback and Inpatient Establishment Setting September 2025**
- **Board Paper January 2026**
- **SNCT February to March 2026 (all areas)**
- **CNSST March 2026**
- **Data analysis, feedback and Inpatient Establishment Setting May 2026**
- **SNCT June to July 2026 (all areas)**
- **July 2026 (2 weeks) CNSST data collection**
- **Board paper July 2026**
- **Data analysis, feedback and Inpatient Establishment Setting September 2026**
- **Board Paper January 2026**

Agenda item	P/116/25
Report	**Maternity and Neonatal Perinatal Quality Assurance Score Card**
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	**Perinatal Mortality**: There was one stillbirth in May and none in April. All perinatal deaths were reviewed using the PMRT tool, with no care issues identified that would have altered outcomes. The local stillbirth rate has increased from 2.68/1000 in 2022 to 3.66/1000 in 2024, prompting continued focus on learning and prevention. **Safety and Incidents**: A total of 32 moderate incidents were reported across both months, all of which were downgraded following MDT review except one PPH case. No Never Events or Coroner Regulation 28 cases occurred. Six safety recommendation have been received in 2025 from MNSI reports following the cluster of stillbirths, all have action plans in place. X1 case was referred to MNSI in April for a baby who required cooling, the parents declined consent for MNSI to conduct the investigation. **Workforce and Staffing**: 100% one-to-one care in labour was achieved in both months. Labour ward acuity was met 89% of the time in April and 82% in May. Recruitment of 7.0 WTE Early Career Midwives will help address staffing gaps. **Training and Compliance**: Compliance with CNST Year 7 standards remains on track. PROMPT and CTG training compliance is high, and neonatal staffing meets BAPM QIS standards. **Patient and Staff Experience**: The MNVP engaged 62 service users so far this year, with a focus on inclusivity and co-production. Staff feedback remains positive, with low sickness rates and ongoing support for Early Career Midwives. **Quality Improvement**: Initiatives include thematic reviews of PPH, enhanced triage service delivery, and the implementation of a supernumerary shift coordinator role in the neonatal unit.

	Rapid Independent Investigation into Maternity and Neonatal Services: On June 23, 2025, the health secretary announced a rapid independent investigation and taskforce to address failings in maternity and neonatal services. Immediate actions will be taken to improve care across the NHS. The investigation will urgently review up to 10 trusts with specific issues to understand and resolve systemic problems affecting women, babies, and families (Appendix 1). The ask is for Every local NHS Board with responsibilities relating to maternity and neonatal care to: • Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay. • Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed. • Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families. • Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both. • Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it. Maternity and neonatal services will collaborate with the South Yorkshire Local Maternity and Neonatal System to benchmark these actions. The findings will be shared in the Perinatal Quality Assurance Scorecard Report in September 2025.
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	Appendix 1 NHS England Letter 23rd June 2025

Perinatal Quality Assurance Scorecard

April & May 2025 Data

The Rotherham NHS Foundation Trust Maternity Services

Ambitious Caring Together

NHS The Rotherham NHS Foundation Trust

Contents

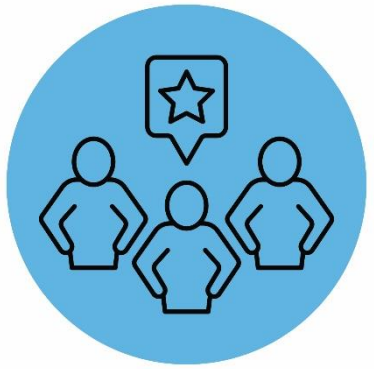
Overall Summary

Workforce

Perinatal Mortality Summary

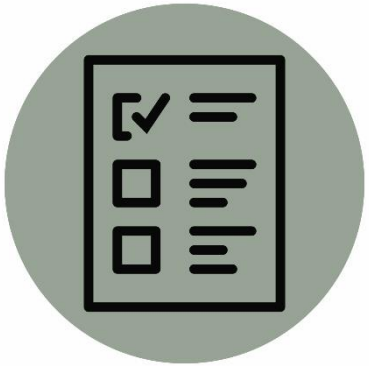
Safety

Patient Experience

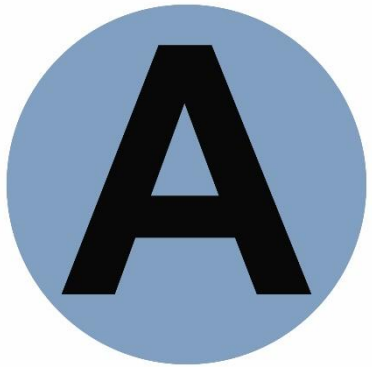

Staff Feedback

Current Issues

SPC Charts


Maternity Incentive Scheme

Saving Babies Lives v3


Attain

Preterm Birth

Month at a glance: April and May 2025

Moderate Incidents in April (17) and May (15)

Perinatal Safety Incidents in April (102) & May (106)

MNSI

1 MNSI Reportable Cases Referred

0 Coroner's Regulation 28

On track for Maternity Incentive Scheme year 7 and 3 Year Delivery Plan

%
MDT PROMPT 87% &
CTG Training 96.5%

87.3% Maternity & % Neonatal staff
Newborn Life Support Training Compliance

Smoking at booking
April: 11.3%

6.3% (April)
(May available late June)
Smoking at Birth

100%
1:1 Care in Labour in April and May 25

3rd and 4th Degree Tears in April (1) & May (5)

Full Term Babies Admitted to NNU in April (15) & May (8)

Blood Loss >1500mls in April (7) & in May (3)

89% April & 82% May
Safe Staffing Met

Vacancy Rate:
Midwives:
Obstetric: 0 WTE

Perinatal Scorecard Summary

Overview

Quality Assurance: Robust quality assurance processes are in place, with all perinatal deaths reviewed through the PMRT and learning shared across the multidisciplinary team. Compliance with CNST Year 7 standards is being maintained, and thematic reviews are actively informing practice improvements.

Performance Monitoring: Key metrics such as 1:1 care in labour, preterm birth rates, and neonatal admissions are closely monitored and reported monthly. Performance against national targets, including Saving Babies' Lives and ATAIN, is regularly reviewed to ensure alignment with best practice and regulatory expectations.

Improvement Initiatives: Ongoing quality improvement projects include enhanced triage service delivery, thematic reviews of PPH and cord gases, and the implementation of a supernumerary shift coordinator role in neonatal care. These initiatives are supported by staff engagement and feedback mechanisms to ensure relevance and impact.

Accountability: Clear governance structures ensure accountability at all levels, with action plans developed for all safety recommendations and regular oversight by the Trust Board. MDT reviews and transparent communication with families reinforce a culture of learning and responsibility.

Resource Allocation: Strategic resource planning has enabled the recruitment of 7.0 WTE Early Career Midwives and maintained safe staffing levels across maternity and neonatal services. Investment in training, governance roles, and digital infrastructure supports sustainable service delivery and compliance with national standards.

Medical care (including older people's care)	29 September 2021	Requires improvement
Services for children & young people	29 September 2021	Good
Critical care	2 March 2017	Good
End of life care	14 July 2015	Good
Maternity	29 September 2021	Good
Outpatients and diagnostic imaging	14 July 2015	Good
Surgery	2 March 2017	Good
Urgent and emergency services	29 September 2021	Requires improvement

Quality & Safety

- X1 referral to MNSI in April for a baby who required cooling. The parents declined MNSI investigation.
- 0 MNSI new referrals in May;
- 32 moderate incidents (17 in April, 15 in May) – all downgraded after MDT review.
- No Never Events or Coroner Regulation 28 cases.
- PMRT reviews: 4 closed (3 in April, 1 in May) – no care issues identified requiring action.

Experience

- MNVP engagement with 62 service users; focus on inclusivity and co-production.
- 15 Steps programme underway in NNU and Pregnancy Advisory Service.
- Continued focus on feedback from diverse groups representative of the Rotherham population.

Outcomes

- Preterm birth rate at 5.9%, below LMNS target for May.
- Term admissions to NNU: 15 (April), 8 (May); ATAIN work ongoing.
- Stillbirths: 0 in April, 1 in May, to have PMRT but initial screen shows no care concerns.
- Neonatal deaths: 1 in April (extreme prematurity), 0 in May.

Training & Learning

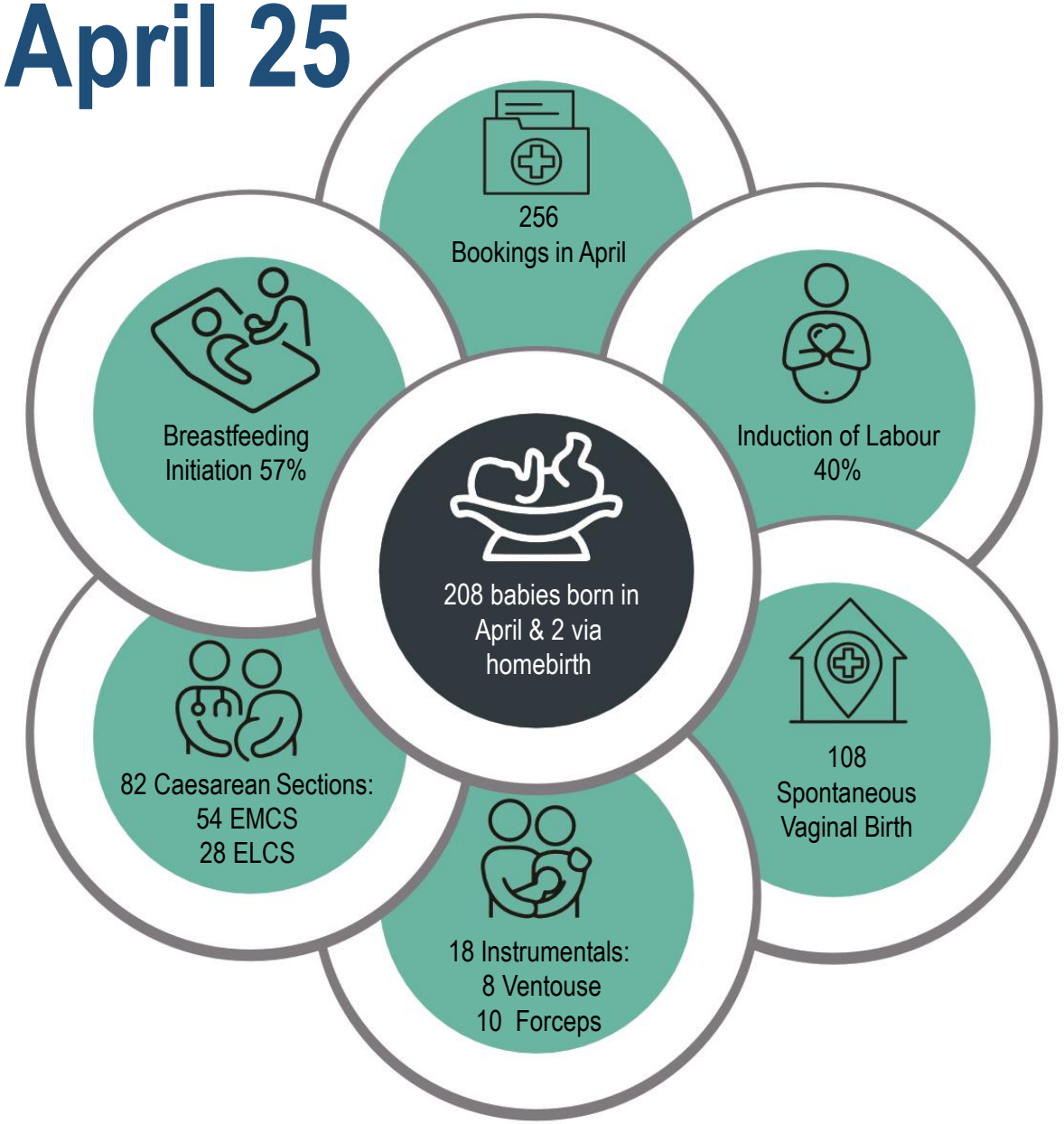
- On track for CNST Year 7 and 3-Year Delivery Plan.
- All MNSI safety recommendations have action plans;
- Compliance with duty of candour maintained.
- Continued focus on embedding learning and improving PMRT processes.

Workforce

- 100% 1:1 care in labour achieved both months.
- 7.0 WTE Early Career Midwives recruited.
- Labour ward acuity met staffing requirements 89% (April) and 82% (May).
- Neonatal staffing met BAPM QIS standards; 78% QIS compliance.
- Midwifery and Obstetric sickness rates below 4.5 % overall..

Overall Monthly Summary

April 25



May 25

Overall Year to Date Summary

Perinatal Mortality Summary

	2023 Total	2024 total	Cumulative 01/01/2025-31/05/2025	In Month: April 2025	In Month: May 2025	Information
Total Stillbirths (all)	6	9	1	0	1	1 stillbirth @ 36/40
Stillbirths >37 weeks	1	5	1	0	0	
Stillbirths 24-36+6 weeks	5	4	1	0	1	
Intrapartum stillbirths	-	2		0	0	
MTOP Anomaly >24 weeks	2	-		0	0	
Adjusted stillbirths	6	9	1	0	1	
Total Neo-natal deaths (NND)	4	5	1	0	1	1 neonatal death @ 19/40, extreme prematurity
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	**1**	**Stillbirth @ 36/40**
MTOP ENND	-	-		0	0	
Stillbirths elsewhere (Booked at TRFT)	-	-		0	0	
Neo-natal deaths elsewhere (outside of TRFT)	2	4	1	1	0	1 neonatal death @ Barnsley. Booked under TRFT community care to birth at Barnsley
Maternal deaths	1	1		0	0	
NVF <24 weeks	10	14	5	0	0	
NPMRT entered	10	14	2	0	0	
NPMRT closed	10	8	1	0	0	

In Summary

What is the local 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.
- Work has begun to look at how the families voice can be more present in the PMRT meetings.
- No themes have been found from MDT and thematic reviews at both local and LMNS levels.

Quarterly Perinatal Mortality Data - Q4 Summary

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 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).

Where do we want to be?

To be the best In England and regionally at meeting the national ambition of reducing stillbirths and neonatal deaths.

2023 - Local and regional stillbirth rates;

TRFT - Births 2569, Stillbirth rate **2.72/1000** birth
Barnsley – Births 2916, Stillbirth rate **2.9/1000**
Sheffield - Births 5549, Stillbirth rate **3.43/1000**
Doncaster and Bassetlaw – 4476 births. Stillbirth rate **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	No case	100%							
Percentage of eligible perinatal deaths notified to MBRRACE-UK with 7 working days (100%)	No cases	1 case 100%	No cases	No cases	No cases	1 case 100%							
Surveillance information completed within 1 calendar month	No cases	1 case 100%	No cases	No cases	No cases	1 case 100%							
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	No cases	1 case 100%							
Percentage of PMRT reviews started within 2 months (95%)	No cases	Met	No cases	No cases	No cases	100%							
Percentage of PMRT reports published within 6 months (60%)	No Cases	For review	No cases	No cases	No case	For review							

Finalised PMRTs – April and May 2025

April 2025

3 PMRT reviews closed and published

Case 1 - was graded – B,A – MDT identified care issued which they considered would have made no difference to the outcome.

Case 2 – was graded B, A, A – MDT identified care issued which they considered would have made no difference to the outcome.

Case 3 – was graded A, A – MDT identified no care issues.

May 2025

1 PMRT review closed and published

1 case – was graded A,A – MDT identified no care issues.

Learning and actions – overall there were no actions identified from the reviews for this trust.

In Summary

What is the data telling us?

- Families are encouraged to share their perspective /impact statement as part of the review process.

What is going well?

- No recurrent themes identified
- Families are encouraged to share their perspective as part of the review process.

What do we need to focus on?

- To await NHS national target anticipated in the 10 year plan.
- Continue the work around preterm birth to maintain the rate below 6.0%.
- Eliminate inequalities in these outcomes based on ethnicity and deprivation.
- Establishing routine data collection on miscarriages.

What is our desired destination?

Maintain CNST Year 7 Standard 1 to demonstrate continued learning and safety at TRFT. Stillbirth rates to be as low as the best European countries. Continue to improve family engagement

Safety

April /May 2025

1 case met MNSI criteria for referral in April 0 cases in May.

3 MNSI Safety recommendations in this month from a published report.

No new PSII's declared in April 2025, 0 in May 2025.

0 Never Events

15 Moderate Incidents were recorded for April and 14 were recorded for May 2025 (all but 1 case was downgraded following MDT review which was a massive PPH, all care was appropriate but due to the level of blood loss, the datix remained a moderate harm with DoC)

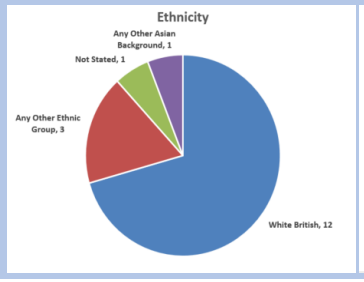
0 Coroner Regulation 28

In Summary

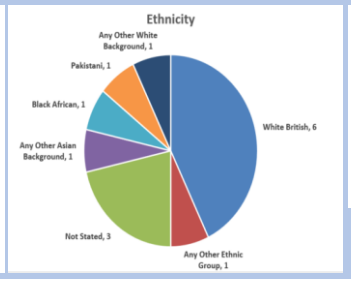
What is the data telling us?

- Moderate harms & ethnicity for April 25

- x7 MOH
- x6 low cord gases
- x1 3rd degree tear1
- x1 shoulder dystocia
- x1 low apgars
- x1 clavicle fracture



Moderate harms & ethnicity for May 25



- x5 low cord gases
- x5 3rd degree tears
- x3 MOH
- x1 shoulder dystocia
- x1 low apgars

MI-038575	16/04/2025	Intrapartum Stillbirth	4 Safety recommendations Relating to triage; admission/staffing/assessment	N/A
MI-039073	28/04/2025	Intrapartum Stillbirth	N/A	3 Safety prompts
MI-039030	14/05/2025 Family do not wish to have a tripartite meeting	Intrapartum Stillbirth	2 Safety recommendations; 1. Relating to obstetric reviews in Antenatal day unit 2. Relating to Induction of labour booking process	2 Safety prompts

What is going well? What do we need to focus on?

- The draft report has been shared with the family for an ongoing PSII report (to be signed off in June).
- The moderate harms recorded appear to be in line with the current % of ethnicity, the demographics of the women we care for with no one group affected disproportionally.
- Thematic reviews for Post Partum Haemorrhage (PPH) are progressing well with good insight into areas that have not previously been considered.
- A thematic review for low cord gases is to commenced to review further opportunities for learning.
- Plans are in place to undertake a 6 monthly, action plan assurance review to ensure that all completed action plan remain embedded after 6 months of being closed.

Where do we want to be?

- 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 prioritised, allowing concerns to be voiced without fear supporting the Just Culture Principles.

Safety

Key Performance Indicator MNSI	2019	2020	2021	2022	2023	2024	2025
MNSI Referrals (Referred & Accepted)	6	3	5	1	0	2	4
Baby cooled	5	1	3	0	0	2	1
Baby cooled but no consent to investigate	0	0	0	0	0	0	1
Stillbirth (SB) /Neonatal Death (NND)	0	1 (NND)	2 (NND)	1 (SB)	0	0	3 (SB)
Stillbirth / Neonatal Death but no consent to investigate	0	0	0	0	0	0	0
Maternal death	1	1	0	0	0	0	0
Maternal deaths but no consent to investigate	0	0	0	0	0	1	0
MNSI Total Safety Recommendations	2	6	9	1	0	2	6

What insights does the data provide?

- The series of stillbirth incidents that took place at TRFT were the primary focus of MNSI's investigations this year.
- In April 2025 MNSI could not obtain consent from the family to conduct an investigation for a baby who needed cooling. The mother involved had no concerns around her care following discussions. An MDT review of the case took place where care was reviewed and found to be in line with guidance with good team working identified. This was presented to the Trust panel.

What is going well?

- TRFT collaborates closely with families connected to MNSI cases.
- Every family is provided with a Maternity Independent Advocate to assist them throughout their investigative process.
- Completed reports are distributed through clinical effectiveness and Safety Champions.

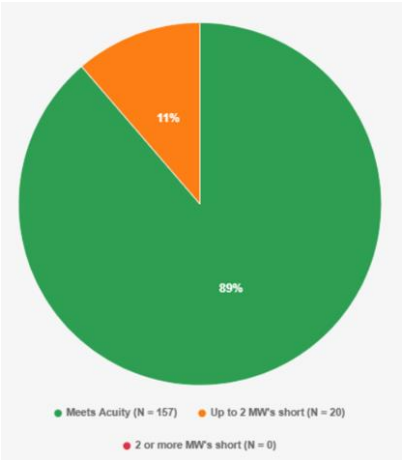
What do we need to focus on?

- That all recommendations and final reports have SMART action plans.
- To undertake a 6 monthly review of closed action plans to ensure that learning is embedded in practice.

Where do we want to be?

- Strive for zero MNSI Safety Recommendations as part of a culture focused on improvement and learning but learn from the ones we may receive.
- Provide full support to women and families affected by traumatic births or poor outcomes, maintaining transparency about findings and demonstrating growth.

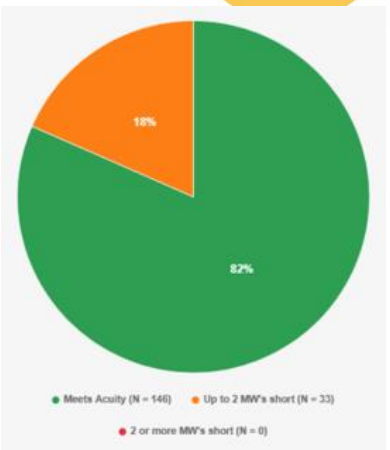
Workforce



Midwifery Staffing: In April, the labour ward acuity was achieved 89% of the time, while in May, it dropped to 82%. When staffing levels did not meet the necessary acuity, the shift leader took steps to reallocate staff within the unit to guarantee 100% one-to-one care for all women in labour, with a focus on safety. It's essential to understand that a staffing shortfall does not always indicate incomplete rosters; it may also result from a temporary increase in activity/acuity. The Maternity servicehas successfully recruited 7.0 WTE Early Career Midwives, set to commence in October 2025, to help manage turnover and fill gaps in the rota caused by maternity leave, which aren't accounted for by the 21% uplift at TRFT.

Medical Staffing: In May 2025, the Medical team experienced 7 vacancies for ST1/2 Doctors and 4 for ST3/7, all of which were filled with locum support. Consultant coverage was needed on 38 occasions for various reasons: 13 for Annual/Study Leave, 10 for Additional Clinics, 5 for Additional Theatres, 8 for Vacancies, and 2 for Sickness Absence. All 38 sessions were covered

April 2025 data



May 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 during out of hours for support in April 2025.
- We have successfully recruited 7.0 WTE early career midwives to cover maternity leave gaps.
- There were no delays in the commencement of Induction of labour in April or May.
- However, 6 red flags were reported in April and 9 in May 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 is being closely monitored to ensure coverage with 2 midwives from 11 am to 11 pm during high acuity periods. In April we achieved this 82% and in May 64% of the time.
- A Quality Improvement project is in progress to enhance service delivery of Triage following learning from investigations.
- Birthrate+ will be recommissioned in 2026 to comply with Year 7 CNST requirements.
- In April, service gaps calculated at 9.81 WTE, decreasing to 6.79 WTE in May due to maternity leave and long-term sickness. NHS professionals are utilised 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.
- 7.0 WTE early career midwives were successfully recruited.
- The unit did not close in the month of April or May 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.
- Supernumerary 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 minute sickness.
- Maintain low sickness and absence levels which are currently the lowest in England as recorded within the Public View NHS data centre.
- Continue to have 100% for all CNST year 7 staffing requirements.

Mandatory training- TRFT

MATERNITY DASHBOARD DATA May 2025	Obstetric Consultants	Obstetric Registrars (ST3-7)	Obstetric Trainees (ST1-2)	Midwives (All bands)	NHSP Midwives	Clinical Support staff	Obs Anaes
Module 1: SBL	96%	95%	67%	94%	96%	77%	N/A
Module 2: FS Study Day	90%	100%	100%	96%		N/A	
Module 3: PROMPT (% of staff that has attended full day within last 12months)	100%	100%	67%	89%	100%	74%	79%
Module 6: NLS *SCBU staff and paediatric staff reported on separately	100%	92%	67%	94%	94%	77%	N/A
Total Attendance Core Competency Day (Modules 1/4/5/6)	100%	92%	67%	94%	100%	80%	N/A
Total Attendance full day PROMPT (Module 3 PROMPT)	100%	100%	67%	89%	100%	72%	79%

May 2025	New-born Life Support annual training Nursing staff	New-born Life Support annual Medical staff
May 2025	86%	95%

In Summary

What does this data indicate?
It suggests that attendance at PROMPT is good for obstetricians, while there has been a small decline in attendance rates among midwives, trainee doctors, and aneasthetists..

What is going well?

- Attendance for the fetal surveillance study day is excellent across all staff categories.
- Most staff groups show high attendance for PROMPT, and where attendance has fallen below the necessary level, a plan has been implemented to ensure compliance with CNST Year 7 standards.
- Attendance rates are lower among Obs SHO groups due to the onboarding of new staff in February 2025, but there is a plan in place to tackle this issue.

What do we need to focus on?

- Ensuring that the plan to capture all trainee medical staff is followed and that the clinical educators continue to work with anesthetic teams to improve training.
- Work with the NNU leads to ensure that the NNU nursing staff reach the 90% compliance.

Where do we want to be?

- Compliance to be maintained above the CNST target of 90% across all subjects

Neonatal Nursing Workforce

At present, 78% of the nursing workforce are Qualified in Speciality Trained (QIS) training, which meets the BAPM Qualified in Specialty (QIS) standards necessary for safe care and the MIS year 7 standard. The roster skill mix includes 5 registered nurses and a minimum of 3 staff per shift who are QIS, some shifts have 4 QIS staff. Compliance against this standard is monitored by the ODN as part of quarterly workforce reports. The accompanying table displays workforce data submitted to the ODN for Q4 24/25. The unit has established a supernumerary shift co-ordinator role from 1st April 2025 utilising the current establishment, the clinical team engaged in the process developing a role descriptor to implement the supernumerary coordinator role effectively. Since going live this has worked well and the team have provided feedback that it is working well and they are feeling the positive impact this role has in safety on the unit.

NB total nurse staffing required to staff declared cots = 39.46, of which 27.62 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	30.40	31.84	31.30	-0.90	0.54
Total reg nurses	28.20	Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY	27.29	0.91	2.35
Total QIS	24.08	23.20	19.10	4.98	4.10
Total non-QIS	4.12	6.44	8.19	-4.07	-1.75
Total non-reg	2.20	2.20	4.01	-1.81	-1.81
Reg nurses as % nursing staff	92.8%	93.1%	87.2%		
QIS as % reg nurses	85.4%	78.3%	70.0%		

In Summary

What is the data telling us?

- The service is currently inline with the BAPM QIS standard, which we anticipate to continue, although, due to turnover we do expect our QIS percentage to decrease but remain inline with the standard.
- There are 2 staff currently undertaking QIS training due to complete this in June 2026.In addition 3 staff will be commencing the foundation course in October 2025 progressing to the QIS course in October 2026.

What do we need to focus on?

- Reviewing induction and education for new staff and staff returning from maternity leave.
- Monitor the effectiveness of the shift co-ordinator role.
- Appointing to clinical educator/ governance vacancy.

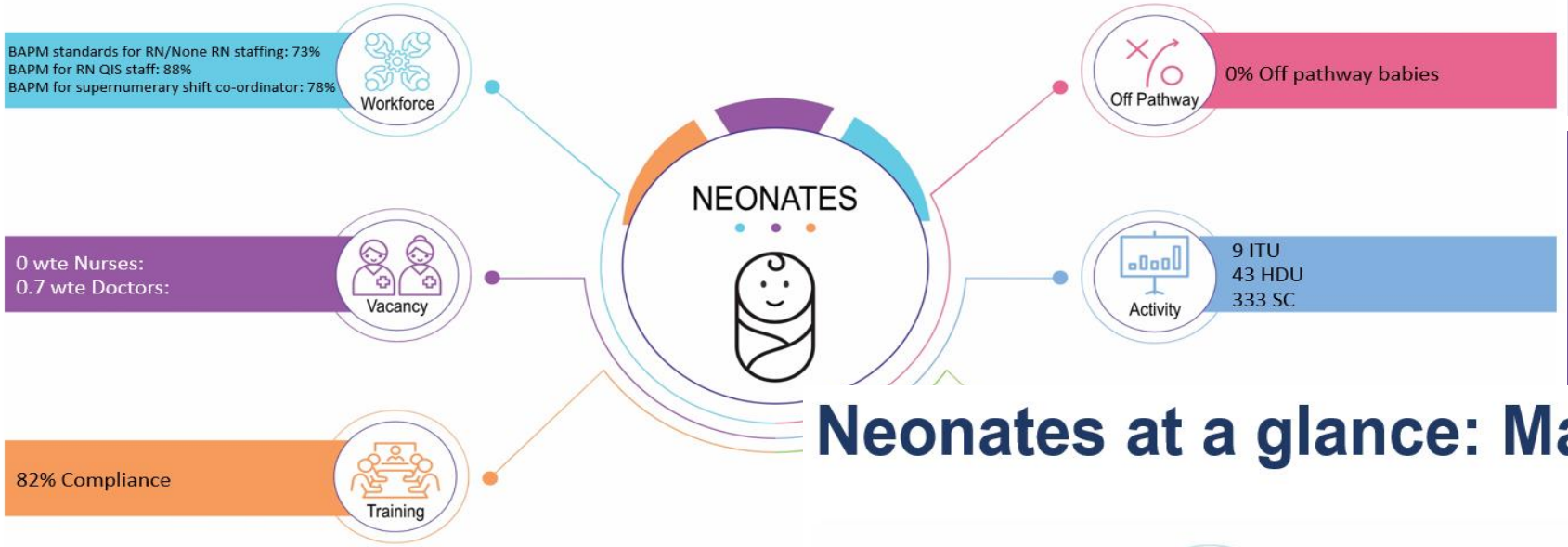
What is going well?

- Implementation of the shift co-ordinator role is improving staff support and leadership.
- Band 6 vacancy advertised and shortlisted.
- No neonatal medical vacancies.

Where do we want to be?

- Permanent Governance /education lead in post by August 25.
- Supernumerary coordinator well embedded.
- Maintain above 70% QIS compliance.
- Funded post to support Neonatal BFI accreditation at stage 2, Bereavement and developmental care.

Neonates at a glance: April 2025



What is going well?

- Maintained no off pathway births
- Supernumerary coordinator

Where do we want to be?

- A Stage 2/3 BFI accredited service
- Maintain and safe personalised care of babies

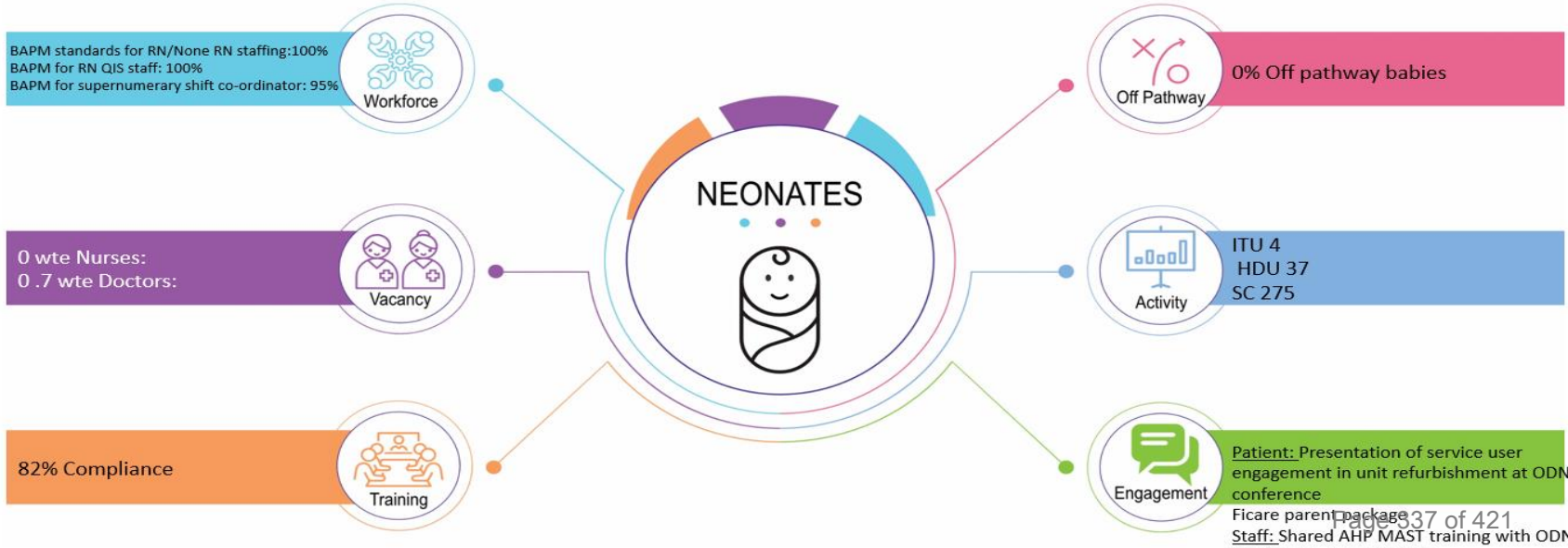
What insights can we gather from the data?

- The training sessions for the four annual resuscitation council's New-born
- Life Support Training are decreasing, but improvements are being planned.
- In May, neonates needed a lesser level of care than in April.

What do we need to focus on?

- Increasing the 4 yearly NLS compliance. The annual in house training continues (see maternity training slide).

Neonates at a glance: May 2025

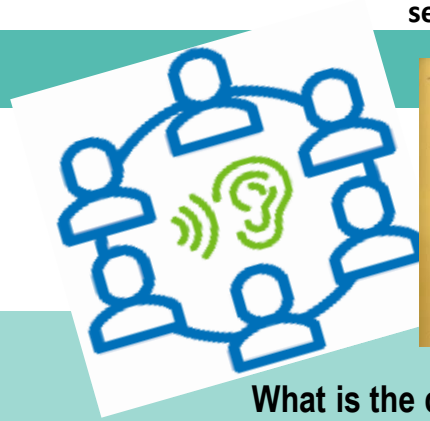


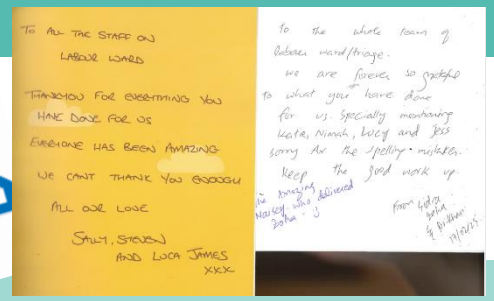
Neonates: April and May2025

Neonates		April 2025	May 2025
Workforce:	BAPM standards for RN/None RN staffing:	73%	100%
	BAPM for RN QIS staff:	88%	100%
	BAPM for supernumerary shift co-ordinator:	78%	95%
Vacancy	Nurses:	0 WTE	0 WTE
	Doctors:	0.7 WTE	0.7 WTE
Training		82%	82%
Off-Pathway		0%	0%
Activity	ITU:	9	4
	HDU:	43	37
	SC:	333	275
Engagement	Patient:	LMNS engagement	F&F focused work
	Staff:	Shift co-ordinator role	Team rostering

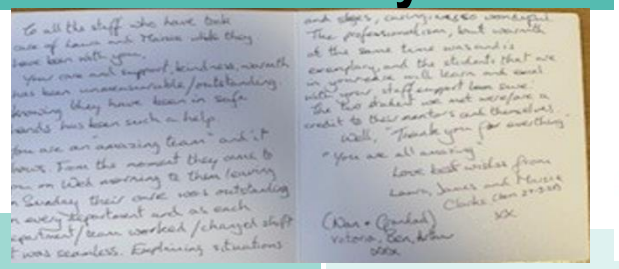
Patient Experience

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 and neonatal services believe it's vital to allocate adequate time and resources for feedback activities, especially under service pressure.





In Summary



What is the data telling us?

- During the 2024/25 period, the MNVP engaged a diverse group of service users to gather insights and feedback on maternity services. A total of 62 service users and partnering organisations participated in various engagement activities, which included focus groups, surveys, and "walk the patch" events.

What is going well?

Below are some projects MNVPs facilitated co-production.

- Personalised Care and Support Plan.
- Discharge video.
- Other patient information leaflets.
- 15 steps planned for the NNU and Pregnancy Advisory Service.

What do we need to focus on?

- Currently, the MNVP is working collaboratively, meeting bi-monthly, with the Matron to review both retrospective and prospective concerns and complaints received in the Labour and Postnatal wards. The aim of this exercise is to explore recurring themes and support the triangulation of these themes with other sources of service user feedback.
- Completion of the 15 steps action plans and carry out in other areas.

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.
- TRFT maternity service aims to be an **outstanding experience for all women and families** who use the service and be fully compliant with the 3 Year Delivery Plan and CNST Year 7.

Staff Feedback

Here is a summary of the "We said We did" initiatives implemented across all areas to ensure that teams feel their feedback has been acknowledged and acted upon. In April 2025, the Safety Champions engaged in discussions with the Neonatal Team, revealing the staff's strong dedication to their work and the care provided. Nursing staff escalated issues to the Safety Champions, highlighting the necessity for office time for Band 6 staff to focus on patient-facing ODN projects. Additionally, there were concerns regarding water standards in the neonatal unit. The Safety Champions have taken these points into account and will communicate updates to the teams through the quarterly newsletter. Another platform for teams to share important feedback is the Early Career Midwife Forum (ECM), which is facilitated by the Interim HoM each quarter, allowing for open dialogue about any concerns or ideas the new team members may have.

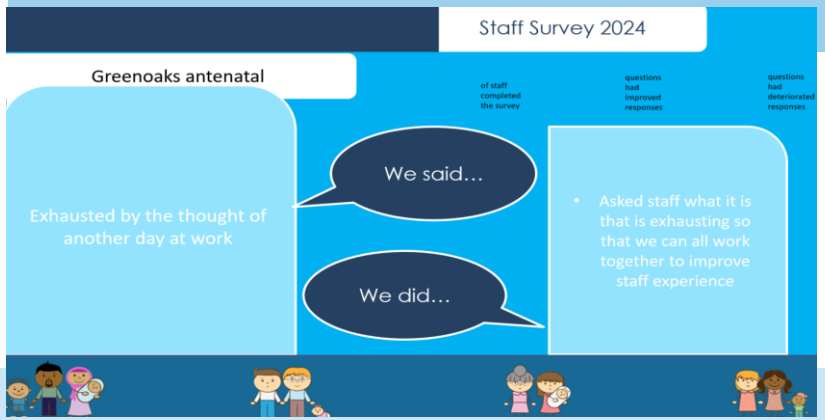
In Summary

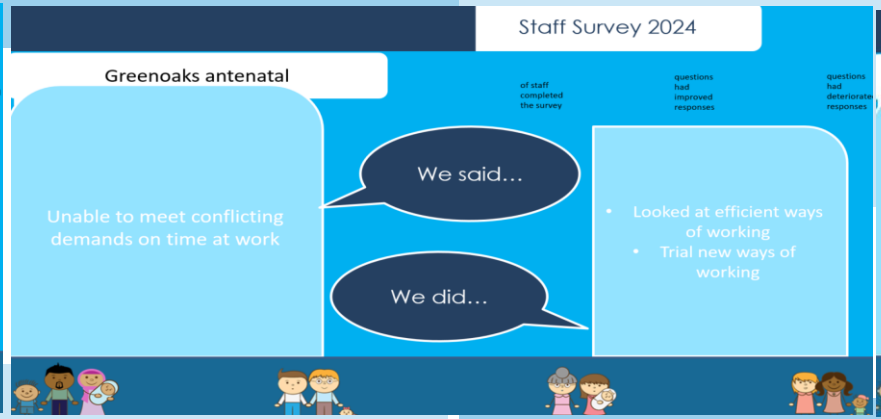
What is the data telling us?

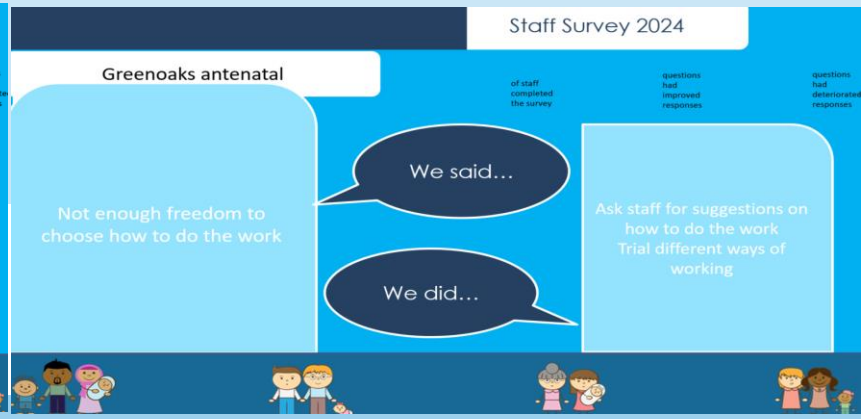
- Overall, the feedback for maternity services as a whole remains positive.
- Area with the most work to be done is the acute maternity services area.
- Sickness rates within the team remain one of the lowest in the country for Midwives.

What is going well?

- Early Career Midwives feel supported and that they are listened to.
- Staff sickness levels is low.
- Maternity has many compliments each month and the staff continue acknowledge good work between each other in the Proud newsletter.







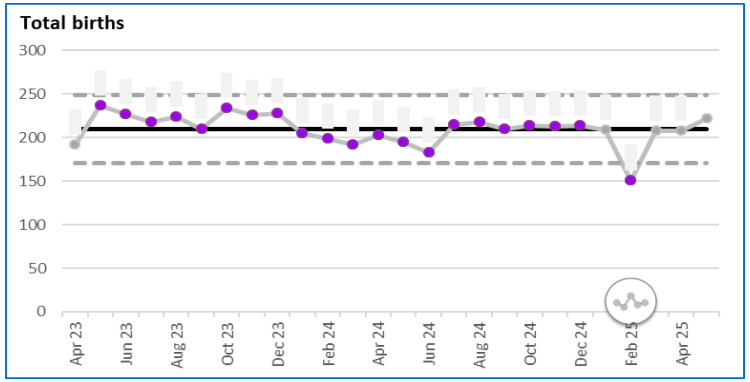
What do we need to focus on?

- Enhance appraisal compliance in the Maternity department.
- Distribute information gathered during the Safety Champions Walk around through a newsletter addressing the raised concerns.
- Maintain open communication with early career Midwives to ensure they receive adequate support.
- Encourage all staff members to become the best versions of themselves and to find joy and success in their work.

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.
- To maintain low sickness rates and high appraisal rates.

SPC Charts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Jun 23
Aug 23
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Aug 24
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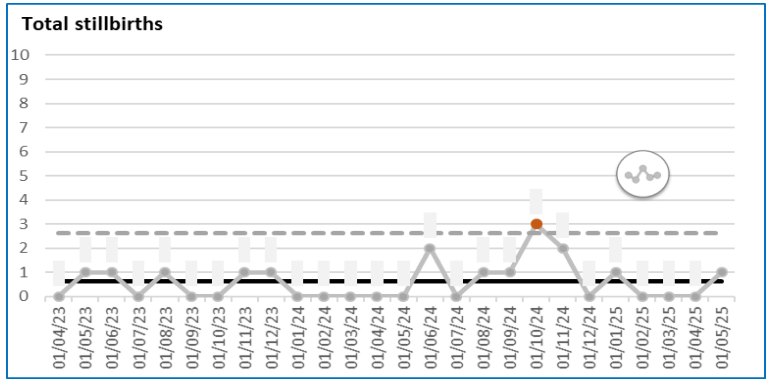
Apr 25


Total stillbirths
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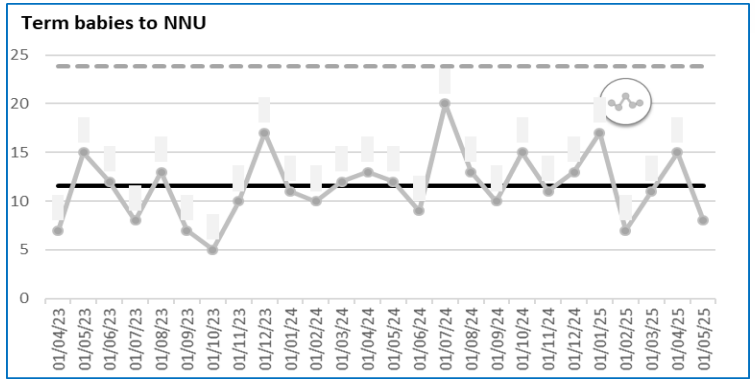
Term babies to NNU
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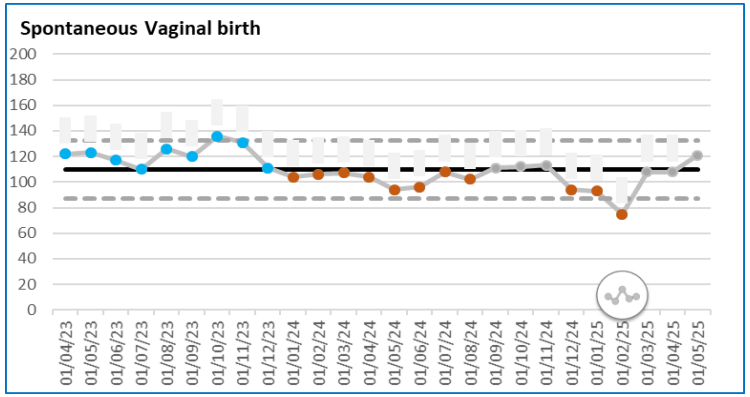
Spontaneous Vaginal birth
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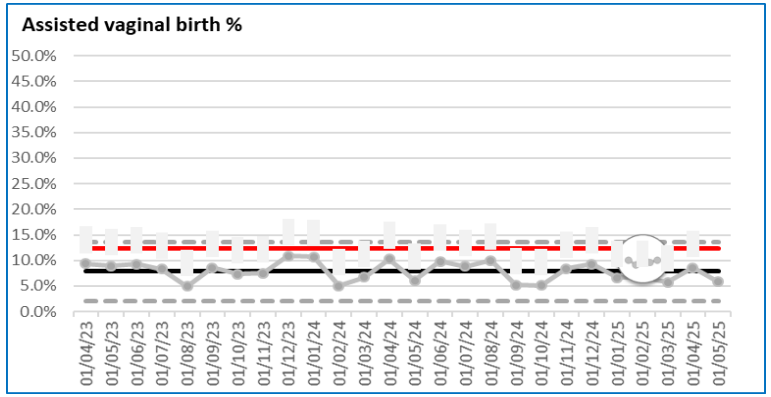
Assisted vaginal birth %
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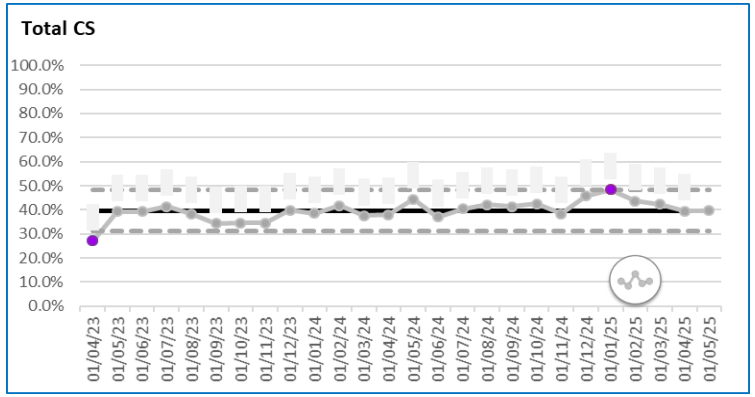
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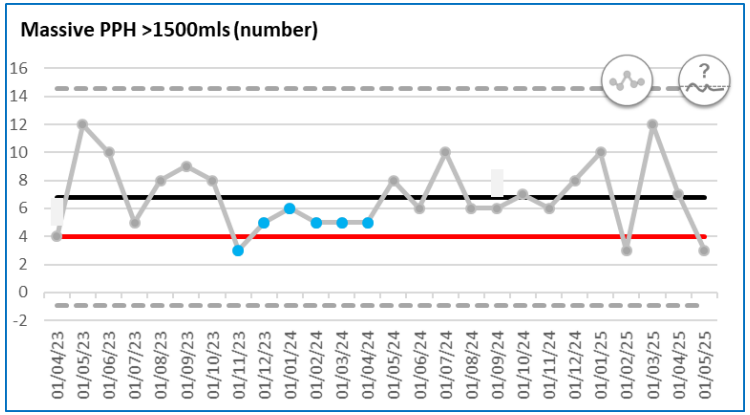
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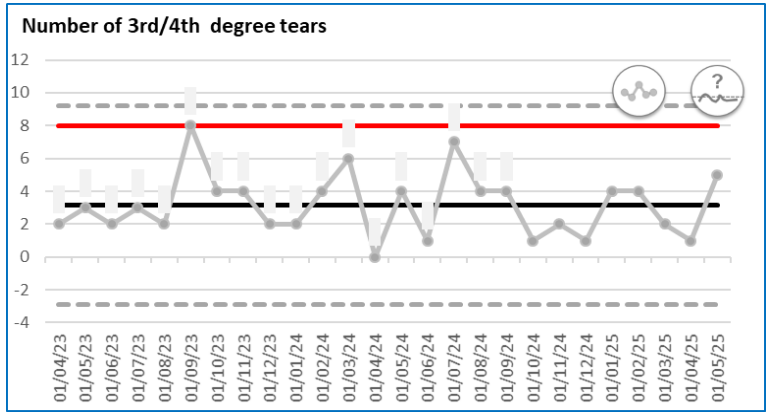
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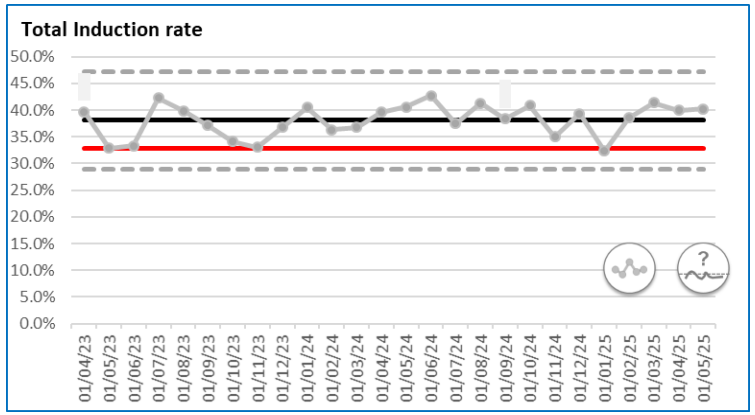
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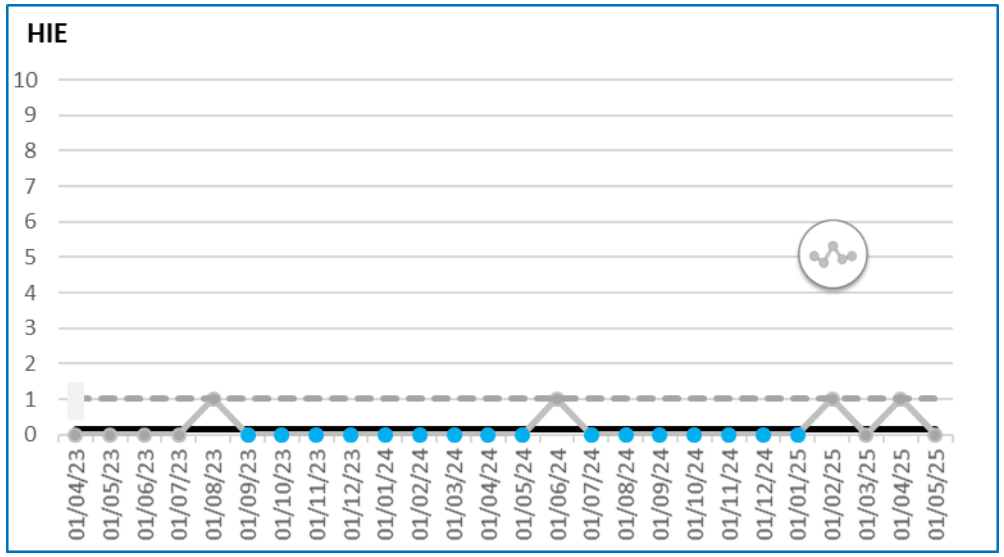
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Maternity Incentive Scheme : Year 7

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? **On track to achieve**

Safety Action 2:
: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? **On track to achieve**

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? **On track to achieve**

Safety Action 4:
Can you demonstrate an effective system of clinical workforce planning to the required standard? **On track to achieve**

Safety Action 5:
Can you demonstrate an effective system of midwifery workforce planning to the required standard? **On track to achieve**

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? **On track to achieve**

Safety Action 7:
Listen to women, parents and families using maternity and neonatal services and coproduce services with users. **On track to achieve**

Safety Action 8:
Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training? **On track to achieve**

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? **On track to achieve**

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. **On track to achieve**

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

- At the March 2025 Local Maternity and Neonatal System (LMNS) assurance visit for the implementation of Saving Babies Lives V3 (SBLV3), there were two areas that TRFT were yet to fully embed.
- 6 elements (Preterm birth) required the unit to have pre-term work within the job plans of an Consultant Obstetricians and a Neonatologist. This has now been achieved.
- The second aspect, element 1 (Smoking in pregnancy) required staff to be trained in the Very Brief Advice, stop smoking support – we are currently at over 80% and anticipate to have achieved the target of over 90% by the next assurance visit.

Three-year delivery plan quarterly oversight

Q4 2024-2025

Select organisation (table)

The Rotherham NHS Foundation Trust

MBRRACE-UK metrics: Better outcomes – Poorer outcomes

All other metrics: More positive – Improvement / support needed

The Rotherham NHS Foundation Trust outlier summary: comparison to national result / benchmark

	Total measures	Negative outliers	Positive outliers
Total	36	3	12
Listening to and working with women and families with compassion	12	1	5
Growing, retaining and supporting our workforce	10		4
Developing and sustaining a culture of safety, learning and support	11	1	3
Standards and structures that underpin safer, more personalised, and more equitable care	3	1	

T1c:Being listened to during antenatal check-ups	95.2%
T1e:Involvement in decisions during labour and birth	83.9%
T1g:Adequacy of information or explanations during postnatal hospital care	70.3%
T1i:Being listened to during postnatal care	84.2%
T1ni:Baby Friendly Accreditation - Maternity	100.0%
T1nii:Baby Friendly Accreditation - Neonatal	0.0%
T2ai:Midwives' satisfaction with recognition for good work	56.3%
T2bi:Midwives' satisfaction with work being valued by your organisation	50.0%
T2hi:Midwife Turnover Rate	3.6%
T2ii:Midwife Sickness Absence Rate	2.6%
T3aii:Obs & Gynae experience of learning culture	100.0%
T3bi:Midwives' confidence in organisations response to concerns about unsafe clinical practice	80.2%
T3ci:Midwives' recommendation of the service	95.1%
T3dii:Recommendation of the training post - Obstetrics and Gynaecology Specialist Trainees	25.0%
T4eii:Preterm Birth Rate (MSDS)	10.7%

Theme families 1: Listening and working with families

- MNVP chair has undertaken focus group work with minority groups to gain feedback.
- Action plan from Maternity 15 steps underway.
- 15 steps planned for NNU and Pregnancy Advisory areas.

Theme 2: Growing, retaining and supporting the workforce

- 7 ECM recruited to TRFT, to commence post in September 2025.
- Midwife sonographer pathway continues to show good results.
- Funding being secured to undertake cultural competency train the trainer.

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

- 'Team of the Shift' handover framework to be commenced on labour ward on the 19th June 2025.
- PPH thematic review presented at Trust Panel and at Safety Champions with actions.
- Funding being found to support Consultant PA for PMRT process.

Theme 4: Standards and structures to underpin safe, more personalised and equitable care

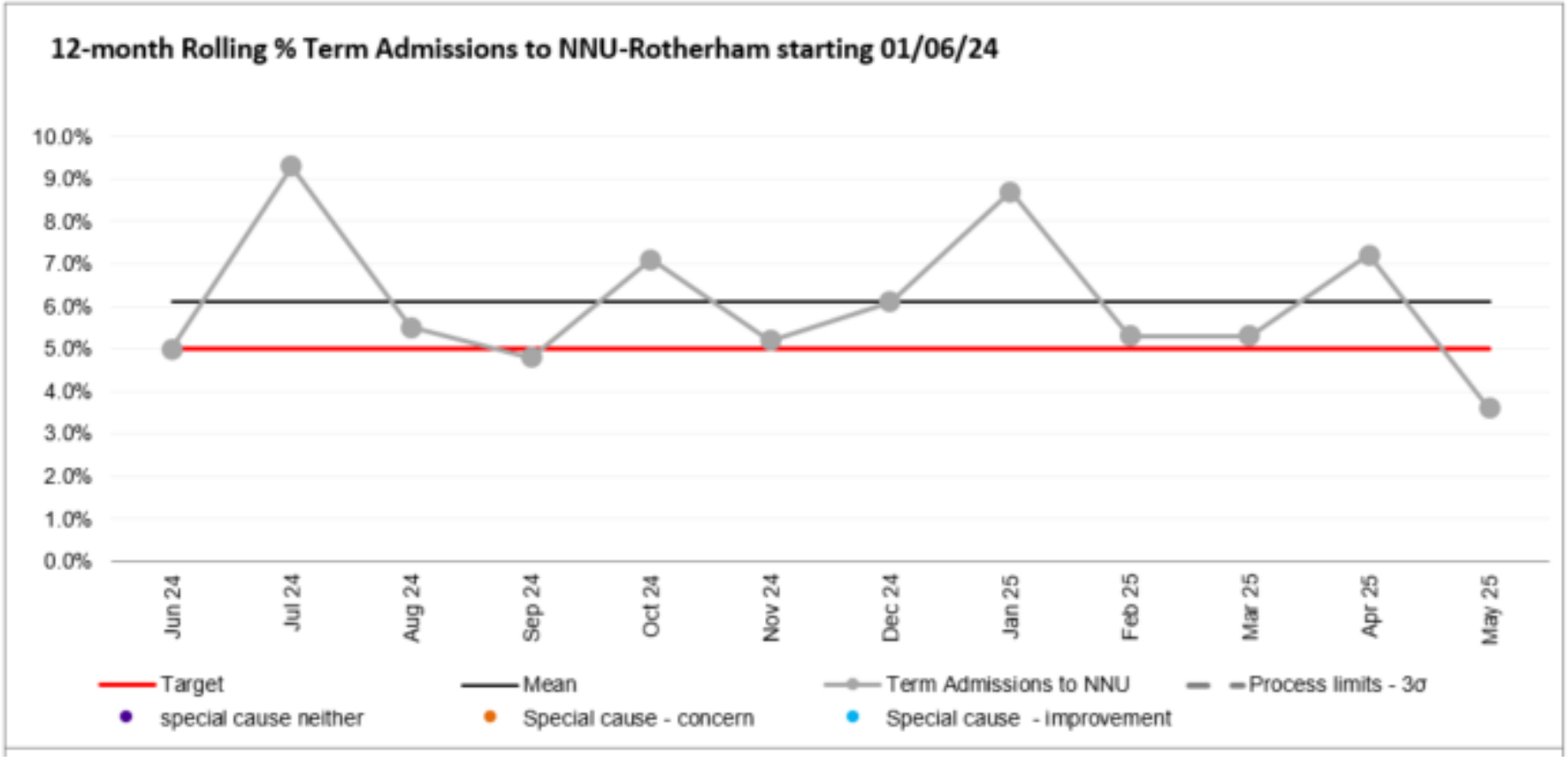
- SBLV3 on track to be fully compliant by July 2025 assurance visit.
- Business case in progress to implement new EPR system for maternity and neonatal services.
- Work has commenced to introduce the new maternity MOEWs within the EPR system.

Outlier issues

Baby Friendly accreditation for NNU	Work ongoing to progress the NNU to full BFI	
Pre term births above 6% target in February 2025.	Thematic review of cases and new Pre-term Midwife post commenced in June 2025. Local data fluctuates but average is 5.9%	
Recommendation of the training post Ob's & Gynae	2023 data showed that TRFT was at 91%. Awaiting results to be able to validate it for 2024 data.	

Escalation	
In progress	
Completed	

ATTAIN



The avoiding term admissions work, referred to as ATAIN (Avoiding Term Admissions Into Neonatal units), is a national initiative focused on reducing avoidable harm leading to full-term babies being admitted to neonatal units. The goal is to improve outcomes for babies, mothers, and families by addressing preventable causes of harm and promoting mother-baby bonding.

In Summary

What is the data telling us?

- The national target for reducing term admissions into the neonatal unit is 6%. The Local Maternity and Neonatal System's (LMNS) stretch target is 5%.
- 4/12 months we have seen "spikes" in admissions
- RFT mean is 6%

What is going well?

- Committed multidisciplinary team carrying out weekly reviews of all term admissions to the neonatal unit. And sharing learning with the LMNS.

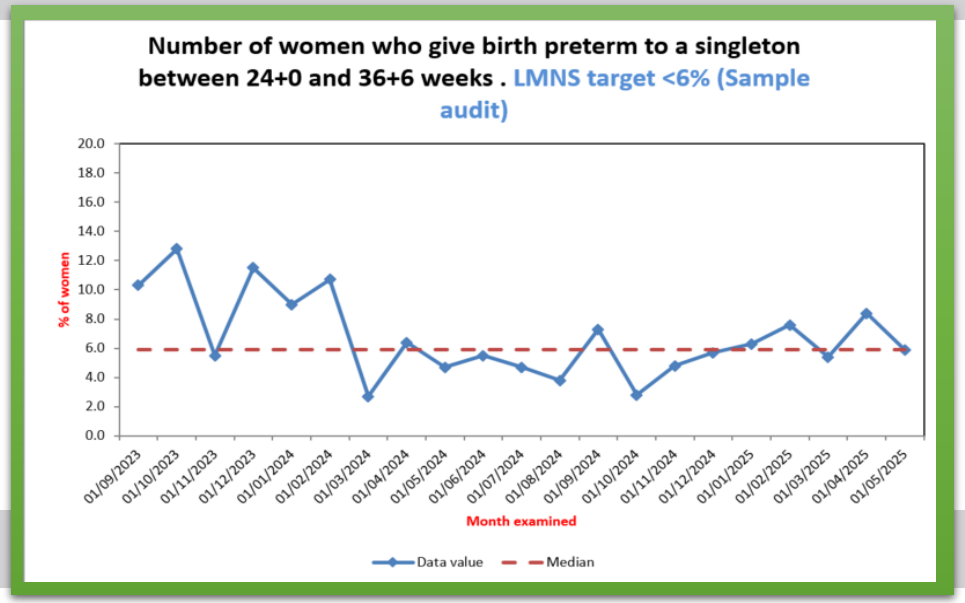
What do we need to focus on?

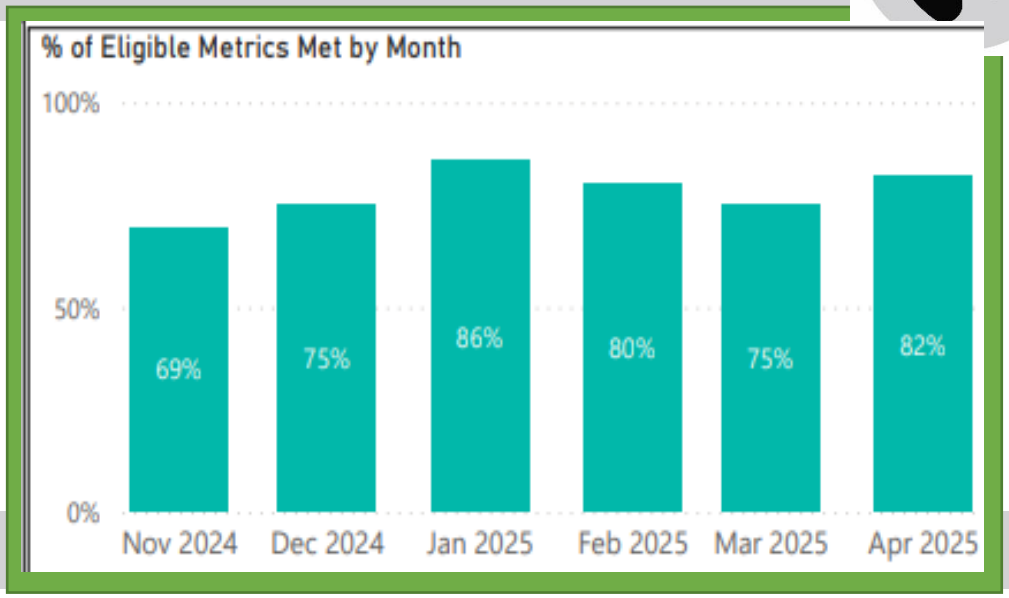
- Ongoing QI work, (AMAT registered) reviewing and aligning neonatal observations and surveillance.
- Embedding the practice of measuring and recording departure temperatures once decision to admit has been made.

Where do we want to be?

- Sustained Term Admission Rate of ≤5%

Preterm Birth





In Summary

What is the data telling us?

- That the TRFT pre-term rate is 5.9% which is just below the Local Maternity and Neonatal System (LMNS) target set.
- The work around pre-term set by the Saving Babies Lives Care Bundle (SBLV3) has been worked against and is fully complaint as of May 2025 – assurance around the set metric are monitored via audit and validated by the LMNS each quarter.

What is going well?

- Metric set by the British Association of Perinatal Medicine (BAPM) can be seen above in the second table. The metric consist of 7 interventions that should take place when a baby is born pre-term to optimise the outcomes for the babies. The LMNS have set a target of 70% of all interventions should be met for all pre-term babies born below 34 weeks gestation. This has been the case at TRFT since December 2024.
- Delayed cord clamping is one of the metrics and has been 100% since November 2024.

What should we concentrate on?

- Funding from the LMNS is supporting midwife time for a Pre-Term Birth Midwife. This is an exciting development with the ambition that this role will not only assist to continue to reduce the pre-term birth rate at TRFT but will significantly improve the experience of women at risk of a pre-term birth.

Where do we want to be?

- We want to continue to reduce pre-term births at TRFT and when a pre-term birth does occur, give 100% of optimising care to babies which will reduce morality and morbidity.
- Maintain off pathway Kpi's ensuring that all women are offered the opportunity to birth their babies in the right place.

Current Issues and Summary

Staffing and Acuity: In the Labour Ward, acuity levels were achieved 89% of the time in April and 82% in May. Measures were implemented to ensure 100% one-on-one care during labour, despite facing staffing difficulties. Staffing Gaps: NHS P was utilized to fill roster gaps, primarily arising from maternity leave and extended sickness
Neonatal Staffing: Qualified in Speciality is 78% maintaining BAPM standards, the supernumerary co ordinator on the neonatal unit has been implemented and is going well with positive feedback from teams.
Safety and Incident Reporting: Moderate incidents from April and May underwent review through a multidisciplinary team (MDT) approach. After MDT review, all cases were classified as no harm or low harm. As of May 2025, TRFT has identified six safety actions from recent MNSI reports, with action plans created and meetings offered to families.
Patient Experience: The MNVP work plan is progressing well, with strong involvement from various minority groups.
Training Compliance: Training is proceeding as scheduled, covering all components of MIS training.
Perinatal Mortality: Four PMRT cases have been examined and closed, all rated as A or B. Families will be updated regarding the investigations.
Governance and Learning: All MNSI and PSII cases have undergone full duty of candour, and where necessary, have been referred to NHS Resolution, along with explanations of implications. As of the end of May, six safety recommendations have been issued to TRFT, with action plans in place and ongoing efforts to learn from these cases.

In Summary

What is the data telling us?

- All Moderate cases have been reviewed via an MDT process.
- PMRT cases have been closed in April and May have been graded as a A or a B.

What is going well?

- Staff experience data and low staff sickness levels would indicate that the team are generally happy in their work with will translate into safer care.
- MNVP work plan is positive and give rich information to improve services within maternity and neonatal areas.

What do we need to focus on?

- Year 7 CNST standard for MNVP suggests that the MNVP Chair attends PMRT meetings and a large number of other meetings. Currently within the region there is not the infrastructure to support this ask. It has been escalated via the LMNS and currently being looked into.
- Continue to drive improvement with the actions from the 3 year delivery plan.
- Await the publication of the 10 NHS plan and the focus for Maternity and Neonatal services.

Where do we want to be?

- We aim to offer an outstanding service in all aspects of the care we give.

To:
- Trust CEOs and chairs

cc.
- ICB CEOs
- Regional directors

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

23 June 2025

Dear colleague

Maternity and neonatal care

Today, the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care.

This announcement comes on the back of significant failings in maternity services in parts of the NHS and we need – with real urgency – to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.

It is clear that we are too frequently failing to consistently listen to women and their families when they raise concerns and too many families are being let down by the NHS. There remain really stark inequalities faced by Black and Asian women and women in deprived areas. In addition, we continue to have significant issues around safety and culture within our maternity workforce.

These have been persistent issues over recent years, so we now need to act with urgency to address these. The vast majority of births in England are safe and we have teams providing good and outstanding maternity and neonatal care every day. However, the variation in quality and performance across the NHS underscores why we can't accept the status quo.

So, between now and December, the independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. We'll meet with relevant leaders of several organisations over the next month and while there will be some challenging conversations, we are really keen to hear what more we can be doing to support you to go further and faster in improving maternity and neonatal care.

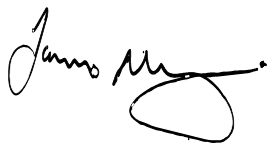
In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

- Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.

- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

This is really challenging for all of us and the most important step we have to take to rebuild maternity and neonatal care is to recognise the scale of the problem we have and work together to fix it.

This will require us all to work together and this includes teams where care is outstanding where you will have a role to play in sharing best practice and supporting others to return their services to where their communities and staff want and need them to be. We hope you understand the importance of this and, as always, please get in touch if you want to discuss this ahead of the CEO call later in the week.



Sir Jim Mackey
Chief Executive

Duncan Burton
Chief Nursing Officer for England

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Public Board of Directors' Meeting

Agenda item	**P/117/25**
Report	**Annual DSPT/CAF 360 Audit Report**
Executive Lead	Bob Kirton Managing Director (SIRO)
Link with the BAF	B7
How does this paper support Trust Values	The Trust aims to achieve compliance year on year against the Data Security and Protection Toolkit/Cyber Assurance Framework (DSPT/CAF), in order to meet its contractual obligations, and this can only be achieved with contributions from all areas (Together) which provides assurance that the Trust is dedicated to protecting the personal information it holds (Caring).
Purpose	**For decision ☐ For assurance ☒ For information ☐**
Rationale for presentation in confidential section	The report includes sensitive information on information governance that should not be publicly available.
Executive Summary (including reason for the report, background, key issues and risks)	Each year the Trust is audited against evidence provided for the DSPT/CAF. The majority of the scope is determined by NHSE (8 outcomes) with an additional 4 outcomes being determined for audit by the Trust. Each of the outcomes can have up to 6 separate areas requiring evidence. The final report is provided but the key points for noting are: • High Confidence Level with an assessment of Low Risk • 2 low risk areas have been identified as requiring strengthening before end of March 2026 **Achievement Met across all 12 audited outcomes**
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Report is provided having been through the 360 Assurance due diligence process.
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	The Board is asked to note this report.
Appendices	None

Data Security and Protection Toolkit

The Rotherham NHS Foundation Trust

26 June 2025

RFT/2526/01

Final Report

Contents

Executive summary

Introduction and background 2

Audit objective 3

Audit assessment 4

Assessment outputs 6

Summary findings / direction of travel 6

Detailed report

Key Findings 8

Appendices

Appendix A –Summary of work undertaken and risks reviewed – mandatory outcomes 11

Appendix B – Summary of work undertaken and risks reviewed – discretionary outcomes 16

Appendix C – Risk assurance rating and confidence level methodology 18

Appendix D – 360 Assurance standing information 20

Distribution

Name, Job Title	For action	For information
Bob Kirton, Managing Director		✓
James Rawlinson, Director of Health Informatics		✓
Laura Mumby, Deputy Director of Digital and Technology Services	✓	
Derek Stowe, Head of Information Governance and DPO		✓
Flordeliza Broughton, Information Governance Manager		✓
Ian Watson, Head of IT Infrastructure and Operations		✓

The report has also been shared with the organisation's standard distribution list for internal audit reports.

Executive summary

Introduction and background

We have completed a review in respect of your 2024/25 Data Security and Protection Toolkit (DSPT) self-assessment. We examined the effectiveness of controls in place in accordance with the Global Internal Audit Standards in the UK Public Sector. We performed our review to provide an impartial and unbiased opinion.

Why data security and data protection issues require attention from Independent Assessors

Data and information are critical business assets that are fundamental to the continued delivery and operation of health and care services across the UK. The Health and Social Care sector must have confidence in the confidentiality, integrity and availability of their information assets and must ensure that any personal data collected, stored and processed by public bodies are aligned to specific legal and regulatory requirements.

The need to demonstrate an ability to defend against, block and withstand cyber-attacks and data breaches has been amplified by the introduction of the Network and Information Systems (NIS) Regulations and the UK General Data Protection Regulation (GDPR). As such, it is essential that Health and Social Care sector organisations that are impacted by those regulations take proactive measures to defend themselves from cyber-attacks and data breaches and evidence their ability to do so in line with regulatory and legal requirements.

The Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) is one of several mechanisms in place to support Health and Social Care organisations in their ongoing journey to manage cyber security and information governance risk.

The CAF-aligned DSPT allows organisations that have access to NHS patient data and systems to measure their performance against the five objectives of the CAF-aligned DSPT, providing valuable insight into the technical and operational security and governance of information control environment and relative strengths and weaknesses of those controls. Another mechanism is to independently assess the security and governance of information control environments of Health and Social Care organisations. Independent assessment providers help to strengthen the trust placed on the CAF-aligned DSPT submissions by Health and Social Care organisations' boards, Department of Health and Social Care and NHS England by assessing the effectiveness of the organisation's security and governance of information controls. This approach ensures that the controls in place are effective in securing patient data throughout the organisation's estate, including staff handling of data and safe storage on the organisation's systems.

The role independent assessment providers play in helping to strengthen the reliance placed on the CAF-aligned DSPT submissions by Health and Social Care Organisations' boards, Department of Health and Social Care and NHS England is summarised in the National Data Guardian report, 'Review of Data Security, Consent and Opt-Outs and the Care Quality Commission report, Safe data, safe care'. Both reports include the following recommendation: 'Arrangements for internal data security audit and external validation should be reviewed and strengthened to a

level similar to those assuring financial integrity and accountability' (NDG 6, CQC 6 Table of recommendations). Therefore, it is essential that independent assessment providers, including internal auditors, focus on the assessment of the effectiveness of health and social organisations' security and governance of information controls, as opposed to simply focusing on the veracity of their CAF-aligned DSPT submissions.

Audit objective

The overall objective of our review was to assess the effectiveness of your data security and protection environment as assessed through the toolkit.

In order to achieve this objective, we have:

- assessed the overall risk associated with your security and information governance control environment i.e. the level of risk associated with weak or failing controls and security and governance of information objectives not being achieved;
- assessed the veracity of your self-assessment/DSPT submission, providing a level of confidence that the toolkit submission reflects your risk and controls.

The scope of the audit was partially determined by NHS England. There are eight mandatory outcomes, these are:

NHS England mandated in-scope outcomes for 2024/25	
A2.a	Your organisation has effective internal processes for managing risks to the security and governance of information, systems and networks related to the operation of your essential function(s) and communicating associated activities. This includes a process for data protection impact assessments (DPIAs).
A4.a	The organisation understands and manages security and IG risks to information, systems and networks supporting the operation of essential functions that arise as a result of dependencies on external suppliers. This includes ensuring that appropriate measures are employed where third party services are used.
B2.a	You robustly verify, authenticate and authorise access to the information, systems and networks supporting your essential function(s).
B4.d	You manage known vulnerabilities in your network and information systems to prevent adverse impact on your essential function(s).
C1.a	The data sources that you include in your monitoring allow for timely identification of security events which might affect the operation of your essential function(s).
D1.a	You have an up-to-date incident response plan that is grounded in a thorough risk assessment that takes account of your essential function(s) and covers a range of incident scenarios.
E2.b	You have a good understanding of requirements around consent and privacy, including the common law duty of confidentiality, and use these to manage consent.
E3.a	You lawfully and appropriately use and share information for direct care.

Executive summary

The Trust was also required to choose four additional outcomes from the remaining 39, to be reviewed as part of the audit. The Trust selected the following:

Four additional outcomes selected by The Rotherham NHS Foundation Trust for this review
A1.a You have effective organisational information assurance management led at board level and articulated clearly in corresponding policies.
A2.b You have gained confidence in the effectiveness of the security and governance of your technology, people, and processes relevant to your essential function(s).
B3.e Before reuse and / or disposal you appropriately sanitise devices, equipment and removable media holding data important to the operation of your essential function(s).
C1.b You hold log data securely and grant appropriate access only to accounts with business need. No system or user should ever need to modify or delete master copies of log data within an agreed retention period, after which it should be deleted.

Limitations of scope: The scope of our work was limited to assessment of the evidence to support the 12 outcomes required to be assessed for this review, as detailed above. The review does not provide assurance that the entire DSPT return is accurate and complete. Our work did not include detailed testing of IT systems and will not cover the submission of the DSPT to NHSE.

As independent assessors, we have used our professional judgement when assessing compliance against each control objective. Where necessary, we may have recognised alternative ways to meet each of the control objective, based on the specific controls in place, local context and reference to supplementary guidance, such as the Big Picture Guides.

Audit assessment

Our review followed the CAF-aligned DSPT Independent Assessment Framework and Guidance published by NHS England. We have reviewed 12 outcomes across the five objectives in the Cyber Assessment Framework, as specified in the previous section.

We produced this report as an output of this review. As a result of our evidence assessment and interviews with key stakeholders, we have delivered two findings in total, both of which were assessed as low risk. All findings and associated management actions have been discussed and accepted by The Rotherham NHS Foundation Trust.

Executive summary

Objective	Outcome	Minimum achievement level (as per the profile set for 24/25)	High	Medium	Low	Outcome result	Minimum achievement level met?	Overall Risk Assurance
A	A2.a	Partially achieved	-	-	-	Partially achieved	Met	Low risk
	A4.a	Partially achieved	-	-	-	Partially achieved	Met	
B	B2.a	Partially achieved	-	-	PA#2 PA#7	Partially achieved	Met	
	B4.d	Partially achieved	-	-	-	Partially achieved	Met	
C	C1.a	Partially achieved	-	-	-	Partially achieved	Met	
D	D1.a	Partially achieved	-	-	PA#2 PA#3 PA#5	Partially achieved	Met	
E	E2.b	Achieved	-	-	-	Achieved	Met	
	E3.a	Achieved	-	-	-	Achieved	Met	
A	A1.a	Achieved	-	-	-	Achieved	Met	
	A2.b	Achieved	-	-	-	Achieved	Met	
B	B3.e	Partially achieved	-	-	-	Partially achieved	Met	
C	C1.b	Partially achieved	-	-	-	Partially achieved	Met	

Executive summary

Assessment outputs

	Overall risk assurance across all five CAF objectives	Confidence level of the Independent Assessment
Independent auditor assessment	**Low risk**	**High**

Understanding your report ratings

Assurance level

The risk assurance level for The Rotherham NHS Foundation Trust (based on the overall risk across all five objectives) is **'Low'**.

This means that **no** outcomes were rated as not meeting minimum achievement levels.

Assessing the veracity of your DSPT self-assessment

We have assessed 12 outcomes, and found that, for 12 outcomes, our rating aligned with the organisation's self-assessment. The confidence level in the veracity of the DSP Toolkit self-assessment is therefore **'High'**.

Areas of good practice

- **A1.a (A#4)** – the Trust has a clear digital strategy with Board level ownership.
- **A2.b (A#1)** – the Trust receives regular internal and external assurance which is tailored to areas of perceived risk.
- **E2.b (All)** – clear training and guidance around consent and privacy is available to staff to allow an understanding of key principles.
- **E3.a (All)** – clear training and guidance around using and sharing information for direct care is available for staff to allow an understanding of key principles.

Summary findings / direction of travel

We identified a small number of areas where the Trust needs to strengthen the arrangements in place to ensure full, embedded and ongoing compliance with the requirements of the data security and protection toolkit.

Executive summary

- **B2.a (PA#2 and PA#7)** – we identified a number of areas where the Trust's authentication policies could be strengthened to fall in line with best practise.
- **D1.a (PA#2, PA#3 and PA#5)** – the Trust's documents which outline incident response could be increased in scope to cover more incident types, and include the roles and responsibilities of the response team in the event of an incident.

Further details on all risk areas identified are set out within the detailed report.

Summary of actions

	High	Medium	Low	Total
Proposed actions	-	-	2	**2**
Agreed	-	-	2	**2**

Follow up

Individual actions agreed in this report will be followed up via our online action tracking system Pentana. Action owners are responsible for ensuring actions are completed by the agreed implementation dates and for providing relevant supporting evidence. Actions not completed by their agreed date are regularly reported to the Audit and Risk Committee and impact on the organisation's Head of Internal Audit Opinion.

Key Findings

The following sections of the report summarise the findings of our review. Our risk assessment process aligns with the ISO 31000 principles and generic guidelines on risk management. The risk matrix and scoring methodology used is prescribed by NHS England.

B2.a You robustly verify, authenticate and authorise access to the information, systems and networks supporting your essential function(s).	**Findings**
	B2.a (PA#2) - All authorised users and systems with access to information, systems and networks on which your essential function(s) depends are individually identified and authenticated. *B2.a (PA#7) – Your approach to authenticating users, devices and systems follows up to date best practice.* The Trust has a technically enforced password policy in place and there is also details provided on passwords in the IT Acceptable Use Policy. We have reviewed the requirements against Open Worldwide Application Security Project (OWASP) good practice, identifying the following which should be incorporated or documented to strengthen authentication requirements within the Password Policies: • increase the minimum password length to 12 characters • remove or extend the duration passwords need to be changed if there is no suggestion of compromise • document that there is a defined process in place for an end user to recover/reset their password if they forget their password • document whether the use of password managers (or password management software) is permitted, and if so, identify which. We also identified non-compliance regarding common phrases being blocked. We understand that the Trust is looking to procure management software which should assist with the detection of common, shared or breached passwords. Additionally, we note that while failed password attempts are logged, these are not reactively investigated and are only investigated when a user flags an issue with regards to their ability to sign in due to being locked out of their account.
Risk rating	**Risk**

Low	If the Trust's password guidance lacks clear alignment to OWASP guidance, then the Trust risks not being in line with best practice for authentication.
	Recommendations
	The Trust to evaluate its passwords and authentication guidance within its Password Policy against best practice such as OWASP to ensure alignment and ensure consistency between technically enforced policy and the IT Acceptable Use Policy.
	Evidence to confirm implementation
	Updated Password Policy including strengthened password guidance in line with best practice guidance such as OWASP.
	Responsible officer
	Laura Mumby, Deputy Director of Digital and Technology Services
	Target date
	31 March 2026

D1.a You have an up-to-date incident response plan that is grounded in a thorough risk assessment that takes account of your essential function(s) and covers a range of incident scenarios.	**Findings**
	D1.a (PA#2) - Your response plan comprehensively covers scenarios that are focused on likely impacts of known and well-understood attacks and incidents only
	D1.a (PA#3) - Your response plan is understood by all staff who are involved with your organisation's response function.
	D1.a (PA#5) - Your response plan covers your obligations as a controller or processor.

	The Trust's incident response documents generally contain the contents to meet the requirements of the DSPT. However, we identified some areas where the Health Informatics Business Continuity Plan could be strengthened. These are: • producing further action cards for more types of cyber incident to help with incident response co-ordination in the event of an incident • referring to the DSPI/SIRI SOP within the plan which provides guidance on the Trust's obligations as a data controller and processor which would be a useful point of reference in the event of an incident • including specific roles and responsibilities for key individuals in terms of those who are involved in the response function. The current plan outlines general roles and responsibilities and key contacts only.
Risk rating Low	**Risk**
	If the Trust's documentation which provides guidance and direction on cyber incident response is not comprehensive, then there is a risk that the Trust's ability to responds to incidents may be compromised.
	Recommendations
	The Trust to update its Health Informatics Business Continuity Plan and incorporate the areas outlined in the finding above.
	Evidence to confirm implementation
	Updated Health Informatics Business Continuity Plan.
	Responsible officer
	Laura Mumby, Deputy Director of Digital and Technology Services
	Target date
	31 March 2026

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

The tables below summarise the evidence items within scope, setting out your self-assessment and our risk assessment. This detailed assessment supports the overall audit assessment presented within the executive summary:

Agree	Understated	Overstated	Agree but insufficient
From the evidence available we are able to agree with the organisation's self-assessment as a reasonable assessment of current performance	From the evidence provided it is our assessment that the organisation is performing at a level higher than recorded	From the evidence available we are not able to agree the self-assessment as a reasonable assessment of current performance.	From the evidence provided it is our opinion the organisation has been accurate with its self-assessment, but it has not currently completed the mandatory outcomes as required by NHSE.

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
A2.a	Your organisation has effective internal processes for managing risks to the security and governance of information, systems and networks related to the operation of your essential function(s) and communicating associated activities. This includes a process for data protection impact assessments (DPIAs).	PA#1	Partially Achieved	Agree	✓ Reviewed the risk management processes documentation	Agree
		PA#2	Partially Achieved	Agree	✓ Reviewed project documentation	
		PA#3	Partially Achieved	Agree	✓ Reviewed completed risk management documentation	
		PA#4	Partially Achieved	Agree	✓ Reviewed documentation showing that the Trust has established thresholds at which risks are monitored and reviewed	
		PA#5	Partially Achieved	Agree	✓ Reviewed the risk management processes documentation	
		PA#6	Partially Achieved	Agree	✓ Reviewed procedural documents and the Risk Registers	
		PA#7	Partially Achieved	Agree	✓ Reviewed the risk management processes documentation	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
A4.a		PA#1	Partially Achieved	Agree	✓ Reviewed risk identification documentation	Agree

	The organisation understands and manages security and IG risks to information, systems and networks supporting the operation of essential functions that arise as a result of dependencies on external suppliers. This includes ensuring that appropriate measures are employed where third party services are used.	PA#2	Partially Achieved	Agree	✓ Reviewed supplier lists and other documentation	
		PA#3	Partially Achieved	Agree	✓ Verified that supplier contracts contain appropriate cyber security and data protection clauses	
		PA#4	Partially Achieved	Agree	✓ Reviewed processes in place to identify all third-party connections to Trust networks	
		PA#5	Partially Achieved	Agree	✓ Reviewed incident management documentation	
		PA#6	Partially Achieved	Agree	✓ Reviewed DPIA and associated registers	
		PA#7	Partially Achieved	Agree	✓ Reviewed assessment documents and associated registers	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B2.a	You robustly verify, authenticate and authorise access to the information, systems and networks supporting your essential function(s).	PA#1	Partially Achieved	Agree	✓ Verified that appropriate processes are in place to verify substantive and temporary staff identity prior to being given access to systems and data	Agree
		PA#2	Partially Achieved	Agree	✓ Reviewed procedures in place to establish if there is a process for ensuring authentication is robust.	
		PA#3	Partially Achieved	Agree	✓ Verified that policy is in place to ensure access levels are appropriate.	
		PA#4	Partially Achieved	Agree	✓ Reviewed documentation to determine whether additional verification methods are required for elevated permission accounts	
		PA#5	Partially Achieved	Agree	✓ Confirm implementation of secure remote access being in place.	
		PA#6	Partially Achieved	Agree	✓ Reviewed documentation provided to determine whether processes are in place to ensure user access is appropriate.	
		PA#7	Partially Achieved	Agree	✓ Tested authentication practices against best practice.	

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B4.d	You manage known vulnerabilities in your network and information systems to prevent adverse impact on your essential function(s).	PA#1	Partially Achieved	Agree	✓ Reviewed documentation provided to show how the Trust gathers and cross-checks threat intelligence	Agree
		PA#2	Partially Achieved	Agree	✓ Reviewed documentation provided to receive, track, analyse, prioritise and address announced vulnerabilities.	
		PA#3	Partially Achieved	Agree	✓ Reviewed documentation provided to mitigate vulnerabilities that cannot be promptly addressed.	
		PA#4	Partially Achieved	Agree	✓ Check that systems becoming end of life or out of support have appropriate plans in place to migrate or mitigate	
		PA#5	Partially Achieved	Agree	✓ Reviewed documentation provided to show how the Trust gathers and cross-checks threat intelligence	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
C1.a	The data sources that you include in your monitoring allow for timely identification of security events which might affect the operation of your essential function(s).	PA#1	Partially Achieved	Agree	✓ Reviewed the data sources to ensure appropriateness.	Agree
		PA#2	Partially Achieved	Agree	✓ Reviewed information from data sources to ensure appropriate processes in place to detect IoCs.	
		PA#3	Partially Achieved	Agree	✓ Reviewed evidence that suitable user monitoring is undertaken.	
		PA#4	Partially Achieved	Agree	✓ Reviewed evidence that suitable network boundary monitoring is undertaken.	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
D1.a	You have an up-to-date incident response plan that is grounded in a thorough risk assessment	PA#1	Partially Achieved	Agree	✓ Reviewed documentation provided to confirm whether essential functions have been considered within response plans.	Agree
		PA#2	Partially Achieved	Agree	✓ Reviewed documentation provided to determine whether plans contain scenarios for known attacks ('play books').	

	that takes account of your essential function(s) and covers a range of incident scenarios.	PA#3	Partially Achieved	Agree	✓ Reviewed documentation provided to determine whether plans outline roles and responsibilities of staff members.	
		PA#4	Partially Achieved	Agree	✓ Reviewed documentation provided to determine whether the plan had been shared with relevant stakeholders.	
		PA#5	Partially Achieved	Agree	✓ Reviewed documentation provided to determine whether plans contain details regarding how the Trust meets its obligations as a data controller/processor during an incident situation.	
		PA#6	Partially Achieved	Agree	✓ Reviewed documentation provided to determine whether plans identify the need to inform system partners of an incident and contain contact details to facilitate this.	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
E2.b	You have a good understanding of requirements around consent and privacy, including the common law duty of confidentiality, and use these to manage consent.	A#1	Achieved	Agree	✓ Reviewed training documentation and guidance provided in respect of ensuring consent processes are in place.	Agree
		A#2	Achieved	Agree	✓ Reviewed policies in place in respect of consent to ensure appropriateness.	
		A#3	Achieved	Agree	✓ Reviewed documentation provided in respect of transparency to ensure appropriateness.	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
E3.a	You lawfully and appropriately use and share information for direct care.	A#1	Achieved	Agree	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	Agree
		A#2	Achieved	Agree	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	
		A#3	Achieved	Agree	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	

		A#4	Achieved	Agree	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	
		A#5	Achieved	Agree	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	
		A#6	Achieved	Agree	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	

Appendix B: Summary of work undertaken and risks reviewed – Discretionary outcomes

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
A1.a	You have effective organisational information assurance management led at board level and articulated clearly in corresponding policies.	A#1	Achieved	Agree	✓ Reviewed information governance and security policies.	Agree
		A#2	Achieved	Agree	✓ Reviewed reporting up to Board and Board committee level regarding cyber and IG	
		A#3	Achieved	Agree	✓ Reviewed responsibilities detailed in Trust policies and reporting including Board-level individuals.	
		A#4	Achieved	Agree	✓ Reviewed reporting to the Board of Directors to establish oversight arrangements for information governance and security.	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
A2.b	You have gained confidence in the effectiveness of the security and governance of your technology, people, and processes relevant to your essential function(s).	A#1	Achieved	Agree	✓ Reviewed security and governance measures in place to protect information, systems and networks	Agree
		A#2	Achieved	Agree	✓ Reviewed the assurance methods the Trust utilises	
		A#3	Achieved	Agree	✓ Reviewed independent assurances the Trust receives, including penetration testing	
		A#4	Achieved	Agree	✓ Reviewed Trust processes for deficiency remediation	
		A#5	Achieved	Agree	✓ Reviewed Trust processes for scheduled assurances	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B3.e	Before reuse and / or disposal you appropriately sanitise devices, equipment	PA#1	Partially achieved	Agree	✓ Reviewed documentation confirming sanitisation of all devices, equipment and remote media holding devices before reuse and/or disposal	Agree

	and removable media holding data important to the operation of your essential function(s).					

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
C1.b	You hold log data securely and grant appropriate access only to accounts with business need. No system or user should ever need to modify or delete master copies of log data within an agreed retention period, after which it should be deleted.	PA#1	Partially achieved	Agree	✓ Reviewed documentation confirming that only authorised staff can view log data for investigation, reviewed the Trust list of authorised users.	Agree
		PA#2	Partially achieved	Agree	✓ Reviewed documentation confirming that only authorised staff can view log data for investigation, reviewed the Trust list of authorised users.	
		PA#3	Partially achieved	Agree	✓ Reviewed evidence confirming that log data is monitored.	

Appendix C: Risk assurance rating and confidence level methodology

Risk assurance ratings

How to determine the indicator of good practice achievement level

The CAF-aligned DSPT Independent Assessor must assess the achievement level for each in-scope DSPT indicator of good practice assessed as part of their DSPT review. The Independent Assessor leverages knowledge and subject matter expertise alongside observations made during the assessment to evaluate each indicator of good practice against the Not Achieved, Partially Achieved or Achieved statements of the Cyber Assessment Framework. These statements are used to assign an achievement level to each indicator of good practice.

This achievement level reflects the maturity of the organisation in being able to meet the expected outcomes through implementation of controls and processes.

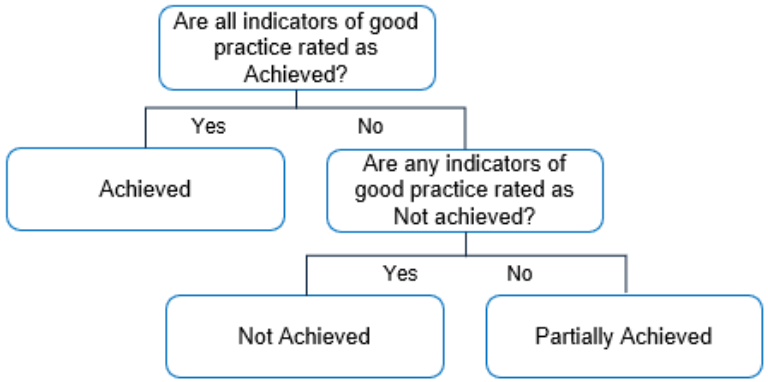
How to determine the outcome level achievement level

The DSPT Independent Assessor must then follow the CAF requirements to assign an achievement level at the outcome level. The CAF states that an outcome will be rated as Achieved if every underlying indicator of good practice is rated as Achieved. An outcome with be rated as Not Achieved if one or more underlying indicator of good practice is rated as Not Achieved. Finally, an outcome will be rated as Partially Achieved if no indicator of good practice is rated as Not Achieved, but not all indicators of good practice are rated as Achieved.

How to determine the overall risk rating for the organisation

The DSPT Independent Assessor then uses the table on the right-hand side to assign an overall risk rating to the organisation.

How to determine the outcome level of the achievement level



Overall Risk Rating across all tested outcomes	
Very High	More than four outcomes are rated as not meeting minimum achievement levels required and/or the organisation cannot comply with mandatory policy requirements.
High	Between two and four outcomes are rated as not meeting minimum achievement levels required.
Moderate	No more than one outcome is rated as not meeting minimum achievement levels required.
Low	All minimum achievement levels have been met.
Very Low	All minimum achievement levels have been met and achievement levels have been exceeded for at least one outcome.

Appendix C: Risk assurance rating and confidence level methodology

Overall Confidence and Risk Levels

The confidence-level in the veracity of the organisation's DSPT self-assessment submission has been determined by comparing our assessment findings against the self-assessment made by the organisation. The following NHS England definitions were used for aiding the decision of applying a confidence-level.

Level of deviation between self and independent assessment	Confidence level
High level of deviation - the organisation's self-assessment against the Toolkit differs significantly from the Independent Assessment. For example, the organisation has declared as "Standards Met" (meeting the expected achievement levels across all outcomes) but the independent assessment has found multiple outcomes as not meeting minimum levels of achievement.	Low
Medium level of deviation - the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment. For example, the Independent Assessor has exercised professional judgement in comparing the self-assessment to their independent assessment and there is a non-trivial deviation or discord between the two.	Medium
Low level or no deviation - the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment.	High

Appendix D: 360 Assurance standing information

Contact details

Leanne Hawkes, Director	
leanne.hawkes@nhs.net	07545 423040
Laura Brookshaw, Client Manager	
laura.brookshaw@nhs.net	07467 444596
Lewis Swann, Assistant Client Manager	
lewis.swann@nhs.net	07776 978646

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The matters reported are only those which have come to our attention during the course of our work and that we believe need to be brought to the attention of The Rotherham NHS Foundation Trust. They are not a comprehensive record of all matters arising and 360 Assurance is not responsible for reporting all risks or all internal control weaknesses to The Rotherham NHS Foundation Trust.

This report has been prepared solely for your use in accordance with the terms of the aforementioned agreement (including the limitations of liability set out therein) and must not be quoted in whole or in part without the prior written consent of 360 Assurance.

Board of Directors Meeting
4th July 2025

Agenda item	P118/25
Report	**Learning From Deaths & Mortality: Quarterly Report 2024/25 Q4**
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 Jan 2025) is **105.6**. 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 Medical Director.
Powers to make this decision	N/A
Who, What and When	The latest **SHMI** score is **105.6.** TRFT remain in the *As Expected* Band. This is an increase from 104.6. The latest reporting month is January 2025. The Trust moved to ECDS 4 (Emergency Care Data Set) in August 2024. Same Day Emergency Care data is now submitted to the ECDS data set. The number of observed deaths in the past 12 month period has remained roughly the same. There has been a reduction in the number of Finished Consultant Episodes of circa 14% which has reduced the number of expected deaths and can explain the increase in SHMI.

	Not all Trusts moved to ECDS 4 at the same time and some still have not. Once all trusts are reporting to ECDS we should expect a more normal position. In the 12 month period Feb 23– Jan 24 there were 1485 deaths compared to Feb 24- Jan 25 there were 1480 deaths. Deaths in January 25 were 131 compared to 124 in January 24. A run of more deaths than expected between Nov 2024 & Jan 2025, in the Septicaemia diagnosis group, has triggered a VLAD Alert. A coding review has been requested and completed SJRs will be reviewed for patients in this group. There have been 125 deaths coded as sepsis in the 12 months Jan24-25 compared to 160 in the previous 12 months. There has been a reduction in the number of expected deaths corresponding to a reduction in number of spells. These review reports and the background SHMI data will be discussed at the July Trust Mortality Group. Decisions will be made with regards to any further required investigation/reviews. Structured Judgement Reviews continue to be completed in a timely fashion. In Q4 20% of deaths had an SJR requested. 83% were completed in less than 60 days exceeding the target of 75%. In 24-25 100% of SJRs were completed with 69% in less than 60 days this compares favourably to 56% in 23-24. The thematic reviews have identified as a priority the use of ReSPECT forms and there is a working group meeting to embed improvements. The Medical Examiner Service have scrutinised 323 deaths during Q4. 98% were scrutinised in less than 5 days with 16% referred to the coroner. 96% of MCCDs were completed within 5 days. The medical examiners also scrutinised 344 deaths in the community as a service is now provided to all Rotherham GPs. This provides timely scrutiny and has prevented referrals to the coroner. 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 Q4 2. SHMI Report – Latest Month's Data Jan 2025 3. Medical Examiner Report 2024/25 Q4

John Taylor
Learning from Deaths & Mortality Manager
June 2025

Learning from Deaths Quarterly Report: 2024/25 Q4

	Due Date	SJR Data	SHMI Latest Month
This Report	-	2024/25 Q4	Jan 2025
Next Report	05/09/2025	2025/26 Q1	Mar 2025

*SJR data is grouped & reported by the date of death

SJR Requests

				Source of SJR Request		
Discharge Date	**Adult Inpatient & UECC Deaths**	**SJR Requested**	**SJR Requested %**	**Medical Examiner**	**Trust Data**	**Other**
2024/25	1038	217	21%	99	110	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
2024/25 Q4	318	65	20%	18	47	0
2023/24	1070	224	21%	111	105	8

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	217	0	100%	69%	27	0
2024/25 Q1	60	0	100%	45%	6	0
2024/25 Q2	45	0	100%	64%	4	0
2024/25 Q3	47	0	100%	83%	8	0
2024/25 Q4	65	0	100%	83%	9	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

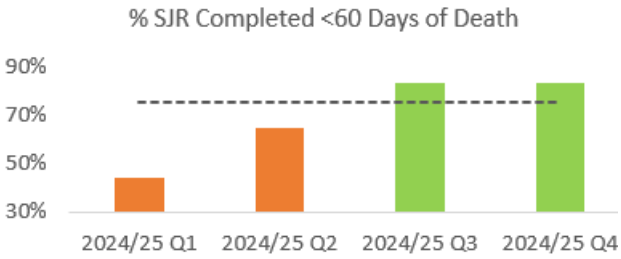
Update

Timeliness figures are monitored by the Trust Mortality Group.

For deaths in 2024/25, 100% of SJRs have been completed. 69% have been completed within 60 days of death, which is below the 75% target.

For the last two quarters the 75% has been comfortably surpassed. Many 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. Changes have been made to the leaving process which means this won't reoccur when reviewers leave.

Measures to maintain 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.



Summary & Distribution 2024/25 Q4 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

Update:

The Thematic Analysis report for 2024/25 Q4 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.

Next Report:

The next Thematic Analysis Report will be completed in Sept 2025 for 2025/26 Q1 SJRs.

Learning from Deaths – Learning Disabilities, Autism & Serious Mental Illness

As recommended TRFT completes SJRs for Trust deaths for those with a Learning Disability, Autism or a Serious Mental illness.

These deaths are identified by the Medical Examiner during scrutiny, from Trust data or from a request by the Matron for Learning Disabilities and Autism. In addition some SJR requests for patients with a Learning Disability or Autism will come from an ICB LeDer Team.

The LeDer Programme is a Commissioner-led review of deaths for patients with Learning Disabilities and Autism, regardless of the place of death. Provider Trusts are frequency asked to assist with LeDer reviews when they have been involved in the care provision for that patient. SJRs are requested if the patient died within 14 days of a TRFT discharge or longer, if appropriate.

Completed SJRs are distributed to the Matron for Learning Disabilities and Autism, the Head of Safeguarding, the Mental Capacity Act Lead Nurse and to the requesting ICB LeDer Team.

SJR Figures for Adults with a Learning Disability, Autism or Serious Mental Illness

Discharge Month	SJR Requested	SJR Completed	SJR Outstanding	Overall Care Score < 3	Preventability Score < 4
2024/25	30	30	0	5	0
2024/25 Q1	8	8	0	1	0
2024/25 Q2	7	7	0	0	0
2024/25 Q3	8	8	0	3	0
2024/25 Q4	7	7	0	1	0
2023/24	33	33	0	7	0

	Requested SJRs	Learning Disability or Autism	Serious Mental Illness
2024/25	30	11	19

Update

All 2024/25 all deaths for those with an identified Learning Disability, Autism or a Serious Mental illness have has an SJR requested. No SJRs are 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.

Learning from Deaths: Incidents & the Patient Safety Incident Response Framework

All SJRs with an Overall Poor Care Score or judged to be more than likely preventable are entered as Incidents on Datix. As with other logged incidents, these are reviewed/investigated by the appropriate Care Group and clinical team/s.

Although infrequent it is mandated that deaths judged to have been more than likely preventable have a Patient Safety Incident Investigation.

Update

The 27 reportable SJRs for deaths in 2024/25 have all been logged as incidents for review and possible investigation on Datix. 19 of these have been concluded in Datix.

All resulting outcomes (Lessons Learnt & Actions) are reported for discussion at the Trust Mortality Group.

Learning from Deaths in the Care Groups & Respective Clinical Support Units

Every four weeks completed SJRs are distributed to the Care Group Mortality leads. Typically 15 to CG1- Medicine, 5 to CG2 – Surgery and 1 to CG1 – UECC.

Each care group is asked to complete a 1-2 minute review of each SJR and determine which ones have learning points, both positive and negative. These SJRs should be disseminated to the relevant CSU for discussion at their Clinical Governance or separate Mortality meeting. All those with an Overall Poor Care Score or judged to be more than likely preventable should be disseminated and discussed.

The suggested format for CSU discussion is a brief presentation of the SJR, followed by a presentation of a local review. This may:

- support findings in the SJR
- refute findings in the SJR
- identify new issues

Each discussion should end in a documented summary with an action plan, if appropriate.

CSUs are invited to present reviews at their respective Care Group Mortality Meeting, held monthly in CG1 – Medicine and bi-monthly in CG2 – Surgery. Where appropriate the CG Mortality leads escalate issues and cases to the Trust Mortality Group, particularly when it has been determined that the problem and solution is system/trust wide.

Due to the small volume, all UECC deaths are discussed at the bi-monthly held CG1-UECC Mortality Meetings.

Update

The Learning from Deaths & Mortality Manager 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.

SHMI

TRFTs latest rolling 12 month SHMI value is 105.6 TRFT remain in the band 2 ‘as expected ‘band. The previous value was 104.6

The change in SHMI may be explained by the move to ECDS 4. It is recognised that the implementation of Same Day Emergency Care Data (SDEC) can impact SHMI. SHMI is calculated using Admitted Patient Care data and TRFT is now submitting SDEC data to ECDS instead of APC.

SDEC activity is low acuity data so the exclusion from APC can increase SHMI. Specifically if the number of observed deaths remains roughly the same (as mortality is low in the SDEC cohort) the expected number of deaths decreases and the SHMI increases.

TRFT have seen a reduction of Finished Consultant Episodes of circa 14%.

End Month	SHMI	Number of spells	Observed deaths	Expected deaths
Jan – 24	102.6	50615	1485	1445
Jan - 25	105.6	44930	1480	1405

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.

Last Alerts & Investigations:

A run of more deaths than expected between Nov 2024 & Jan 2025, in the Septicaemia diagnosis group, has triggered a VLAD Alert.

A coding review has been requested and completed SJRs will be reviewed for patients in this group.

Theses review reports and the background SHMI data will be discussed at the July Trust Mortality Group. Decisions will be made with regards to any further required investigation/reviews.

Sepsis SHMI comparator;

	SHMI	Observed deaths	Expected deaths	Episodes
Jan 2024	120.1	160	135	620
Jan 2025	112.5	125	110	530

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 SJRs Have Gone in 2024/25 Q4

Number of SJRs	Destination	Purpose
9	Patient Safety team (Logged Incidents on Datix)	For further review and if necessary investigation
52	CG1 Mortality Lead & CG1 SJR Review Group	To be reviewed to select SJRs for discussion within the CG/CSU
12	CG2 Mortality Lead	To be reviewed to select SJRs for discussion within the CG/CSU
65	UECC Mortality Lead	To be reviewed to UECC SJRs & the 1st 24 Phases of Care comments
1	Family Mortality Lead	To be reviewed to select SJRs for discussion within the CG/CSU
1	Resus Team	Requested to assist workstream to reduce unnecessary resuscitations
7	Deteriorating Patient Group & Sepsis QI	To be reviewed & discussed at the Deteriorating Patient Group or QI Sepsis Group
7	Trauma Group	To be reviewed & discussed at the Trauma Group
7	Safeguarding & Learning Disability Teams	To be reviewed for discussion at Team meetings
2	ICB LeDer Team	To assist with ICB led LeDer Reviews
2	Legal Team	To assist with reviews/inquest
18	Medical Examiner Service	To give feedback on their escalations
65	Thematic Analysis Reports	To group comments together to be reviewed by various Groups/Teams
18	Trust Mortality Group	To be reviewed & discussed in response to a SHMI VLAD Alert for Septicaemia deaths

John Taylor
Learning From Deaths & Mortality Manager
Mobile: 07833 634440
Email: john.taylor21@nhs.net

The Rotherham NHS Foundation Trust

02/06/2025

Learning From Deaths
Thematic Analysis SJRs 2024/25 Q4

Reducing Reocccurance Rate of Poor Care for Future Patients & Sharing Good Practice

This is the ultimate objective of the Learning From Deaths Programme.

In order for this report to be affective, it must be read by Trust individuals and groups who can subsequently suggest, design and implement changes that do this.

Content

This report contains the Thematic Analysis of Structured Judgement Reviews (SJRs) completed for deaths in 2024/25 Q4. 65 were completed, at the time of this report.

Thematic analysis is a method for analysing and coding qualitative data to determine themes.
Thematic analysis of SJRs involves analysing free text comments and assigning these comments to codes.

In this analysis the comments are assigned to a code based on whether they are positive, negative and what healthcare factor the positive or negative comment relates to.

Purpose of Thematic Analysis in Learning From Deaths

Grouping comments into categories to highlight recurrent instances/themes will:

:Identify new problems

:Identify the reappearance of problems

:Highlight that some problems thought to be rare are more commonplace

:Provide evidence for problems that are reported anecdotally

:Identify good practice

Content

Thematic Analysis 2024/25 Q4: Comments Detailing Poor Care

Delay/Omission/Choice - Medication or Treatment	Page 3
Delay/Omission - Escalation	Page 4
Delay/Omission - Assessment/Opinion/Review	Page 5
Delay/Omission/Interpretation - Tests/Results/Monitoring	Page 6
End of Life/Palliative Care/DNACPR	Page 7
Location of Care/Bed Availability/Inappropriate Moves	Page 9
Communication	Page 10

Thematic Analysis 2024/25 Q4: Comments Detailing Good Care

Delay/Omission/Choice - Medication or Treatment	Page 11
Delay/Omission - Escalation	-
Delay/Omission - Assessment/Opinion/Review	Page 12
Delay/Omission/Interpretation - Tests/Results/Monitoring	-
End of Life/Palliative Care/DNACPR	Page 12
Location of Care/Bed Availability/Inappropriate Moves	-
Communication	Page 12

Data Tables

Overall Care Scores	Page 13
Preventability	Page 13
Concern Area	Page 13
Problems in Care	Page 14

The Rotherham NHS Foundation Trust

Thematic Analysis 2024/25 Q4: Comments Detailing Poor Care

Delay/Omission/Choice - Medication or Treatment

Patient had Covid pneumonitis but did not receive the antivirals in a timely manner due to poor communication within teams.

There was missed doses of antiviral medication and no communication with medical team for alternative plan

Patient developed pressure sores as likely SSKIN bundle snot implemented effectively

Initial assessment was good and all investigations completed and diagnosis made (sepsis) however antibiotics were not given within the hour although patient was reviewed and plan made at least 2 hours earlier

2hrs 50 mins delay in offload - preventing treatment and investigation in this time did not affect the outcome but poor care

over 7 hours to analgesia in abdominal pain then only iv paracetamol with perforation

no fluids until 11 hrs

no antibiotics for over 7 hours

Keppra was not given on day one due to dose not being available, patient with known seizures - could have had IV dosing potentially.

This gentleman lost a significant amount of weight during a short hospital stay (the one prior to his final hospital admission) which is concerning given he was within a hospital environment and shows we were not meeting his nutritional requirements. This was challenging, and it was felt that an NG was not an appropriate treatment option as his dementia made him aggressive on occasion and it was felt this would cause him distress and highly likely to be pulled out. However despite his behavioural issue they were clearly managing to provide adequate nutrition in the care home from which he came, and we did not manage to do this in hospital.

It is however concerning that this vulnerable gentleman with known swallowing issues was potentially given the wrong type of fluids for his swallowing needs due to a miscommunication

Problem occurred with dosing of steroids. The steroid were to be increased on neuro advice but were accidentally stopped (8 days).

some of his longstanding medications were not prescribed including opiate patch, despite being clearly documented in previous discharge summary

He had poor management of hyperkalaemia, which unlikely changed his outcome, but meant that too much focus was place on trying to correct this, rather than recognising why it was happening

the patient was documented to have oxygen saturations above the target range, but the oxygen was not reduced leading to periods of hypercapnia.

Felt that he was not managing with current care package and was deemed MFFD on arrival and needed increase to QDS care as a minimum. Care package in place at home were not able to manage his needs.

Patient given analgesia enterally when this route was unlikely to be effective, could

Delay/Omission - Escalation

Deterioration in EWS score at 23.00 (score of 7) escalated appropriately and had a ART review within an hour. During the review the plan was for obs as per protocol (which for a score of 7 would be every 30 minutes), he only had one further set of obs documented at 01.14 with a score of 6 (which as per EWS policy means medical team should have been informed and hourly observations done - there is no evidence of this

If do NEWS need to have plan for response and respond quicker

no documented review on one of the days of weekend although scoring NEWS >3 on numerous occasions.

Poor weekend response to deteriorating patient - worsening of conditions and NEWS score were found by daughter not staff.

Delay/Omission - Assessment/Opinion/Review

Long delay from the patient being referred to medicine (from UECC) before the patient was reviewed by the medical team (around 12 hours)

Nil by mouth for a few days after admission pending decision on conservative management vs surgery due to the weekend - could decision making been earlier so that patient can have oral intake earlier for comfort?

Areas for improvement: the patient had a BM and ketone measured by the paramedic crew (elevated BM, normal ketone) which was not commented on by any of the 3 physicians who reviewed her so it is unclear if this measurement had been factored in and if it was not, would the raised BM have changed the management decision to send her home

Cardiology review was delayed over 48hrs

Did not have a senior review within the first 24 hours (was admitted early hours Sunday morning and PTWR midday on Monday)

Access to chest physio was delayed (36 hrs after admission), which appears to be a communication issue

Presumably due to being moved quickly to the respiratory ward, he didnt receive daily review from a doctor over the weekend, which given he was then escalated to critical care would have been appropriate.

Potential for a more comprehensive falls assessment to be carried out at initial presentation. Little record of collateral history and past medical history to explain frailty.

Admitted for elective ascitic drain but no plan for the management of that

Earlier input from gastroenterology consultant should have happened

The LD team were unable to review the patient at the time the referral was made. Decision making about best interests had taken place and active treatment had stopped and palliative care had commenced by the time the LD team reviewed

Decision made in best interest for ward based care due to lack of mental capacity. No formal documentation of Mental capacity assessment however.

Severe changes on ECHO was noted however no discussion with HF nurse/ Cardiology documented

Delay/Omission/Interpretation - Tests/Results/Monitoring

Deterioration in EWS score at 23.00 (score of 7) escalated appropriately and had a ART review within an hour. During the review the plan was for obs as per protocol (which for a score of 7 would be every 30 minutes), he only had one further set of obs documented at 01.14 with a score of 6 (which as per EWS policy means medical team should have been informed and hourly observations done - there is no evidence of this

When investigations planned, follow up in a timely manner and if decision to not follow through then document rationale

No observations were carried out on arrival to the surgical ward, is it standard of care that observations are undertaken on a patient after transfer from a different area of the hospital?

Documented that patient was delirious on numerous occasions however no screening tool completed.

Overall care would be graded as poor since patient developed pressure ulcer and suffered from fluid overload and delays in initial antibiotic administration

although viral infection is suspected, there is no evidence I can find on EPR for a respiratory swab sent

He had a positive Covid swab, on first day of admission, but doesnt appear to have been acknowledged until 3 days later

Poor hand over of abnormal blood results leading to delayed response, and also not considered whether appropriate to treat.

No observations undertaken for the last 8-9 hours of this ladies life, despite being on active management for 7 of those, and the medical notes documenting unrecordable BP and low sats off oxygen during this time. Only set of obs on AMU score a EWS of 6, is stated that this has been escalated but no further obs done,

Timely actioning for investigations - In a patient with suspected sepsis a FBC was delayed for 24hrs.

urine output monitoring should have been better given the treatment of heart failure

End of Life/Palliative Care/DNACPR

Cardiac arrest call put out despite DNACPR being agreed with patient by lung CN

Discussions should have taken place about limits of treatment and DNACPR in community.

Patient had community DNAR and this was not checked and implemented until around 12 days into the stay, this could have resulted in harm to the patient if she would have arrested and CPR undertaken, good practice is to have this decision made and documented within 24 hours of admission.

There were trends of signs and symptoms that could have led to earlier recognition and implementation of end of life care.

may have benefited from earlier recognition of deterioration despite good medical care and earlier palliation for comfort, avoiding multiple invasive procedures.

Earlier decision to palliate and involvement of palliative care team in the last days of life could have benefited patient and family

poor documentation especially of end of life care and perhaps earlier initiation of same given patient had been deteriorating for sometime

DNACPR in surgical clerking plan at 18.30 'DNACPR to be completed (already discussed with the daughter)' but this was not completed and the patient received inappropriate CPR, this should have been undertaken there and then by the doctor who made the decision.

The only thing is, whether or not poor prognosis could be shared with patient/family a bit earlier than in his last short hours of life

Missed opportunity to discuss this patients wishes with him on admission and fill in a respect form, which dependent on the outcome of that discussion may have prevented inappropriate CPR

There was no referral to RESPECT form until 5 days after admission

Fast track discharge when patients are approaching EoL needs to more pragmatic to allow patients to die at home in line with their wishes. Resources appear to be wasted without achieving anything.

EOL care pathway could have potentially been initiated 24 hours earlier

This man had 10 admissions in the last year of his life, for various different reasons, but he went from independent living to being a resident in a nursing home. Although DNACPR discussion was had, I can see no evidence that further care planning was attempted during any of these admissions, or recognition that he was in the last year of his life.

Lack of recognition that this patient was approaching the end of his life

RESPECT form was in patient's toiletries bag - not appropriately filed as part of admission process. This later on led to inappropriately commenced CPR.

This lady with advanced cancer was referred late to palliative care in the community such that she hadn't been seen prior to her last admission

Only seen by palliative care 36 hours before her death and she had developed further evidence of progressive disease including intestinal obstruction, it was unnecessary for her to have CT to establish this as she would not have been able to have anything but palliative care. She continued to have interventions including observations and blood tests until day before her death. Her wishes weren't explored until day before her death

May have been appropriate to have palliated patient earlier in admission

in meditech the ward round notes state that there is a DNAR in place at the head of the page, but the foot of the page there is an escalation plan that states no DNAR in place.

Neither the patient not the family appear to have had a clear discussion about the prospect of patient dying. Death not mentioned until patient actively dying.

EOL care should of been considered sooner as it was clear from his course that the BP , infection and heart failure could not be successfully managed

Location of Care/Bed Availability/Inappropriate Moves

He was looked after in several wards during his admission (respiratory initially due to pneumonia, then gastro and then Geriatric medicine). Given he had dementia and was very elderly it seems that geriatric medicine would have been an appropriate place of care throughout

Avoid frequent ward moves in elderly patients with dementia as likely to exacerbate confusion and delirium

Prolonged time spent in ED (14 hours), the patient was on an ED trolley for around 5 hours

The patient was transferred after 9pm at night, and his EWS score had gone from 1-4 prior to transfer, is there a policy for stability of patient and ward transfers and if so does this fit within that policy?

Moved wards several times and not enough evidence of thorough review of his notes.

Was in ED for around 18 hours before transfer to AMU and was on a ED trolley for a large proportion of that time

Had we been able to organised a respite bed for this gentleman (which he was willing to self fund) he would likely to have not had a failed discharge

he should not have been nursed in side room given falls risk and this was addressed but he still fell

He was repatriated from HASU where he had been transferred 1 week previously, he had no real benefit from this transfer and not clear if any discussions about appropriateness of initial transfer decision, or what would be in his best interests

Communication

Records later on documented known ischaemic heart disease and recurrent NSTEMIs, but this was not documented on ED / initial admission, which would have been relevant.

some miscommunication about blood transfusion led to delay in administering

The communication between teams -CHC/medical/nursing/ palliative care seems very poor from what is documented leaving the family with lot of confusion and unnecessary distress.

There is issue of poor communication and mixed messages to NOK by different teams.

documented as not for surgery by consultant in the morning that this had been decided during the night but this is unclear in the notes .

Lack of communication with patient and family about expected poor outcome and what he and they would want

Confusion for patient and family regarding where and why he should present at the hospital and investigation he should undergo.

Confusion over call put out - code red put out after the patient vomited and aspirated (not lost output), however, staff who requested call thought it was for cardiac arrest call.

There is not a clear discussion with patient regarding TAVI and its risks and benefits. However, this then seems to become the goal of ongoing treatment, some of which the patient repeatedly declined.

It appears during the bronchoscopy an expected complication occurred and was dealt with appropriately. The consent is not available on EPR, hence unable to comment if the risks of procedure had been explained to patient including haemorrhage/ CVA/ death albeit rare.

The timeline during procedure, for how long patient was potentially hypoxic is undocumented. There is a discrepancy between medical notes and nursing notes re: the saturation during the complication

The Rotherham NHS Foundation Trust

Thematic Analysis 2024/25 Q4: Comments Detailing Good Care

Delay/Omission/Choice - Medication or Treatment

Excellent care demonstrated. Quick joint decision making and move to theatre for attempt at life saving surgery but did not survive the insult despite aggressive ITU care. Excellent communication with family.

Excellent care evidenced by the patient being reviewed by an ED consultant on arrival into resus and treatment immediately initiated, discussion regarding escalation of care and DNACPR had with the patient and his family within a few hours of presentation by ED consultant

Very good and clear plans made for active medical management.

Very good clinical care in short admission, including out of hours input received from various specialties

Overall, very good medical care received, with clear documentation of events and rationale of decision making.

In general that notes show excellent interactions and documentation by the team as well as a clear management plan for the raised INR new CVA symptoms

This patient was a young man with severe global developmental delay and autism. He was admitted with pneumonia and increasing seizures. He was excellently managed throughout with appropriate treatment

Excellent care as evidenced by early and ongoing consultant involvement, utilisation of the MDT in care (CNS, microbiologists, palliative care) and regular

Medical treatment was of a high standard with multiple specialities involved as well as dietetics and the multidisciplinary team.

Excellent in UECC seen by 3 consultants who noted low BP was normal for him and appropriate treatment started seen within 1 hour of arrival

Delay/Omission - Assessment/Opinion/Review

Good example of liaising with different specialties in a timely manner to ensure appropriate investigations arranged

End of Life/Palliative Care/DNACPR

Excellent care as evidenced by rapid recognition that the patient was moving into the final stages of his life, face to face conversation with the family regarding his deterioration and family very much on board with the plan to move towards palliative management

Excellent end of life care and involvement of the Palliative Care team

Excellent discussions between Dr Hendry and family and focus of care switched to last days of life.

Well managed withdrawal of life sustaining treatment on ITU

Excellent involvement form the palliative care team.

Communication

Excellent care demonstrated. Quick joint decision making and move to theatre for attempt at life saving surgery but did not survive the insult despite aggressive ITU care. Excellent communication with family.

Excellent communication from his final medical team to family

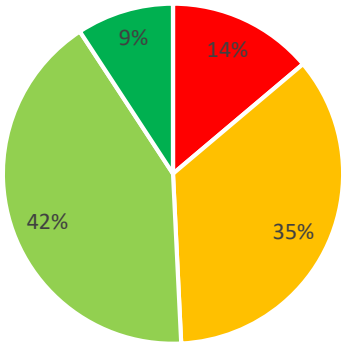
Excellent patient centred care with discussion with him and his family as to continuing non invasive ventilation.

Communication with his family was excellent throughout

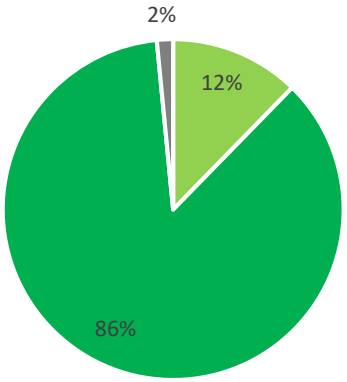
He was quickly recognised to be deteriorating and an excellent assessment and conversation was had by the doctor on stroke unit with his family. He had very good end of life care, given the circumstances

Data Tables

Overall Care Score	SJRs
1 - Very Poor	0
2 - Poor	9
3 - Adequate	23
4 - Good	27
5 - Excellent	6
Not Recorded	0
Total	65



Preventability	SJRs
1 - Definitely preventable	0
2 - Strong evidence	0
3 - Possibly (more than 50:50)	0
4 - Possibly (less than 50:50)	0
5 - Slight evidence	8
6 - Definitely not preventable	56
Not Recorded	1
Total	65



Comment Relates to	Negative Comments	Positive Comments
Delay/Omission/Choice - Medication or Treatment	17	10
Delay/Omission - Escalation	4	0
Delay/Omission - Assessment/Opinion/Review	13	1
Delay/Omission/Interpretation - Tests/Results/Monitoring	11	0
End of Life/Palliative Care/DNACPR	22	5
Location of Care/Bed Availability/Inappropriate Moves	9	0
Communication	11	5
Total	87	21

Type	Problems
Problems leading to readmission	3
Problems in assessment	3
Problem with medication	5
Problem with nutrition	3
Problem with infection control	1
Problem related to operation	1
Problem in clinical monitoring	10
Problem in treatment plan	5
Problem in resuscitation	4
Problem in IV fluids	2
Problems in communication	4
Problems in relatives communication	6
Problems in team communication	9
Problem of any other type	3
Total	59

John Taylor
Learning From Deaths & Mortality Manager
Medical Directorate
The Rotherham NHS Foundation Trust

E-mail: john.taylor21@nhs.net
Phone: MS Teams/07833 634440

Latest Publication Date: 12/06/2025
Latest Data Month: Jan-25

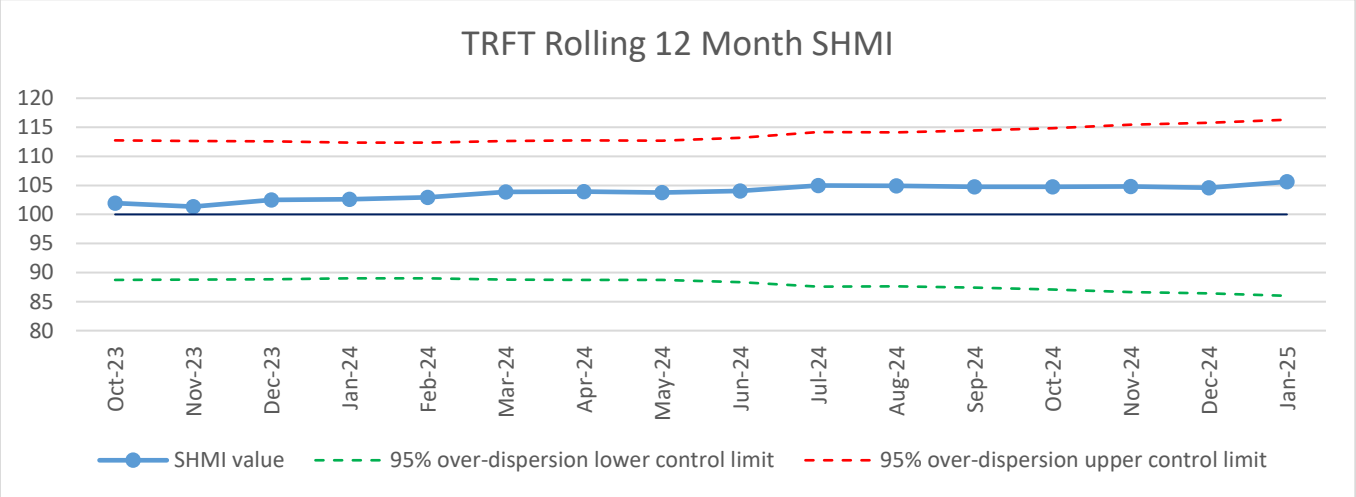
TRFT SHMI Report

Summary

TRFTs latest Rolling 12 Month SHMI Value is 105.6 TRFT remain in the Band 2 'As Expected' band. The previous value was 104.6.

TRFT has 0 Diagnosis Group in the Higher than Expected Band.

TRFT has had 1 Diagnosis Group VLAD Risk Accumulation Chart Alert.
This is the Septicaemia (except in labour), Shock Diagnosis Group

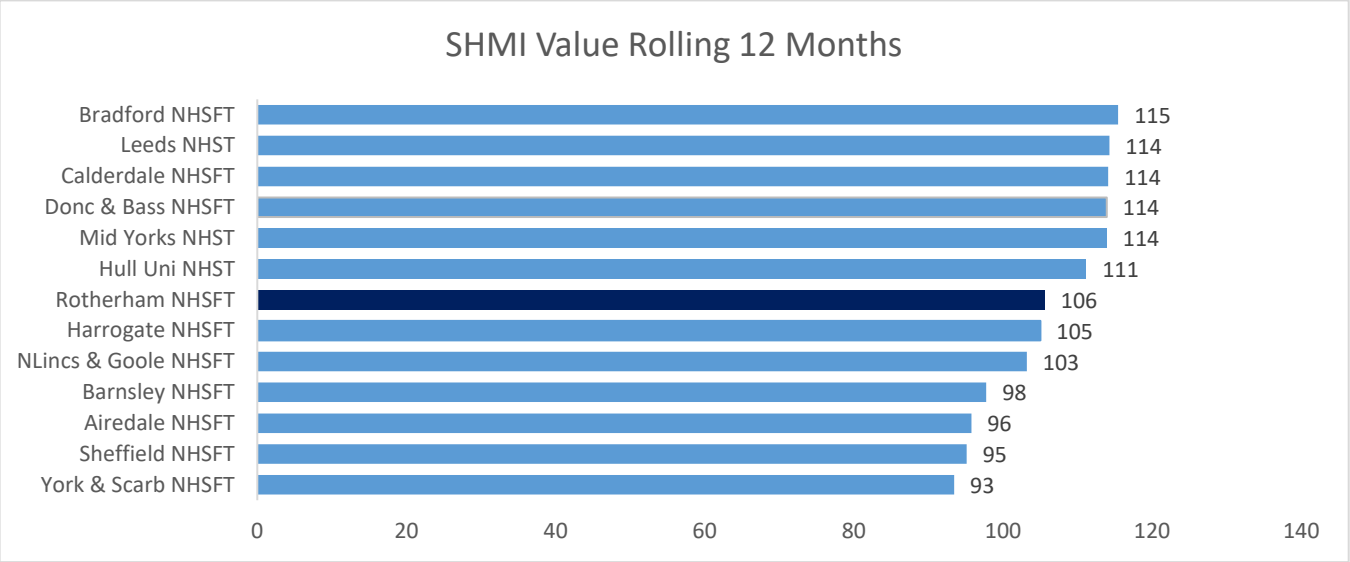


TRFT Latest SHMI Value

End Month	SHMI value	SHMI banding	Number of spells*	Observed deaths	Expected deaths
Jan-25	105.6	2	44930	1480	1405

* Excluded Day Cases and Regular Attendances

Region Comparator - Yorkshire & Humber Non Specialist Trusts



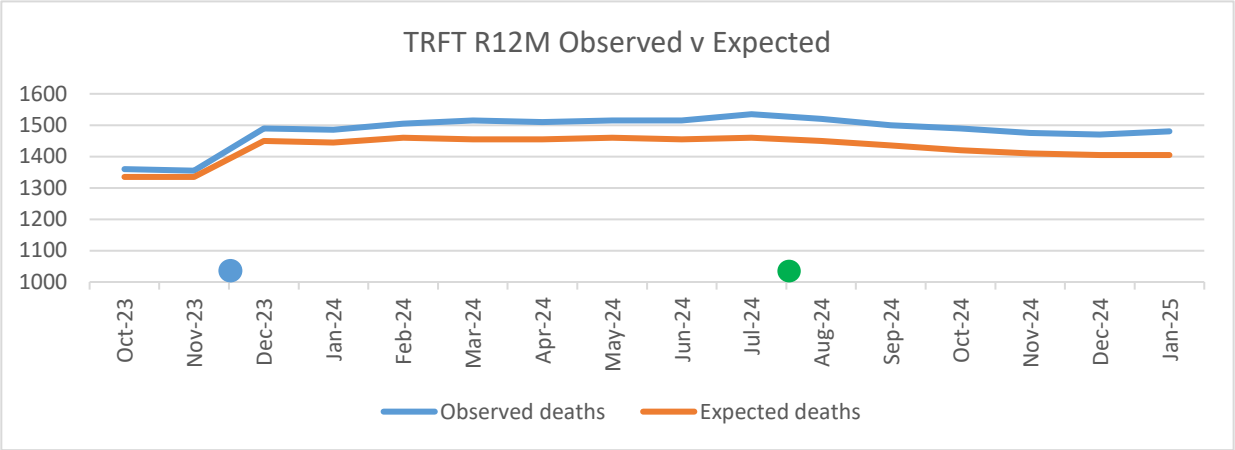
SHMI Diagnostic Group Breakdown

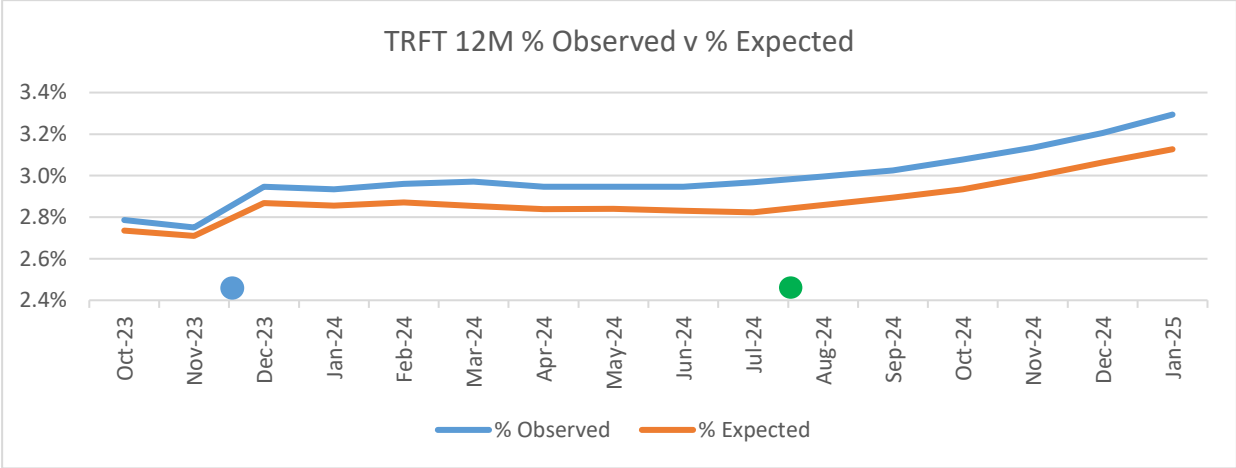
Diagnosis Group	Number of spells	Observed deaths	Expected deaths	SHMI Value	SHMI banding
Septicaemia (except in labour), Shock	530	125	110	112.5	2
Cancer of bronchus; lung	55	15	20	88.7	2
Secondary malignancies	110	25	25	103.5	2
Fluid and electrolyte disorders	340	30	20	134.0	2
Acute myocardial infarction	415	40	30	119.3	2
Pneumonia (excluding TB/STD)	1745	255	230	110.9	2
Acute bronchitis	1015	25	25	93.6	2
Gastrointestinal hemorrhage	335	15	15	97.9	2
Urinary tract infections	770	30	35	84.0	2
Fracture of neck of femur (hip)	360	35	30	118.2	2

Coding Metrics

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 Elective**	**% of Spells with palliative care**	**% of deaths with palliative care**
Harrogate NHSFT	29.1	17.8	4.8	1.8	31
Rotherham NHSFT	15.4	3.2	7.5	2.1	45
Bradford NHSFT	8.5	1.5	4.0	1.4	44
Mid Yorks NHST	8.7	0.5	6.7	2.3	44
NLincs & Goole NHSFT	17.5	0.1	4.6	1.2	26
Donc & Bass NHSFT	13.3	0.1	5.2	2.2	52
Barnsley NHSFT	14.5	0.0	7.7	2.9	55
York & Scarb NHSFT	13.4	0.0	6.1	1.2	27
Sheffield NHSFT	10.0	0.0	5.2	1.8	39
Leeds NHST	5.4	*	6.6	2.2	36
Calderdale NHSFT	6.3	*	7.3	3.4	52
Hull Uni NHST	8.6	*	6.2	2.3	36
Airedale NHSFT	14.8	*	4.7	1.2	23
England	14.9	2.9	6.1	2.1	44

Comparison of the SHMI Observed and Expected Deaths

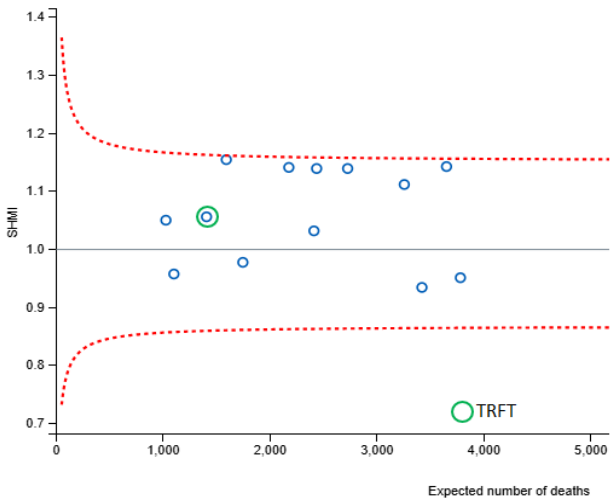




SHMI Methodology Change Dec 2023
Covid Activity was included in the SHMI after being excluded. This increased spell, expected and observed death numbers.

NHS Data Change Aug 2024
As per a national directive, TRFT SDEC activity began to be submitted in the Emergency Care data set, rather than Inpatient, removing it from the SHMI.

SHMI Funnel Plot Yorks & Humber



Above Upper Red Control Limit = *Higher than Expected*
Between = *As Expected*
Below Lower Red Control Limit = *Lower than Expected*

Medical Examiner Service (MES) – Q4

The junior doctors & Consultants have continued to complete the MCCDs in a timely manner. The quality of MCCD's has improved with the help of the discussions held with M.E.s & MEOs which has reduced the quantity of referrals to the coroner.

Achievements

- Continued high rate of scrutinises in a timely manner
- Continued support for GP / Clinicians
- Improved communication with coroner's office

Operational Issues

- Issues with incorrect responsible consultant named on Meditech
- Some doctors still deleting Job Role on Meditech
- Regarding community deaths - The delay of GP's providing MCCD's in a timely manner has reduced slightly

Concerns about care, action taken and escalation

There have been a few issues with the incorrect lead physician on the medical records causing issues with the patient's death being put under the incorrect consultant. We now contact the consultant who they are down under directly to confirm that they are under that consultant, and if incorrect we amend our records.
No themes / trends but M.E.s have noticed delay in radiology reports being produced.

Acute deaths

During Q4 there were 323 deaths.
98% of the deaths were scrutinised within 5 days or less
16 % of deaths were referred to Coroner
96 % of MCCDs were completed within 5 days and sent the Register office on the same day received

The out of hours service has provided cover every weekend and we have completed 1 OOH faith death

Community Deaths

During Q4 there were 344 deaths.
89% of the MCCDs were completed within 5 days or less and 97% of the deaths were scrutinised and sent to the Register office the same day received.

Several GPs have used the service for advice which has prevented unnecessary referrals to the coroner.

BOARD OF DIRECTORS: MEETING IN PUBLIC
4 JULY 2025

The Rotherham NHS Foundation Trust

Agenda item	P119/25
Report	**Well Led Developmental Review**
Executive Lead	Bob Kirton, Managing Director Peter Walsh, Interim Director of Corporate Affairs
Link with the BAF	Links with all BAF risks
How does this paper support Trust Values	Supports all three core values, Ambitious, Caring and Together
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	NHS England encourages trusts to commission a well led developmental review. We are publishing the executive summary of a review conducted by the Advancing Quality Alliance (Aqua) in 2023/24. This review is very positive about the progress the Trust has made in this area, and the current strengths of its approach. It also set out a number of areas for continued attention. In response we have developed an action plan, which sets out the trust's work in each of the eight areas in the CQC's well led framework.

Due Diligence	Board members were involved in interviews which have informed the development of this report.
Who, What and When	Executive directors will take forward work in the action plan. The whole board will be involved in a development programme, which will be finalised after publication of the Ten Year Health Plan.
Recommendations	It is recommended that the Board of Directors: 1. Note the Well-Led Developmental Review (Appendix 1), and the findings in each of the eight well led areas; and 2. Approve the accompanying Action Plan (Appendix 2)
Appendices	Appendix 1: Well Led Developmental Review executive summary Appendix 2: action plan

1. Background

The Well-Led framework is a cornerstone of quality governance. It is essential to ensuring that that NHS provider boards lead the organisation effectively, foster a culture of continuous improvement, and remain accountable to patients, staff, and stakeholders.

NHS England encourages boards to commission an external developmental well-led review to provide independent assurance that governance systems are fit for purpose. The review also identifies the areas of leadership and governance that would benefit from targeted developmental work.

In line with this, in 2023/24, the Trust commissioned the Advancing Quality Alliance (Aqua) to perform this review. In performing their review, Aqua followed the current CQC well led framework, which has eight quality statements.

2. Summary of Key Findings

The executive summary of Aqua's report is attached as appendix 1. Aqua stated:

> "The overall conclusion from our review is that this is an ambitious organisation with substantially strengthened leadership, respected by system partners. There are shared values, trust, a focus on quality and a clear commitment to system transformative solutions. Leadership stability, skills and experience have been established at the very top levels and across key non-executive positions. Leadership focus has resulted in a transformation of the culture of the organisation which is both visible in actions and feedback. Executive and deputy changes provide the foundations for a strong team, but its capacity and resilience continue to be tested given the operational, financial, workforce and partnership challenges."

Aqua concluded that the Trust's recent improvements mean that:

> "The Trust is well-positioned in terms of governance and oversight, with a clear focus on quality, risk, and financial resilience. The organisation's strengths lie in its committed leadership, effective use of data, and constructive challenge culture."

The review set out a number of areas for continued attention, noting that the Board is aware of its risks and challenges:

- Aligned to the review of community services, the Trust needs clarity of the type of organisation it aspires to be focusing on services it provides well
- There is opportunity to strengthen the alignment of underpinning strategies to provide a clear framework aligning with the Trust's broader strategic goals. In particular, the alignment of the Clinical Strategy with workforce and financial sustainability plans will be critical.
- Embedding governance and wider risk changes that are in the process of being reviewed. Standardisation at Care Group level needs to be key to this work.
- As partnerships and system working progresses the Board needs to be alert to growing capacity challenges and alignment to wider system ambitions, including advancing talent management and succession planning.
- Continuing to strengthen estates and facilities leadership. Increasing the visibility of the Trust's commitment to the environmental challenges.
- Progression of the commitment to reducing health inequalities.

Board members will recognise that be aware that these have all been discussed in formal and strategic board meetings.

3. Action Plan

We have developed a comprehensive action plan, which covers each of the eight themes. The action plan brings together existing work and plans, with additional actions which have been prompted by the findings of the review. As such we are proposing that progress is monitored through existing executive and board committees, rather than through establishing a new route.

Key actions include:

- Finalising the clinical strategy and estates strategy
- Updating Executive Director succession planning, and carrying out succession planning in partnership with Barnsley for priority areas
- Expanding Call for Concern to include all elements of Martha's Rule
- Improving and standardising Care Group governance
- Increasing focus on health inequalities, including by completing the leadership self-assessment

We will also begin a new board development programme, which will include a focus on how we will work in partnership with other local providers. We also expect to focus on place and integration, and will consider how the programme should evolve after publication of the government's Ten Year Health Plan, which we expect to include a greater focus on neighbourhood health.

4. Recommendations

The Board is asked to:

1. Note the Well-Led Developmental Review, and the findings in each of the eight well led areas; and
2. Approve the accompanying Action Plan (Appendix 2)

1. Introduction

NHS providers are encouraged to carry out a developmental well-led review for several reasons:

- Good governance is essential in addressing the challenges the sector faces.
- Oversight of governance systems is the responsibility of Boards.
- Governance issues are increasing across the sector.
- Regular reviews can provide assurance that governance systems are fit for purpose.

It is in this context that the Trust has commissioned Aqua to carry out an independent review of governance arrangements in accordance with the Well-Led Framework. CQC published revised regulatory review guidance that came into effect in February 2024. As part of the revision the emphasis of some of the domains within the Well-Led Guidance were updated. The fundamentals of the guidance did however remain embedded in the Code of Governance requirements.

In conducting this review, Aqua has adopted the current CQC framework, we do however recognise that changes are likely following the review of CQC by Penny Dash, (The Dash Review). Furthermore, in applying our approach we have recognised insight from other providers regarding learning from their response to regulatory feedback, this very much focuses on how we engage the wider workforce in implementing and owning the required developments by:-

- Describing what good and fantastic care looks like shaping direction at the front line.
- Embedding learning and assuring full implementation across a provider.
- Shaping an action plan around the outcomes to be achieved and aligned to the route to achieving that measurable outcome.

An objective of the well-led review process is that NHS providers will be confident that there is a shared and consistent view forming the basis of regulatory judgements on the concept of well-led. For example, CQC will ask providers how they are assured in respect of their governance arrangements. This may include asking for information about any independent reviews and how they have been acted upon. The expectation is that a completed well-led review, highlighting areas for further targeted development, will be the preferred evidence to be shared.

To gain a breadth of understanding of the organisation, in addition to the documentary review, the team interviewed internal stakeholders, external stakeholders and observed the Board and 4 committees. We would very much like to thank all parties for their engagement with this review.

The report is constructed around the eight quality statements set out in CQC's guidance. Each section provides a summary of findings, stakeholder feedback and development themes. Preceding those sections is the Executive Summary.

This is a full scope review i.e., we have not been asked to restrict our coverage.

Our findings in this report are based upon the views expressed by Board members, senior staff, external stakeholders, and our observations. We have assumed that the information provided to us, and management's representations are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness, or reliability.

2. Management Summary

2.1 Overview

The overall conclusion from our review is that this is an ambitious organisation with substantially strengthened leadership, respected by system partners. There are shared values, trust, a focus on quality and a clear commitment to system transformative solutions. Leadership stability, skills and experience have been established at the very top levels and across key non-executive positions. Leadership focus has resulted in a transformation of the culture of the organisation which is both visible in actions and feedback. Executive and deputy changes provide the foundations for a strong team, but its capacity and resilience continue to be tested given the operational, financial, workforce, and partnership challenges.

The Trust is well-positioned in terms of governance and oversight, with a clear focus on quality, risk, and financial resilience. The organisation's strengths lie in its committed leadership, effective use of data, and constructive challenge culture.

It was evident that the joint leadership model with Barnsley was deriving benefits for both organisations particularly in respect of shared leadership and learning. The expansion of this model was recognised as providing an opportunity in terms of population health and service viability.

Whilst recognising that this is a strong organisation, with clear strategic ambition and commitment to lead for the benefit of the wider system, the challenge of ensuring that what may be regarded as the operational and governance foundations remains. Regulatory peer reviews continue to have a strong bias on these features. This is a Board that has a clear strategic direction and is aware of its risks and challenges. In that context the following are key areas for continued attention:

- Aligned to the review of community services, the Trust need clarity of the type of organisation it aspires to be focusing on services it provides well, increased vertical integration significant challenges in terms of capacity and the current performance issues. This includes assessment of community leadership expertise and giving a voice to all partners.
- There is opportunity to strengthen the alignment of underpinning strategies to provide a clear framework aligning with the Trust's broader strategic goals. In particular, the alignment of the Clinical Strategy with workforce and financial sustainability plans will be critical. Supported by how research will be integrated into clinical practice; and how quality improvement will deliver the Trust's quality strategy.
- Embedding governance and wider risk changes that are in the process of being reviewed. Standardisation at Care Group level needs to be key to this work. Progressing the maturity of the Care Groups in terms of leadership development, accountability, autonomy, visibility, and increased awareness of wider corporate issues.
- As partnerships and system working progresses the Board needs to be alert to growing capacity challenges and alignment to wider system ambitions. Advancing talent management and succession planning.
- Continuing to strengthen estates and facilities leadership. Increasing the visibility of the Trust's commitment to the environmental challenges. Clarifying strategic direction, board and committee oversight and embeddedness into governance processes.
- Progression of the commitment to reducing health inequalities.

The Trust demonstrates its ambitions to 'Deliver Good Care That is Consistent with CQC 'Good'.

In reporting our findings, we have considered the Trust's evidence, the areas where the Trust believes improvements can be made, and our advice on additional developments.

Clearly the challenges that the Trust is facing now, and in the period ahead, will test the resilience of all aspects of the Trust's governance arrangements. Whilst recognising that the Trust has a grip on many of these issues, it is in this context that the areas for improvement set out in the review have been suggested.

2.2 Findings

Shared Direction and Culture

The Trust has developed a clear and aspirational corporate strategy for the period 2022–2027, aiming to provide exceptional healthcare to the communities of Rotherham. The strategy, is rooted in the Trust's vision statement: "*We will always ACT the right way and be PROUD to provide exceptional healthcare to the communities of Rotherham.*" This vision is complemented by core values—Ambitious, Caring, and Together.

The strategy refresh, completed in June 2024, outlines specific priorities for 2024/25 across four main areas:

- Focus on improving patient care and experience.
- Improve staff experience and develop a compassionate work culture.
- Enhance operational performance and access to care.
- Ensure financial stability and productivity.

These priorities are supported by a comprehensive strategy and robust plans for delivery with clear objectives and timescales. The board also promotes the long-term sustainability of the Trust as part of its integrated care system (ICS) serving the wider population and healthcare system.

Integration of community services, especially vertical integration and place-based healthcare is also a critical focus, with recognition of the need for stronger GP relationships to drive neighbourhood provision.

The strategy is underpinned by various supporting strategies, including Digital Strategy (2024-2028); Estates Strategy (2022-2027); People and Culture Strategy (2024-2027). However, some supporting strategies, like the Clinical Strategy, need further development. It is also acknowledged that a reset is required in relation to Estates that has not had sufficient leadership stability or board oversight. The Trust recognises the importance of aligning all strategies and ensuring sufficient resources for execution.

The commitment to transparency and active engagement has fostered a culture of collaboration. The Trust also aligns its strategy with local and national health systems to ensure that services are tailored to meet the needs of its population. There is a continuous focus on improving communication and involvement with front-line staff.

The Trust is focused on creating a positive organisational culture. There has been clear transformation in relation to culture change which has been recognised and commended by staff. The Trust emphasises psychological safety, open reporting, and a just culture that supports continuous improvement. In 2023, the Trust was recognised as the second most improved NHS Trust in England for staff satisfaction, a reflection of its commitment to fostering a supportive and inclusive environment.

The Trust is also committed to tackling health inequalities, embedding compassionate care across services, and using charitable funds to support marginalised groups. Local community engagement is integral to the Trust's operational model, particularly in reducing health disparities.

Capable Compassionate Leaders

The People and Culture Strategy 2024-2027 outlines a comprehensive approach to leadership development, focusing on retention, recruitment, inclusivity, and engagement.

The Trust has revitalised its behavioural framework to ensure leadership at all levels is aligned with core values. Programs are in place to enhance the capabilities of managers, focusing on effective communication of the Trust's mission, milestones, and achievements. Initiatives such as bespoke leadership training for Care Group directors, regular sessions for the Medical Director and clinical leads, and compassionate leadership initiatives for triumvirates are positively received.

The strategy focuses on developing clear career paths and opportunities for staff progression, with a strong emphasis on building leadership capabilities. There is a commitment to providing clinicians with the necessary support for leadership roles, ensuring a clinically led organisation. While progress is made, more structured development for medical leaders is needed, particularly in encouraging clinical staff to take on leadership roles.

Trust leadership is recognised for its experience, capability, and commitment to delivering practical actions that benefit patient care. The Board has a balanced mix of clinical and non-clinical expertise, with regular reviews to ensure skills alignment. There is strong executive team morale and collaboration, with clear leadership responsibilities and a positive focus on nurturing internal talent.

The NEDs have a good distribution of experience, with the recent addition of an associate NED role providing a pipeline for continuity. The relationship between executives and NEDs is seen as productive, though further development of joint NED roles is under consideration.

The Care Groups are still evolving, having recently reduced from six to four. Despite some staffing changes, there is significant leadership development.

Challenges in culture and performance have been addressed through triangulated data, coaching support, and shared learning initiatives with Barnsley Hospital NHS FT. There is a need for a standardised approach to governance across the Care Groups and opportunity for greater working across the groups.

The Trust has successfully implemented succession planning, including the transfer of managing directors between trusts. However, there is no formal plan below executive, though one is under development.

Leaders across the Trust promote a culture of health, safety, and wellbeing, prioritising the holistic health of staff and fostering an inclusive, compassionate working environment. The Trust emphasises leading with integrity, openness, and honesty, with ongoing development initiatives for leaders to enhance their behaviours and principles. The leadership team consistently demonstrates shared values that align with the broader goals of inclusivity and equality.

Senior leaders are recognised for being approachable and visible, actively engaging with staff and visiting services regularly. Board members also demonstrate leadership through their direct involvement in service provision and feedback collection. Board-level engagement includes listening events, walkarounds, and staff feedback, which are integral to understanding both successes and areas for improvement. There is an opportunity to further structure feedback from walkarounds to maximise its effectiveness and impact on leadership decision-making.

Freedom to Speak Up (FTSU)

The Trust has successfully established a *Speaking-Up / Listen-Up* culture where staff feel empowered and safe to speak up without fear of retaliation. This culture is actively promoted by leaders who model positive behaviours, with clear mechanisms in place to encourage openness and transparency. The FTSU arrangements are an integral part of the Trust's People Strategy, which emphasises listening to staff and patients, and acting on their feedback. The Trust has made notable efforts to enhance communication, especially regarding patient care and staff concerns.

Leaders, including the Chief Executive, actively promote and demonstrate the importance of speaking up. The Trust fosters a safe environment where staff can raise concerns without experiencing disadvantageous treatment. Various mechanisms, such as the Team Brief and Resident Doctor Forum, are in place to facilitate open dialogue.

FTSU processes are overseen by the Chief Nurse and aligned with Equality, Diversity, and Inclusion (EDI) initiatives. The new FTSU Guardian, who started in March 2024, has brought fresh perspectives to the role, ensuring a more proactive stance in addressing clinical concerns.

The number of FTSU Champions has increased to 12, with plans to grow this network further. These Champions play a key role in promoting the speaking-up culture across the organisation. The recruitment of Champions is carefully managed to ensure diverse representation across staff groups and prevent role overcommitment. Champions are no longer responsible for case management, in line with new national guidelines. Champions receive appropriate training and support, including National Guardian Office Level 2 certification. There is also a peer support network with Barnsley NHSFT. There are opportunities to further develop softer skills among non-clinical Champions, particularly in areas like coaching, unconscious bias, and appreciative inquiry.

Staff confidence in the FTSU process is improving, with a steady increase in reported concerns, signalling a more proactive approach to addressing issues. Fundamental to good oversight is curiosity and appreciative inquiry and knowing when to seek external review and when to directly address concerns. This is important at all levels of the organisation and especially the board.

There are recognised opportunities to further strengthen the processes. The Trust is refreshing its policies, aligning with National Guardian guidance and separating the FTSU and whistleblowing policies into distinct standalone documents. Estates and Facilities have not received as much attention in the context of FTSU compared to other areas, and an action plan is being developed to address this gap. While FTSU arrangements have been described as effective, feedback to those raising concerns remains a challenge, with low uptake in feedback sharing. Continued efforts are needed to ensure that the themes raised through FTSU are identified and acted upon effectively.

Workforce Equality, Diversity and Inclusion

The People and Culture Strategy 2024-2027 aims to create an inclusive and equitable work environment where every individual, regardless of background, is valued and empowered to reach their full potential. The strategy places a strong emphasis on inclusive leadership, fairness, and actively promoting equality, diversity, and inclusion (EDI) within the Trust. It underscores the commitment to preventing discrimination in all aspects of employment, including pay, recruitment, career development, and ensuring a safe, respectful, and

supportive working environment for all staff, including those from marginalised or excluded groups.

At the heart of the Trust's EDI efforts is the Integrated EDI Plan, which focuses on building organisational capacity over a three-year period. This plan includes key objectives such as improving workforce race equality, addressing the disability employment gap, and narrowing gender pay gaps. The strategy also highlights the Trust's proactive steps to empower staff with protected characteristics, ensuring that the workforce reflects the diversity of the local community, with diverse representation at all levels of the organisation, including board-level leadership.

The commitment to EDI is reflected in the Board's actions, which include embedding EDI objectives in the performance reviews of directors and signing up to the Anti-Racist Charter. Additionally, the Trust works to address any workforce inequalities by promoting fairness in recruitment and career progression, ensuring that outcomes for staff from equality groups are on par with their peers. Regular reviews of disciplinary processes, along with reasonable adjustments for disabled staff, ensure fairness across all employment practices.

A key focus for the Trust is engaging with staff and supporting staff networks, such as those for BAME, LGBTQ+, and Disability groups. The Trust recognises the importance of empowering staff voices and has developed systems like the 'We said, we did' plans to improve engagement and address issues raised by staff. Despite challenges with staff network leadership and capacity, particularly around recent leadership changes, the Trust is committed to reinvigorating these networks and improving their effectiveness. Collaboration with Barnsley NHSFT could provide an opportunity to address these challenges.

Furthermore, the Trust has taken clear actions to prevent and address bullying, harassment, and sexual harassment, resulting in improvements in Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) outcomes. While the Trust has made progress in reducing gender and ethnicity pay gaps, there is an ongoing need to address specific issues in the medical and dental workforce, where these gaps continue to widen. Additionally, the Trust has placed an increased focus on ensuring sexual safety in the workplace, with new measures being implemented to support staff.

Governance, Management and Sustainability

The Trust continues to demonstrate a strong commitment to effective corporate governance, with clear assurance, risk, and accountability structures in place. Governance is reflective and dynamic, with regular reviews in place to ensure continuous development. Committees are generally well-structured, with delegated responsibilities that allow for detailed scrutiny, and constructive challenge is a well-embedded part of the culture. Non-Executive Directors (NEDs) provide valuable independent oversight, particularly in relation to data interpretation, risk management, and performance assurance. The leadership consistently demonstrates compassionate and values-driven behaviours. Care Group reporting into committees is a noted strength, offering meaningful triangulation and clear sightlines to frontline service delivery. Furthermore, the integration of the new Integrated Performance Report (IPR) and structured performance reviews using SPCs has improved the Trust's ability to monitor and respond to operational trends effectively.

Risk management practices have matured significantly, with active Board involvement and growing consistency in how risk appetite is discussed and defined. The Board Assurance Framework (BAF) is increasingly used as a strategic tool, and internal audit reviews have offered significant assurance on its robustness. Risk escalation processes within Care Groups are generally well-understood, though it is acknowledged that further work is required to ensure that risk scoring, reporting, and triangulation are consistent and clearly communicated from Care Groups through to Board level. There is a recognised need to improve the integration of risk intelligence across committees and ensure all areas, such as estates compliance, are adequately represented and mitigated.

Financial governance remains a strong area for the Trust. The Board has a shared understanding of the financial challenges it faces and remains committed to returning to financial balance. There is confidence in financial leadership and clear evidence of grip and control, with recent improvements implemented following external audit recommendations. The rebranding of the Cost Improvement Programme (CIP) as the Innovation Meeting, led by the CEO, has enhanced engagement. However, the scale of the underlying deficit demands earlier and wider engagement in planning for recurrent savings, and greater involvement from the medical workforce to ensure alignment with clinical priorities.

Performance and information systems are a growing strength. There is a commitment to transparency in reporting, and the use of evidence-based methodologies such as Making Data Count is helping to ensure that performance is monitored with a clear understanding of variation and trends. However, opportunities exist to improve the clarity of action planning within reports, the presentation and the interpretation of metrics. In addition, a more explicit focus on health inequalities data and greater linkage between quality, safety, and operational performance indicators would enhance the impact of reporting.

Emergency preparedness and cyber security governance structures are in place, with relevant oversight by the Finance and Performance Committee. An annual Cyber Security Report has been introduced, and internal audit provides assurance of compliance. The Emergency Preparedness, Resilience and Response (EPRR) policy is comprehensive and well-aligned to national standards; however, the Trust's current compliance rating of 65% highlights a clear area for improvement. An action plan is in place to address the gaps, and this should be monitored closely through relevant assurance channels.

Partnerships and Communities

The Trust is committed to fostering strong partnerships and collaborative working across the healthcare system to improve the delivery of integrated health and care services. When governance operates collaboratively, all parties who have an influence in the delivery of healthcare outcomes recognise, understand and respect each other's needs, and work together to align their governance arrangements. The Trust's strategic ambition is centred on working alongside various stakeholders, including voluntary and community organisations, mental health providers, Primary Care Networks, and the Integrated Care System (ICS), with a clear goal to provide effective, person-centred care across Rotherham and the wider region.

Key initiatives include active participation in South Yorkshire and Bassetlaw's Integrated Care System, the Rotherham Integrated Care Partnership, and various joint ventures with Barnsley Hospital NHS Foundation Trust, such as shared executive leadership and joint service. The Trust's leadership is deeply invested in collaboration, fostering relationships to address system challenges and improve outcomes. Potential expansion of the current partnership model needs to align with system ambitions.

The Trust is also focused on addressing health inequalities, with initiatives aimed at improving service access for underrepresented and underserved communities. By focusing on information sharing, proactive engagement, and collaborative decision-making, the Trust is addressing unwarranted health variations, with particular emphasis on tackling smoking and promoting healthy weight programs. In line with this commitment, leadership appointments, including a dedicated NED with expertise in health inequalities, reflect the Trust's priority in this area. There would be benefit in having a shared narrative on plans, priorities and progress.

Service user engagement is a cornerstone of the Trust's approach, with a focus on co-production, direct patient involvement in care decisions, and continuous feedback loops. Recent projects, such as the Youth Work Support initiative and the Carer and Care Partner Promise, demonstrate the Trust's commitment to listening to and acting on the voices of patients, carers, and communities. There was recognition of the need to ensure that care is tailored to individual needs and that patients and communities are empowered to play an active role in the design and delivery of services.

Learning and Improvement

The Trust is committed to enhancing patient care through a strategic focus on quality improvement, research, and digital transformation. The Trust's leadership promotes a shared purpose and vision that aligns improvement activities with strategic goals, fostering a culture of innovation, learning, and continuous improvement. Key initiatives include empowering teams to engage in improvement work, learning from success, and removing barriers to change. The Trust is actively enhancing its research capabilities, partnering with institutions, and striving to address health inequalities through community engagement in research. A clear research strategy or plan is essential for any NHS Trust seeking to deliver high-quality, evidence-based care and drive continuous improvement, providing a clear framework for how research is supported, prioritised, and integrated into clinical practice, while aligning with the Trust's broader strategic goals.

The Trust's Quality Improvement (QI) strategy aims to build capacity and create a culture of continuous improvement, with staff supported to lead and implement small-scale changes. Training in QI is integral to the Trust's staff development strategy, but there are challenges in scaling this training and aligning QI initiatives with productivity outcomes. Notable patient-centred innovations, such as virtual wards and community x-ray pilots, demonstrate progress, though the connection between QI and health inequalities needs further development. The QI strategy will require review and realignment to the delivery of the new quality and clinical strategies.

In patient safety, the Trust is progressing with the implementation of the Patient Safety Incident Response Framework (PSIRF), which emphasises proportionality, patient involvement, and multidisciplinary engagement engendering a culture of openness. Key priorities for 2025/26 include the recruitment of a Patient Safety Partner and further development of After-Action Reporting.

The Trust's Digital Transformation Strategy for 2024-2028 aims to enhance digital capabilities, improve systems integration, and drive innovation in patient and staff experiences. Despite past challenges with digital leadership, the Trust has resolved these issues and is focused on becoming a digital leader in the healthcare sector.

Environmental Sustainability

The Trust demonstrates strong leadership intent in environmental sustainability, with a commitment to achieving net-zero emissions and advancing green initiatives. Their strategy aligns with the NHS-wide goals to reach net-zero emissions by 2040. The Trust is focused on supporting staff and local communities to reduce their environmental impacts, underlining their commitment to environmental stewardship and leadership in the Rotherham area.

The environmental strategy covers multiple critical areas including the buildings, energy, technologies, waste generation, alongside a robust recycling policy aimed at further environmental gains. Wider plans include medical gases, medicines, transportation, food and nutrition. Digital transformation initiatives include adopting energy-efficient cloud hosting solutions, contributing to a reduction in the overall carbon footprint. While these initiatives are ambitious, the Trust faces challenges in maintaining leadership continuity. It is timely that the Green Plan is under review providing opportunity for alignment with current targets and emerging goals.

Increased visibility and workforce engagement is crucial to the Trust's impact and effectiveness of environmental strategy. The Trust recognises that greater staff engagement is needed and has already taken steps to integrate environmental considerations into operational processes. Regular communications and engagement opportunities, such as quarterly staff network meetings, could be designed to empower employees, giving them a platform to suggest improvements and share experiences. There is opportunity to establish connections with regional and national partners to further environmental sustainability goals, and working on projects to improve community health, such as expanding access to green spaces. By promoting sustainability through these initiatives, the Trust would foster a culture of environmental responsibility across its workforce.

The Trust's Estate Strategy also emphasises the importance of integrated planning with system partners, ensuring that the quality of community facilities is improved and that the environmental impact of their operations is reduced. The strategy outlines the need for continued investment in carbon reduction measures across the built environment, infrastructure, and other sectors. This approach aligns with the Trust's broader sustainability goals and reflects the importance of coordinated action in improving environmental outcomes at both the local and system-wide levels.

2.4 Next Steps

We suggest that the Chairman and Chief Executive, in consultation with the Board, consider the findings and development themes outlined within this report.

Theme 1: Shared Direction and Culture

Sub-theme	Key improvements to date	Future objectives	Key actions & milestones
Strategy alignment	• Work has commenced on the development of the Trust Quality Strategy. This has included engagement across Snr Leadership and Care Group management • The development of the Quality strategy and a new Estates Strategy has been included within the organisational priorities for the Trust in 2025/26	• Finalisation of the Quality Strategy • Engagement and development of the Trusts Estates Strategy • The Trust will explore the development of a Clinical Strategy in 2025/26 as current focus is on workforce development including application to gain Teaching Hospital Status	• Q2-3 - Engagement and Development of Estates Strategy • Q4 - Finalisation and approval of estates strategy • TBC - Finalisation of the Trust Quality Strategy
Sharing and embedding the vision	• Communication of the Trust strategy and Organisational Priorities has been done with Care Group Leadership and Senior Leaders • Stretch Strategy, agreed at Board of Directors, has aligned to the '4 quadrant' approach of the Trust organisational priorities • Clear strategic focus for the Trust, across all areas, embedded within the Strategic Board sessions held on alternative months – bringing all Executives and NEDs into all strategic discussions	• Translation of organisational priorities into sharable media to be shared across the Trust • Continued alignment of our approach to yearly organisational priorities and our wider strategy, in particular as we prepare for our strategy refresh towards the end of 2026, to ensure a common framework which support wider engagement. • Establishment of a 'strategy committee' to support delivery and focus on the Trust strategic ambitions	• Q1 – Publication and sharing our the Trusts organisational priorities across the organisation • Q3 – Establishment of a 'strategy committee' within the Trust's governance • 2026 – Develop a clear framework for our strategic direction and yearly organisational priorities, ensuring alignment

Theme 2: Capable, compassionate and inclusive leaders

Sub-theme	Key improvements to date	Future objectives	Key actions & milestones
Leadership development	• Executive leadership strengthened over time • Care Group leadership development put in place jointly with Barnsley Hospital NHS FT • Strengthening of Executive team via appointment of substantive Director of E&F	1. Put in place clear approach to senior leadership development (with Barnsley) 2. Refresh behavioural framework and support for tackling inappropriate behaviours 3. Consider approach to Medical leadership development 4. Appoint NED from Board of Barnsley hospital NHS FT 5. Review NED link role to Care Groups and how Board walkabout feedback is responded to	1. Develop proposal for new approach to leadership and manager development to include tiered approach to support including coaching and mentoring (with Barnsley) Q3/Q4 2025/26 2. Refresh framework and support Q4 2025/26 3. Develop proposal MedD/DoP tbc 2025/26 4. Q2 2025/26 5. Q3 2025/26
Talent management and succession planning	• Development of Executive Director succession plan • Identification of succession planning priorities • Talent management approach for MD appointment • Progress on embedding appraisals and improving tools based on feedback (90% completion staff survey)	1. Ensure regularly updated Executive Director succession plan in place 2. Carry out succession planning in priority talent areas (joint methodology with Barnsley) 3. Focus on quality appraisals 4. Consider use of Scope for Growth tool	1. Nomination and Remuneration committee Q2 2025/26 2. Focus on Care Group leadership and Operational management Q2/3/4 2025/26 3. Senior leader launch Q1 2025/26 'We said we did' 4. Proposal Q4 2025/26

Theme 3: Freedom to Speak Up

Sub-theme	Key improvements to date	Future objectives	Key actions & milestones
Governance	• Clear processes in place with good alignment to EDI policies • Good oversight process in place for assurance from Executive and Non-Executive leads	• Increased reporting of themes linked to FTSU • Develop a more robust data storage process than current excel system, whilst ensuring confidentiality of data is maintained	• Strengthened quarterly reports from September 2026, including use of SPC charts • Develop metrics for appropriate time scales for responding to FTSU concerns • Consider options for data storage by December 2025 • Increased triangulation with other data sources (Exit interviews, FFT, complaints)
Embedding FTSU principles	• Clinical credibility of FTSU Lead • People and Culture Strategy promotes the FTSU process • Good listening culture at executive and senior level • Early implementation of Call for Concern	• Increase knowledge of FTSU process with increase ambassadors and reporting in areas with low current profile but weaker staff survey results • Expand Call for Concern to encompass all elements of Martha's Rule as part of Cohort 2 • Increase understanding of managerial responsibilities when a FTSU concern is raised	• Implement FTSU action plan for Estates and Facilities - Q3 • Accepted for cohort 2 of Martha's Rule and as an early implementer of Martha's Rule in Maternity Services- complete by March 2026 • FTSU Lead to present at Senior Leaders Meeting - Q2 • Consideration of use of anonymised case studies to raise profile of role of FTSU
Network of ambassadors / champions	• Number of champions and range of coverage has increased during the last year	• Further increase the number of champions and ensure all large services / remote geographical areas are covered • Ensure all champions receive appropriate support and training, including in 'softer skills' such as coaching, unconscious bias and appreciative enquiry	• Liaise with Care Groups & Corporate Leads to extend representation - March 2026 • Consider additional skills training for non-clinical champions with 'softer skills' focus - July 2026

Theme 4: Workforce Equality, Diversity and Inclusion

Sub-theme	Key improvements to date	Future objectives	Key actions & milestones
Integrated plan	• Board approved integrated EDI Plan in place • EDI objectives in Director appraisals • Successful cultural celebration events held	1. Further cascading of EDI objectives review of behavioural framework 2. Development of allyship and active bystander approach 3. Promotion of key inclusion events/celebrations e.g. Pride Month 4. Consider joint approaches with Barnsley	1. Q3 2025/26 2. Q4 2025/26 3. Ongoing 4. Q2 2025/26
Data and Insight	• Development of EDI reporting and analysis leading to greater understanding of issues	1. Focussed actions from WRES, WDES, Gender pay gap reporting as per individual report actions	1. WRES, WDES- Q3; Gender Pay reporting – Q4
Engaging with Staff	• Director and Non Exec Director sponsors put in place for staff networks	1. Relaunch staff networks	1. Q2 2025/6

Theme 5: Governance, Management and Sustainability

Sub-theme	Key improvements to date	Future objectives	Key actions & milestones
Care group governance	• Effective and well-structured committee governance in place, including strong care group reporting into committees	• Improve and standardise Care Group governance	• Complete review of governance Q2 • Implement recommendations Q3 and review 2026/27
Risk management	• Robust reporting of risks from monthly Care Group meetings through to executives and committees, then board • Refreshed Board Assurance Framework; significant assurance from auditors for BAF process	• Refresh standard risk management reporting • Strengthen committee scrutiny of risk, including through Audit Committee	• Revised risk management report structure & content – Q2 • Agree and implement process with committee Chairs – Q3
Financial sustainability	• Strong governance and grip and control, as demonstrated in delivering financial targets for 2024/25	• Oversee delivery of financial targets for 2025/26 through governance, including Improvement Programme Board • Oversee development and delivery of £22.4m efficiency programmes against the six KLOEs identified in the multi-year financial plan	• Monthly reporting through Improvement Programme Board throughout 25/26 • Actions overseen through existing trust governance, and brought together in Improvement Programme Board

Theme 6: Partnerships and Communities

Sub-theme	Key improvements to date	Future objectives	Key actions & milestones
Communities	• A formal review of our Community Services provision, in collaboration with Rotherham Place partners, with dedicated resources has commenced. This will support the best use of resources, the 'left shift' agenda, improve health equality and the provision of improved services for the population of Rotherham	• The community services review has a programme of work planned over 2025/26 • The Trust will undertake the Health Inequalities Leadership Framework self-assessment with any actions identified	• Q4 - Finalisation of the review and recommendations • Q3 – Undertake the Health Inequalities self-assessment
Engagement	• The Trust continues to work with place partners to develop to implement and develop key areas of work. This includes the Trust hosting a role funded by the ICS to work across Primary and Secondary Care to improve diabetes care across Rotherham and ongoing work to implement services such as Advice and Guidance.	• A large scale engagement event is planned for June/July 25 across clinical teams within the Trust and GP / Primary Care colleagues within Rotherham. • The Trust continues to proactively engage with Rotherham place with respect to potential neighbourhood models and care provision. The changes within the ICS will guide future engagement.	• Q3 – Primary Care Engagement Event

Theme 7: Learning, Improvement and Innovation

Sub-theme	Key improvements to date	Future objectives	Key actions & milestones
Quality Improvement	• Established QI team and governance through corporate nursing structure • Developed QI strategy 2024-28, aligned to overall and People and Culture strategies	• Deliver against specific quality priorities for 2025/26 (diabetes management, antimicrobial stewardship, reducing delays in cancer diagnosis and treatment) • Align QI strategy against developing quality strategy • Develop stronger mechanisms for sharing best practice and celebrating success • Continued expanded roll out of Exemplar Accreditation Programme	• Each quality priority has a detailed delivery plan for completion by April 2026 with quarterly reporting of progress to the Quality Committee • Qi is a golden thread in the Quality Strategy which launches in July 2025 and will be implemented over the next two years • Programme of Qi success sharing programme to be developed by September 2025 • Expand Exemplar Accreditation into UECC in 2025 and develop a plan for other areas by October 2025 to ensure all areas included within 2026/27
Digital	• Digital Transformation strategy agreed for 2024-28 to enhance digital capabilities and integration, and improve patient and staff experience	• Deliver goals set out in strategy across four areas: digital systems, technology, information, and our people • Conclude Business case and begin preparations for the deployment of new EPR system to replace our end-of-life system	• Q2 - Data Academy launched • Q4 - Clinical messaging app delivered • Q3 - EPR Strategic decision made • Q4 AI innovation capabilities and governance in place

Theme 8: Environmental Sustainability

Sub-theme	Key improvements to date	Future objectives	Key actions & milestones
Strategy and governance	• Work has commenced on the development of the Trust Green Plan, which is an organisational priority for the Trust in 2025/26. This has included engagement across Snr Leadership, Corporate and Care Group management • Have begun work to establish a clear strategic focus for the Trust, across all areas, embedded within the Strategic Green Plan.	• Finalisation and Board approval of the Green plan. • Establishment of an Executive Led Sustainability Group with Nominated Senior Responsible Owner • Continued alignment of our approach to yearly organisational priorities and our wider strategy, in particular as part of our sustainable healthcare and sustainable procurement policies.	• Q2-3 – Board submission and approval • Q3 – Publication of the Green Plan on the Trust website (national requirement) • 2025 Q3 – Establishment of a 'Trust Sustainability Group' within the Trust's governance. • 2025 Q4 Align with Barnsley NHS Trust Sustainability Group • 2026 – Develop a clear framework for our strategic direction and yearly organisational priorities, ensuring alignment across both organisations
Environmental impact	• The Trust has seen a noticeable decrease in CO2 emissions since 2022-23. This is consistent for both gas (the main contributor) and electricity usage.	• Further reduce direct CO2 emissions, as well as indirect emissions from water supply and treatment, waste disposal, and procurement	• Establish Trust milestones – in green plan

	PUBLIC TRUST BOARD MEETINGS		2025 Jan	March		May	June	July	Sept	Nov	2026 Jan	March
			9	7		2		4	5	7	9	6
			M10	M12		M2	Annual Acc.s	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	●	●		●		●	●	●	●	●
	Matters arising (not covered elsewhere on the agenda)	Chair	●	●		●		●	●	●	●	●
	Action Log											
	OVERVIEW & CONTEXT											
	Board Committee Chairs Reports QC, FPC, ARC, P&CC	NEDs	●	●		●		●	●	●	●	●
	Chairman's Report	Chair	●	●		●		●	●	●	●	●
	Chief Executive's Report	CEO	●	●		●		●	●	●	●	●
	CULTURE											
	Patient Story	CN		●				●		●		●
	Staff Story	DoP	●			●			●		●	
	Annual Staff Survey	DoP		●								
	Staff Survey Action Plans	DoP				●						
	Freedom to Speak Up Quarterly Report	CN		●		●				●		●
	Freedom to Speak Up Annual Report	CN				●						
	Gender Pay Gap Report and Action Plan	DoP		●								●
	Integrated EDI Plan - WRES, WDES, PSED	DoP							●			
	Patient Experience and Inclusion Annual Report	CN						●				
	End of Life Annual Report	DCN						●				
	Medical Education Quality Report	MD	●								●	
	STRATEGY & PLANNING											
	TRFT Five Year Strategy 6 month Review	CEO				●				●		
	Operational Plan: 6 Month Review	DCEO				●				●		
	Annual Operational Planning Guidance	COO									●	
	Winter Plan	COO								●		
	Estates Strategy	DoF	●dfd									
	Fire Safety Strategy			●		●						
	SYSTEM WORKING											
	SYB ICS and ICP report	DCEO	●	●		●		●	●	●	●	●
	SYB ICS CEO Report (included as part of CEO report)	CEO	●	●		●		●	●	●	●	●
	Partnership Working	MD				●			●			
	SYB ICS - Wider Needs of Rotherham Community	Public Health		●					●			
	PERFORMANCE											
	Integrated Performance Report:	COO	●	●		●		●	●	●	●	●
	Safe Staffing & Establishment (6 monthly)	CN	●					●			●	
	Finance Report	DoF	●	●		●		●	●	●	●	●
	ASSURANCE FRAMEWORK											
	Board Assurance Framework	DoCA	●	●		●		●	●	●	●	●
	Quarterly Risk Management Report	DoCA		●		●			●		●	
	Corporate Risk Register	DoCA	●	●		●		●	●	●	●	●
	Annual Review of risk appetite	DoCA							●			
	Health and Safety Annual Report	DoE									●	
	Quality Assurance Quarterly Report	CN		●		●			●	●		●
	SIRO Annual Report	DCEO							●			
	Safeguarding Annual Report	CN							●			
	Infected Blood Inquiry	MD							●			
	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 Accounts	CN					●					

	Maternity & Neonatal Safety Report	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		•			•			•	•		
	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	MD										•	
	BOARD GOVERNANCE												
	Register of Sealing (bi-annual review)	DoCA			•					•			•
	Register of Interests (bi-annual review)	DoCA			•					•			•
	Review of Board Feedback	DoCA										•	
	Board Committee ToRs - Audit & Risk Committee	DoCA									•		
	Board Committee ToRs - FPC, QC, PC	DoCA					•						
	Review of Standing Financial Instructions	DoF									•		
	Review of Scheme of Delegation	DoF									•		
	Review of Standing Orders	DoCA									•		
	Going Concern	DoF			•								•
	Segmental Reporting	DoF			•								•
	Accounting Policies	DoF			•								•
	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								•	•	•	•
	Annual Planner	Chair		•		•	•		•	•	•	•	•
	Board feedback			RS	SH		HW		JBe	MT	MW	RS	SH
	NED Review of complaints files (Quarterly)			RS			SC		KM		JB	HW	