Council of Governors

The Rotherham NHS Foundation Trust

Schedule	Wednesday 12 February 2025, 5:00 PM — 7:00 PM GMT
Venue	Board Room, Level D
Organiser	Angela Wendzicha

Agenda

5:00 PM	PROCEDURAL ITEMS	
	COG/1/25.	Chairman's Welcome and announcements - Verbal For Noting - Presented by Dr Mike Richmond
	COG/2/25.	Apologies for absence and quoracy check - Verbal Section 17.4 of Constitution; A meeting of the Council of Governors shall be quorate if not less than half of the elected Governors are present. For Noting - Presented by Dr Mike Richmond
	COG/3/25.	Declarations of Interest - Verbal For Noting - Presented by Dr Mike Richmond
	COG/4/25.	Minutes of the previous meeting held on 20th November 2024 For Approval - Presented by Dr Mike Richmond
	COG/5/25.	Minutes from the meeting held on 10th September 2024 For Ratification - Presented by Dr Mike Richmond
	COG/6/25.	Matters arising from the previous minutes (not covered elsewhere on the agenda) - Verbal For Discussion - Presented by Dr Mike Richmond

	COG/7/25.	Action Log - nil by return For Decision - Presented by Dr Mike Richmond
	COG/8/25.	UECC Capital Build Presentation presented by Jodie Roberts and Tom Nield For Information
	COG/9/25.	Planning Guidance 2025/26 Presentation For Information - Presented by Bob Kirton and Ben Gray
	COG/10/25.	Chair's Report - Verbal For Noting - Presented by Dr Mike Richmond
5:45 PM	REPORTS FROM NON EXECUTIVE CHAIRS OF BOARD COMMITTEES For Noting	
	COG/11/25.	Report from the Non-Executive Director Chairs of the Board Assurance Committees: i. Quality Committee - Julia Burrows ii. People & Culture Committee - Dr Rumit Shah iii. Finance and Performance Committee inc. Finance Report - Martin Temple iv. Audit and Risk Committee - Kamran Malik v. Charitable Funds Committee - Heather Craven For Noting
	COG/12/25.	Integrated Performance Report For Noting - Presented by Bob Kirton
	COG/13/25.	Exemplar Accreditation Programme For Noting - Presented by Victoria Hazeldine
6:40 PM	SUB GROUPS OF THE COUNCIL OF GOVERNORS	

	COG/14/25.	Governor Membership Engagement Group Chairs Report presented by Geoffrey Berry, Lead Governor For Noting
	COG/15/25.	Membership Engagement - Feedback from the Staff Governor Lunchtime Lectures presented by Matthew White & Rachel Bell For Noting
6:50 PM	COMMITTEE GOVERNANCE	
	COG/16/25.	Issues to be escalated to Board of Directors - Verbal For Approval
	COG/17/25.	Calendar of Business for Council of Governors 2025 For Information - Presented by Dr Mike Richmond
	COG/18/25.	Any Other Business For Discussion
	COG/19/25.	Next meeting to be held on 21st May 2025
	CLOSE OF MEETING	

Draft until approved at 12th February 2025 Council of Governors meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON WEDNESDAY 20 NOVEMBER 2024 IN THE BOARDROOM, LEVEL D, ROTHERHAM FOUDATION TRUST AND MS TEAMS

Chair: Dr M Richmond, Chair

Public Governors: Mr G Berry, Public Governor Rest of England & Lead Governor
Mr M Skelding, Public Governor Rotherham Wide (via Teams)
Mr A A Zaidi, Public Governor Rotherham Wide
Mr M Ayub, Public Governor Rotherham Wide
Mrs M Gambles, Public Governor Rotherham Wide
Mr S Goodwin, Public Governor Rotherham Wide (via Teams)

Staff Governors: Mrs P Keta, Staff Governor
Ms R Bell, Staff Governor
Mr S Nordkil, Staff Governor

Partner Governors: Dr J Lidster, Partner Governor Sheffield Hallam University

Members of the Board of Directors, other Trust staff and invited guests in attendance either for the whole or part of the meeting:

Mr K Malik, Non-Executive Director (via Teams)
Ms J Burrows, Non-Executive Director
Dr R Shah, Non-Executive Director
Mr M Temple, Non-Executive Director
Mrs H Craven, Non-Executive Director
Mr A Mondon, Associate Non-Executive Director
Dr R Jenkins, Chief Executive
Mr S Hackett, Director of Finance
Ms A Wendzicha, Director of Corporate Affairs
Mr A Wolfe, Deputy Director of Corporate Affairs
Mr B Gray, Deputy Director: Strategy and Delivery
Ms C Rimmer, Corporate Governance Manager (minutes)

Apologies: Ms I Ogbolu, Public Governor Rotherham Wide
Mr R Taylor, Public Governor Rotherham Wide
Mr A Ball, Public Governor Rotherham Wide
Ms H Watson, Non-Executive Director
Mr F Kler, Public Governor Rest of England
Ms V Ball, Public Governor Rotherham Wide
Ms J Mallinder, Partner Governor Voluntary Action Rotherham
Mr M White, Staff Governor
Mrs K Smith, Staff Governor

ITEM	PROCEDURAL ITEMS	ACTION
COG/54/24	**CHAIRMAN'S WELCOME AND ANNOUNCEMENTS** Dr Richmond welcomed all those present, and those attending virtually.	
COG/55/24	**APOLOGIES FOR ABSENCE & QUORACY CHECK** The apologies were noted and it was confirmed that the meeting was not quorate. The public meeting could continue as planned, as no decisions needed to be made. For the confidential meeting, any decisions by the Council of Governors would be ratified outside the meeting. The Council of Governors agreed to continue the meeting.	
COG/56/24	**DECLARATION OF INTEREST** Dr Jenkins and Ms Wendzicha's interest, in terms of their joint roles at both the Trust and Barnsley Hospital NHS Foundation Trust, were noted.	
COG/57/24	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting held on the 10th September 2024 were approved as a correct record. This will be ratified at the next Council of Governors meeting.	**Committee Secretary**
COG/58/24	**MATTERS ARISING FROM PREVIOUS MINUTES (NOT COVERED ELSEWHERE IN THE AGENDA)** No matters were raised.	
COG/59/24	**ACTION LOG** Nil by return.	
COG/60/24	**CHAIR'S REPORT - Verbal** Firstly, Dr Richmond updated Governors on the recent Board meeting and the suspension of the meeting for a short period due to disruption from members of the public. The group of people did not follow protocol and were disruptive when raising an issue regarding the staff accommodation blocks and were asked to leave the meeting. Dr Jenkins reminded the Governors of the issues regarding the accommodation blocks that was discussed at the last meeting. There have been concerns over the fire safety of the blocks and whilst mitigations have been put in place, these are short term and	

	the long term solution is not affordable due to works needed. Dr Jenkins apologised for the communication issues that have been raised by colleagues. The Trust is honouring all tenancy agreements and holding open meetings as well as offering one to one meetings to support affected colleagues. Ms Bell queried the impact on International recruits and the Trust's support for them. Dr Jenkins detailed that they are working through each case and finding the most appropriate way to prioritise the available accommodation and support colleagues if they need to find alternatives. Secondly, Dr Richmond informed the Governors that the Trust is entering into a specific review called 'Well-Led'. Ms Wendzicha explained that the Trust has procured and commissioned an external organisation to conduct the review which will look at Ward to Board and how the Trust manages its flow of information. There will be a series of meetings and group discussions, observation of meetings and documents, resulting in a final report. Ms Wendzicha detailed that there is no grading, but there will be some recommendations and areas of development for the Trust. Lastly, Dr Richmond reflected on the discussions at the previous meeting on the Darzi report. The report had now been published and there is a degree of consultation taking place, working with the ICB with the focus on collaboration, productivity and standardisation. Dr Jenkins commented that there had been discussions on the clarification of NHSE and ICB around performance, and the strategy for commissioning and driving community care, neighbourhood care and hospitals not being the default approach to those unwell. Documents would be released soon and Dr Jenkins anticipated that there will be more focus on leadership, accountability and management.	
COG/61/24	**REPORT FROM NON EXECUTIVE DIRECTOR CHAIRS OF BOARD ASSURANCE COMMITTEES** i. Quality Committee Ms Burrows presented the chairs report and highlighted key items such as the Care Group attendances, the Quality Priorities, Patient Experience and commended the successful recruitment campaign for Registered Nurses. Ms Burrows detailed that Care Group 1 raised concerns at their previous attendance at Quality Committee on violence and aggression, but at the last meeting, were pleased to report that although the issues still remain, the staff feel more supported by the Trust and partners. Ms Burrows updated the Governors that the December Quality Committee meeting would be held as a development workshop to further improve the business and effectiveness of the committee.	

	With the intense operational pressures, Mr Nordkil queried how governors can be assured that the impact on quality is mitigated. Ms Burrows acknowledged the significant pressures that are detailed through Care Group presentations to the committee and that there is strong work ongoing by the Executive team to monitor. Dr Jenkins explained that the staffing is planned to manage a certain level, however this is impacted by significantly higher demands. This is not exclusive to the Trust, and other organisations are experiencing this as well. The limitation of GP services may also impact here. Mr Temple raised that this is also monitored by Finance and Performance Committee and that it is clear that the previous winter pressures and subsequent planning for this year, do not consider this significant increase in demand. Mr Temple reflected on the operational performance in Care Group 1 that showed a positive trend, however, with increased demands, they are struggling and working immensely hard to not let it effect on quality of service. This has a subsequent financial impact to cover staffing costs. Mr Nordkil noted the encouraging patient survey results and queried the assurance that there are plans in place to continue this trajectory. Ms Burrows cross-referenced the reporting from the Patient Experience Committee to the Quality Committee and the feedback from Care Groups during the meeting, reflecting their ambitions for continuous improvements. Mr Nordkil referred to the complaint section of the IPR and questioned the higher rates alongside the new Patient Liaison Service (PALS). Ms Burrows detailed the positive feedback that had been shared in regard to the new PALS and also reflected positively on her recent review as Non-Executive Director (NED) of the handling of complaints. Dr Jenkins highlighted that he signs off almost all complaints and that they are a valuable tool to identify areas of concern so would encourage reporting, rather than seek to reduce. Mr Nordkil queried the lack of metrics for the Quality Priority: Diabetes Management. Ms Burrows explained the conversations at the last committee around the development of the priority, ensuring the foundations are correct and the high level of engagement which will prove beneficial in the long term. The priority and progress will be monitored closely through the sub-committee and reported to Quality Committee. Referring to the IPR report and pressure ulcers in the community, Mr Nordkil asked how governors can be assured on the actions to bring these rates down. Ms Burrows explained that this is an important metric monitored closely by the committee.	

ii. People and Culture Committee

Dr Shah introduced the chairs report and drew attention to the update on the EDI plan, adding that the new EDI Lead had made significant progress and that the Chief Executive and Chair had allocated the NEDs specific areas of the plan as part of their annual objectives. On the WRES and WDES, Dr Shah noted the improvements year on year, however there is still work to do and detailed the commitment made by Board to the Sexual Safety charter. On long term sickness, Dr Shah reiterated the committee's focus on this and the efforts ongoing to address issues in the appropriate manner; it is a regional issue as well as a local issue and Dr Shah noted the escalation from Quality Committee on staff sickness which had been responded to.

Mr Skelding queried whether the committee had any concerns over the lack of progress on sickness and Dr Shah detailed that the committee continues to see a lot of work continuing in this area and have no serious concerns.

Mr Skelding asked what steps are in place to support staff who raise concerns, such as Care Group 4 concerns on violence and aggression. For this group, Dr Shah explained some of the common concerns and the steps to improve safety and support staff, such as working in pairs and wearing body cameras. Dr Shah confirmed that they were assured that violence and aggression is being actively addressed by the Trust.

iii. Finance and Performance Committee incl. Finance Report

Mr Temple reported that the committee continues to meet monthly with a deep dive into each Care Group and Corporate Services presented on rotation. Mr Temple reflected on earlier discussions around the high demand and impact on flow, but that despite this, achievements have been made reaching operational delivery targets, for example, in Cancer Care which has been a key focus for the committee.

Mr Temple updated the governors on the financial pressures which are driven by high non-elective work, beyond what is commissioned. This causes difficulties reaching targets and cost saving measures and needs a different approach long term. Mr Temple acknowledged the challenges to achieve the financial plan and that the committee was assured of the plans in place, but could not be assured of delivery.

iv. Audit and Risk Committee

Mr Malik presented the Audit and Risk Committee report and updated the Council on the Conflict of Interest annual requirement and the work to address the non-compliance, the internal audit limited assurance on Cost Improvement Plan (CIP) due to the particular challenges and the need for multiyear focus, working with partners and cross-departmental collaboration for the most effective cost saving, and lastly the limited assurance for Medicines Management and the work required on the governance function.

Mr Berry queried the timescale for improvements to Medicines Management and Mr Malik detailed that each action on the action plan has a specific deadline and is monitored through Audit and Risk Committee. Overall, Mr Malik expressed that there is a good track record for completion of audit actions.

v. Charitable Funds Committee

Mrs Craven introduced the report highlighting the difference in the committee and governance structure compared to the Board Assurance committees. The charity exists to support patients, families, carers and staff. Mrs Craven updated the committee that the charity is in year three of a three year strategy which has key focus around engagement in the community and wider business networks. There has been successful engagement through Business Breakfasts which has resulted in partnership with local businesses through Corporate Social Responsibility (CSR).

Mrs Craven detailed the vast number of fundraising events and also the closure of the first big appeal by the charity, commending the achievements of £157k raised for Tiny Toes appeal, surpassing the target of £150k.

In terms of grant giving, Mrs Craven explained that these are discharged on a regular basis, providing memory boxes, coats, gifts which have been donated, with oversight of the community services as well as the main hospital.

Lastly, Mrs Craven updated the Council on the work in progress to develop the next three year strategy to progress the charity even further.

Mrs Keta noted the next appeal around Dementia Care and queried whether there was a specific target. Mrs Craven explained that the trust identified this an area of progression and the appeal signifies the Trust and Charity partnership. Currently, the

	Safeguarding Team are working through a list of items for the appeal which could be changes to spaces or some more specific items for purchase.	
COG/62/24	**INTEGRATED PERFORMANCE REPORT** Dr Jenkins presented the IPR and noted that elements of the report had already been discussed. Dr Jenkins acknowledged the high operational pressures and commended the achievements of the team on no patients waiting more than 65 weeks. The Trust is continuing to deliver diagnostic standards and the Cancer performance remains good. Dr Jenkins noted that C Difficile had been an issue, but had recently returned to common cause. On 52 week waits, Dr Jenkins gave reassurance on the line of sight here and the commitment to reduce by 50%. From discussions with the Chief Operating Officer, this is achievable and although this is not a national expectation, the Trust is keen to be ahead of the curve and continue the journey back to constitutional standards. Mrs Gambles queried the barriers to reduce 52 week waits and Dr Jenkins detailed the other aspects of the patient journey that can contribute and the competition for theatre time. This is a critical aspect and work is ongoing on theatre productivity and utilising the MOEC centre. Dr Jenkins also referenced the shortage of staff in the anaesthetics department. On Did Not Attend (DNA), Mrs Gamble asked whether there were common reasons here, noting the drain on resources from these missed appointments. Dr Jenkins explained that some patients from specific backgrounds have higher DNA rates and there is more support to offer here. There is also scope for the use of digital reminders and reviewing notes and access policies to limit automatic re-issuing of appointments. Mrs Gambles queried the concern around overdue follow ups and Dr Jenkins described that this is a common issue and there is work to do to break the data down. More follow ups are needed, however there is prioritisation elsewhere, such as waiting lists.	
COG/63/24	**FIVE YEAR STRATEGY UPDATE** Mr Gray introduced the report, highlighting the strategy refresh to compliment and join the existing five year strategy. Mr Gray also drew attention to the progress to date and detailed the integration of Quality Improvement (QI) methodology and joint working across South Yorkshire on skills development as well as patient services. Mr Gray highlighted the work to continue digital progress and AI x-ray decision support tools, which has had positive feedback.	

	Ms Bell commented that, from her staff role perspective, the AI technology had been successful and gave reassurance to clinicians, summarising that it had been a great advantage. Mr Nordkil also gave positive feedback from a staff role perspective. Dr Richmond highlighted that the digital progression is an emerging opportunity and had confidence in the Rotherham IT offering and that looking to the future, Rotherham will be at the forefront.	
	GOVERNOR REGULATORY AND STATUTORY REQUIREMENTS	
COG/64/24	**EXTERNAL AUDITORS REPORT FOLLOWING CLOSURE OF ANNUAL AUDIT – DANIEL WATSON** Mr Watson presented the report to the governors for the financial year end 2023/24 and outlined the key messages regarding the financial statements, value for money, and the auditor's wider powers. From a governance perspective, Mr Watson explained that the risks detailed are standard risks seen across NHS Trusts. There is significant weakness on financial sustainability, but this is due to the financial circumstance across the sector and Mr Watson was satisfied with the plans in place. Mr Watson commended the quality of the financial statements received and the good, open relationship and engagement with management.	
	COMMITTEE GOVERNANCE	
COG/65/24	**ISSUES TO BE ESCALATED TO BOARD OF DIRECTORS** None were noted.	
COG/66/24	**CALENDAR OF BUSINESS FOR COUNCIL OF GOVERNORS 2025** The Council noted the planner.	
COG/67/24	**ANY OTHER BUSINESS** It was the final meeting for Ms Keta, who would be leaving the Trust in December. Mr Berry thanked Ms Keta for her valuable contributions and for being a supportive member of the Council of Governors.	
COG/68/24	**NEXT MEETING TO BE HELD ON**	

	Wednesday 12th February 2025	

Draft until approved at 20th November 2024 Council of Governors meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON TUESDAY, 10 SEPTEMBER 2024 IN THE BOARDROOM, LEVEL D, ROTHERHAM FOUDATION TRUST AND MS TEAMS

Chair: Dr M Richmond, Chair

Public Governors: Mr G Berry, Public Governor Rest of England & Lead Governor
Mr A Ball, Public Governor Rotherham Wide
Mr M Skelding, Public Governor Rotherham Wide
Mr A A Zaidi, Public Governor Rotherham Wide
Mr M Ayub, Public Governor Rotherham Wide
Mrs M Gambles, Public Governor Rotherham Wide
Mr M Ramzan, Public Governor Rotherham Wide
Mr F Kler, Public Governor Rest of England
Ms V Ball, Public Governor Rotherham Wide

Staff Governors: Mr M White, Staff Governor
Mrs P Keta, Staff Governor
Ms R Bell, Staff Governor
Mr S Nordkil, Staff Governor

Partner Governors: Dr J Lidster, Partner Governor Sheffield Hallam University

Members of the Board of Directors, other Trust staff and invited guests in attendance either for the whole or part of the meeting:

Mr K Malik, Non-Executive Director
Ms J Burrows, Non-Executive Director
Ms H Watson, Non-Executive Director (via Teams)
Dr R Jenkins, Chief Executive
Mr S Hackett, Director of Finance
Ms A Wendzicha, Director of Corporate Affairs
Mr A Wolfe, Deputy Director of Corporate Affairs
Mr M Wright, Managing Director
Ms C Rimmer, Corporate Governance Manager (minutes)

Apologies: Mrs H Craven, Non-Executive Director
Dr R Shah, Non-Executive Director
Mr M Temple, Non-Executive Director
Mr M Ukpe, Public Governor Rotherham Wide
Ms I Ogbolu, Public Governor Rotherham Wide
Mr S Goodwin, Public Governor Rotherham Wide
Mr R Taylor, Public Governor Rotherham Wide

ITEM	PROCEDURAL ITEMS	ACTION
COG/38/24	CHAIRMAN'S WELCOME AND ANNOUNCEMENTS	

	Dr Richmond welcomed all those present, and those attending virtually.	
COG/39/24	**APOLOGIES FOR ABSENCE & QUORACY CHECK** The apologies were noted and the meeting was confirmed to be quorate.	
COG/40/24	**DECLARATION OF INTEREST** Dr Jenkins and Ms Wendzicha's interest, in terms of their joint roles at both the Trust and Barnsley Hospital NHS Foundation Trust, were noted.	
COG/41/24	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting held on the 15th May 2024 were approved as a correct record, subject to a minor amendment.	
COG/42/24	**MATTERS ARISING FROM PREVIOUS MINUTES (NOT COVERED ELSEWHERE IN THE AGENDA)** No matters were raised.	
COG/43/24	**ACTION LOG** The Council received the action log and agreed for the outstanding action to be closed.	
COG/44/24	**CHAIR'S REPORT** Dr Richmond provided a verbal update to the Council of Governors and highlighted that the NHS has been in the spotlight and will continue to be with the Darzi report published soon; the Trust looks forward to receiving this with interest. Dr Jenkins gave comment on their understanding of what the report will contain, reviewing from 2001 to present and would likely report significant deterioration in waiting times and describe causal factors underpinning this. The view is that the report will help to shape the next 10 year health plan and could initiate seminal change. Dr Richmond updated the Council on the issues regarding the on-site accommodation blocks for staff including the Trusts' fiscal and social responsibility. Dr Jenkins detailed the actions completed and in place to mitigate the fire risk and that the cost to remedy fully would be circa £5mil. The Trust is looking for alternative arrangements for current residents as required and conducting one to one meetings and holding further open meetings to move forward.	

COG/45/24	**REPORT FROM NON EXECUTIVE DIRECTOR CHAIRS OF BOARD ASSURANCE COMMITTEES** i. Quality Committee Ms Burrows presented the chairs report and highlighted key items such as the development of the Care Group updates focusing on quality aspects, the Chief Nurse and Medical Director walkarounds and monthly reports, the Trusts' Quality Priorities that the committee monitor, the vast improvements showcased in Patient Experience reporting both internally and externally, and the challenges and concerns over staff sickness. Ms Burrows celebrated the recent award nominations and commended the excellent recruitment and retention in nursing. In regards to committee development, Ms Burrows updated the Council that the Quality Committee would be undertaking a workshop in November to determine the future strategy and vision for quality and hoped that it would initiate some changes to further strengthen the committee. Mr White sought clarification on the moderate harm reporting and assurance that it was addressed. Dr Jenkins explained that there are trigger levels for duty of candour and Ms Burrows discussed the monitoring governance, as well as the learning gained and would include more detail in future reports. Dr Richmond reflected on the sheer demand for services and the risk to patients here that can result in moderate harm. Mr Berry questioned the increased C.Difficile rates whilst the Trust has such high calibre Infection Prevention and Control (IPC) and Dr Jenkins explained that the increase had been seen across a number of Trusts and there are other impacting factors; a national review is looking into it to understand in more detail. ii. People and Culture Committee Ms Watson introduced the report on the bi-monthly meetings and detailed the interim meetings held between the Chair, Vice Chair and Director of People. June's committee meeting welcomed Care Group 1 who discussed their challenges with sickness levels and the effects of the recent divisional merger and benefits in joint working. Ms Watson highlighted the oversight of the People and Culture organisational priorities and the positive trends in retention,	

	and regarding job planning, updated the council on the work in progress to ensure these are in place. Lastly, Ms Watson commended the recent Proud awards and the fantastic celebration of our people. Mr Skelding queried whether the previously discussed residence issues would have an impact on retention and it was discussed that is not foreseen, to a noticeable degree; the one to one meetings will help to address the support that some individuals require. iii. Finance and Performance Committee incl. Finance Report Mr Hackett presented the report as Executive Lead of the Committee and described how the presentations from Care Groups have come with a range of opportunities and challenges, with good balancing of financial performance and operational performance. Mr Hackett detailed the good performance in 65 week waiters and that the Trust is doing well compared to other organisations. The committee is clear on its responsibility for the organisational priorities around performance and elective recovery, although Mr Hackett drew attention to the high demand on the Emergency department that presents a challenge. Referring to the Financial Report, Mr Hackett outlined key headlines and main drivers towards the deficit including Industrial Action and sheer continuous demand. A number of organisations in South Yorkshire are also off plan, and there are reports across the NHS that areas are struggling. Mr Hackett confirmed that the Trust's financial plan had been signed off and it was clarified that the Trust is doing everything in its power to meet that plan. Mr White queried the level of concern from the board regarding the current financial status. Mr Hackett explained that the board is concerned and the Executive Team have discussed a range of actions to take, with a specific group now meeting regularly to discuss the management action required to improve the position. Mr Hackett confirmed that at this point in the financial year, it is recoverable. There is also a lot of pressure felt from the ICB. Mr Berry drew attention to the lack of assurance in regards to CIP (Cost Improvement Programmes) and Mr Hackett agreed that the Trust is not on plan to meet CIP and that it is focused on corrective action, continuing to drive forward and take a	

	longer term view. Some challenges are beyond the Trust control and involve lots of other organisations with difficult issues to resolve. Governors queried the impact on patients from CIP and Mr Hackett confirmed that part of the programme includes Quality Impact Assessment to stop decisions not in the best interest of patients. However, Dr Jenkins highlighted that there are a range of areas where Quality Improvement (QI) and financial improvements are entwined. iv. Audit and Risk Committee Mr Malik presented the Audit and Risk Committee report and updated the Council on the vast amount of work done at Financial Year End and the internal and external assurance required. Mr Malik drew attention to the improvements in risk management at the Trust, triangulating with assurance from internal audit. Mr Malik described the broader scope, looking at emerging risks and the mitigations and outcome trajectory. Mr White queried the increased risk register for Care Group 4 and Mr Malik detailed the changes in leadership and governance, bringing fresh perspective. Lastly, Mr Malik noted the work required for the Standards of Business Conduct (SoBC) for the annual report. Mr Skelding questioned the barriers for declarations and Ms Wendzicha detailed the work in progress to support colleagues and the expectation that the position will be significantly improved by the next committee. v. Charitable Funds Committee Mr Hackett presented the report on behalf of Mrs Craven who chairs the meeting. Mr Hackett highlighted the alignment to the charity strategy and objectives, linkage with communities and Rotherham business networks, digitisation with a new CRM system, and positive income generation, ensuring the funds are spent wisely. Dr Richmond commended the good news story.	
COG/46/24	**INTEGRATED PERFORMANCE REPORT** Mr Wright presented the IPR report, noting the references made to metrics and performance in the Committee chairs reports. Mr Wright drew attention to the positive quality metrics such as mortality, the improved C.Difficile rates and Friends	

	and Family Test, and that the Trust is achieving all three Cancer Metrics. Challenges reported were on the 4 hour target, sickness rates and appraisals.	
COG/47/24	**PARTNERSHIP UPDATE** Mr Wright updated the Council on the strengthened governance arrangements, the joint roles and the joint meetings held. Mr Wright highlighted the service sustainability reviews pioneered by Barnsley and Rotherham for which the Acute Federation are now using and running workshops for specific areas. Dr Jenkins and Dr Richmond discussed the Board to Board meeting held with Barnsley and the positive outcome. The partnership allows shared influence to have a bigger voice and there is much alignment and common purpose between the Trusts in terms of the communities it serves. Dr Jenkins summarised that there are lots of opportunities to learn from each other.	
	GOVERNOR REGULATORY AND STATUTORY REQUIREMENTS	
COG/48/24	**GOVERNANCE REPORT: ANNUAL APPOINTMENT OF VICE CHAIR AND SENIOR INDEPENDENT DIRECTOR** Mr Malik noted his interest in terms of this agenda item. Dr Richmond presented the report and the Council of Governors supported Kamran Malik as Vice Chair for a further year and supported Heather Craven as Senior Independent Director for the remainder of her current term of office.	
	SUB GROUPS OF THE COUNCIL OF GOVERNORS	
COG/49/24	**MEMBER ENGAGEMENT GROUP REPORT** Mr Berry requested that Governors consider attending individual sessions with Non-Executive Directors (NEDs) who Chair the Board Assurance Committees on a quarterly basis to discuss the activities within these meetings. Mr Berry suggested that this is confirmed outside of the meeting. Mr Berry drew attention to the Governor Surgery rebranding and Mr Nordkil reflected on his recent involvement in a Governor Surgery and the feedback received, and noted the conversations held outside of the meeting regarding moving the Surgery to different locations. Mr Berry highlighted that a key role of Governors is to represent the public and this is a good opportunity to gather	

	feedback. Moving locations would also present opportunities to speak with different visitors and patients, than those attending the hospital.	
	COMMITTEE GOVERNANCE	
COG/50/24	**ISSUES TO BE ESCALATED TO BOARD OF DIRECTORS** None were noted.	
COG/51/24	**COUNCIL OF GOVERNORS WORK PLAN** The Council noted the planner.	
COG/52/24	**ANY OTHER BUSINESS** Ms Wendzicha reminded the Governors of the NHS Providers Governor Development Day held on 1st October.	
COG/53/24	**NEXT MEETING TO BE HELD ON** Wednesday 20th November 2024	

COUNCIL OF GOVERNORS MEETING: 12 February 2025

Agenda item: **COG/9/25**

Report: **Planning Guidance 2025/26**

Presented by: **Ben Gray, Deputy Director: Strategy and Delivery**
Author(s): **As above**

Action required: **For information**

NHS England has published its Priorities and Operational Planning Guidance for 25/26. This sets out the priorities for the NHS and the organisations within it over the next year, the main delivery mechanisms as well as the resources available to deliver this.

For 2025/26 the guidance has seen a significant reduction in the number of targets the NHS is expected to deliver. However, many of these targets remain challenging.

There is also a clear expectation that the NHS will 'live within its means' and this will place significant financial stress into systems (i.e. ICS') and providers with providers expected to make efficiencies of above 4%.

2025/26 Operational Planning Guidance

Council of Governors

The 2025/26 priorities and operational planning guidance sets out the national priorities for the NHS over the coming year

- The priorities and operational planning guidance is a response to the governments mandate to the NHS
- That mandate, and the subsequent planning guidance has seen a reduction in the number of objectives and priorities - designed to given local systems more flexibility on how they meet the needs of their population
- There is a significant ask for systems (and those organisations within it) in terms of the returns and plans needed (outlined later)

Summary Messages

- Reduced number of priorities within the guidance with greater focus on a smaller number of areas – also reduction in ring fenced budgets
- Finances will continue to be very challenging. Absolute expectation that the NHS will live within its means – local leaders may need to be make difficult decisions on low value activity and will be supported to do this
- ICBs will lead on planning and arranging of services – strategic commissioner role

2025/26 National Priorities

A	**REDUCE THE TIME PEOPLE WAIT FOR ELECTIVE CARE**	• NHS to achieve 65% RTT target by March 2026 *(63%)* • Each Trust delivering a minimum 5% improvement
B	**IMPROVE CANCER PERFORMANCE**	• 75% compliance with 62-day target by March 2026 *(80%)* • 80% compliance with 28-day FDS by March 2026 *(84%)*
C	**IMPROVE A&E WAITING TIMES**	• Achieve 78% for 4hr target by March 2026 *(58%)* • Cat 2 Ambulance response no longer than 30mins throughout 25/26
D	**INCREASE ACCESS TO GENERAL PRACTICE AND URGENT DENTAL**	• 700,000 additional urgent dental appointments
E	**IMPROVE FLOW IN MENTAL HEALTH CRISIS AND ACUTE PATHWAYS**	• Reduce the LoS for adult acute beds • Provide care to 345,000 more C&YP (0-25) than in 2019

In delivering these priorities, ICBs and providers must work together to:

F **Drive reform to support delivery of the immediate priorities and ensure the NHS is fit for the future**	• Reduce demand through the **development of Neighbourhood Health Service models** with an immediate focus on preventing long and costly hospital admissions and improving timely access to urgent care • Make use of **digital tools** to drive the analogue to digital shift • **Address inequalities** and shift towards secondary **prevention**
G **Live within the budget allocated, reducing waste and improving productivity**	• Deliver a balanced net financial position • Prioritise resources and stop lower-value activity
H **Maintain focus on overall quality and safety of services**	• Particular attention on fragile services including maternity and neonatal services • Continue to address variation in access, experience and outcomes

MEASURES OF SUCCESS IN 2025/26

NHS
The Rotherham
NHS Foundation Trust

Priority	Success measure
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
	Improve performance against the headline 62-day cancer standard to 75% by March 2026
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26
Improve access to general practice and urgent dental care	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more

act

MEASURES OF SUCCESS IN 2025/26

Priority	Success measure
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds
	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction
Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
	Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)
Maintain our collective focus on the overall quality and safety of our services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'
Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

COUNCIL OF GOVERNORS MEETING: 12 February 2025

Agenda item: **COG/11/25i**

Report: **Report from Quality Committee (QC)**

Author and Presented by: Julia Burrows, Chair of Quality Committee

Action required: To note

1.0 The Quality Committee (QC) continues to meet monthly, with Chair's Assurance Logs from recent meetings provided to the Board of Directors to demonstrate the degree of assurance received on all key matters.

2.0 Care Group Updates

2.1 Since the last report to the Council of Governors, the QC have received presentations from the Senior Management Teams from Care Group 3 (November) and Care Group 4 (January).

2.2 The Committee received a presentation from Care Group 3, highlighting their quality compliance, clinical effectiveness audits, and NICE guidance compliance. Significant achievements included the highest outcome from the SEND inspection and the successful World Prematurity Day event. Challenges discussed included the transition to adult services, which is a national challenge, and estate challenges. Future plans included Quality Improvement (QI) projects for all Same Day Emergency Care (SDEC) areas, and the role of the public health midwife in triangulating patient outcomes with public health initiatives.

2.3 The Committee received a presentation from Care Group 4, with key updates including the proactive care model with Comprehensive Geriatric Assessments (CGA) in care homes and collaborative work with Yorkshire Ambulance Service (YAS) and a portable X-ray service. The presentation gave a thorough overview of Virtual Ward, emphasising the importance of patient choice, shared decision-making and the benefits of the service through individual patient feedback.

3.0 Quality Priorities

3.1 The committee continue to have oversight and assurance on the agreed Quality Priorities for 2024/25 of Acute Pain Management, Diabetes Management, and Frailty.

Acute Pain Management:
It was reported that there have been changes to clinical systems which will be helpful moving forward and the launch of Pain champions had good engagement. The committee challenged flagged pain scores, and it was clarified that the assessment included all areas, even those where pain assessment may not be appropriate, such as Gynaecology counselling sessions.

Diabetes Management:
The committee received updates on the work on pathways, risk assessments, and Standard Operating Procedures (SOPs), and the significant differences made with changes to the admin processes. An audit within UECC is reviewing patients with a diagnosis of diabetes to identify what could have prevented their attendance.

Frailty:
It was reported that there had been difficulties and complexities in measuring this priority however, multiple meetings and stakeholder involvement have continued to move this forward. The dashboard is now live, and more data will be shared in the next report to the committee, enhanced by the improved number of Comprehensive Geriatric Assessments (CGA) that will provide more data, and the medicine bed reconfiguration which will also feed into this.

3.2 The proposed Qualities Priorities for 2025/26 were presented to and supported by the QC, subject to addressing some complexities and further discovery stages. The proposed three priorities were: Diabetes Management, Antimicrobial Stewardship, and Delayed Diagnosis.

Diabetes Management:
The proposal to continue the Diabetes Management priority was based on its expanded scope of work through the discovery stage over the past year and the committee noted the positive engagement from staff and the evolving work streams to be continued. The importance of the discovery stage was highlighted, and work in the Urgent and Emergency Care Centre (UECC) and community caseload reviews were identified as areas for further development.

Antimicrobial Stewardship:
This priority was proposed reflecting on the Infection, Prevention and Control reporting and the increased rates of C. difficile, with the appointment of a new Consultant Microbiologist expected to help drive this priority forward. The committee emphasized the need for a focused approach to antimicrobial practices and the importance of this priority in improving patient safety.

Delayed Diagnosis:
This priority was proposed following a comprehensive thematic review focused on patient safety which identified key elements across different domains. Significant gains were expected from areas of highest risk of impact and the committee agreed that this priority would require further discovery time with the Quality Improvement (QI) team and stakeholder involvement during the inclusion and exclusion stage of the process to ensure alignment and integration with current transformational workstreams.

4.0 Board Assurance Framework (BAF) and Risk Register

4.1 The committee continues to review and scrutinise the BAF Risk P1 to reach a consensus on the risk score, for recommendation to Board.

4.2 In January, the committee agreed for the BAF Risk score to remain at a score of 8, acknowledging and reflecting on the increased pressures, however there was

assurance through quality reporting that this was not triangulating with a significant decrease in quality of care.

4.3 The Committee continues to receive monthly update reports regarding the risks rated at 15 or above, which have been monitored and checked at the monthly Risk Management Committee. The reporting also provides further details on all approved risks aligned to the committee for more triangulation with Care Group presentations and other committee reports.

5.0 Maternity and Neonatal Safety Report

5.1 The committee receives monthly reports presented by the Head of Midwifery and were informed of the recent cluster of still births and the appropriate internal and external reviews that followed. The outcome of these reports will be formally sighted in February's report to the committee and to the Board of Directors report in March, however the committee were updated on the co-produced approach between TRFT, Local Maternity and Neonatal System (LMNS) and the Maternal and Neonatal Voices Partnership (MNVP) to identify commonalities and develop an action plan.

5.2 The committee welcomed the Clinical Negligence Scheme for Trusts (CNST) presentation noting that standards were well embedded with a lot of Multidisciplinary Team (MDT) work ongoing. The Committee also noted the effectiveness of the Executive's role in the evidence collection for the report with the increased levels of check and challenge raising the quality of the evidence presented and that all actions had been achieved. The committee supported the CNST position to recommend sign off to Board.

6.0 Quality Strategy

6.1 The committee are taking an active role in the development of the new Quality Strategy for the Trust. This strategy will be launched in Quarter 1 and Governors will receive a draft version in Quarter 4 for oversight and comment.

7.0 Committee Development

7.1 In December, the committee will be held a committee planning workshop, facilitated by the Head of Organisational Development and Inclusion. The session looked at the format and structure of the meeting to strengthen it going forward, shifting from retrospective focus to more proactive horizon scanning and active planning and utilising the committee to drive quality improvement in the organisation.

Julia Burrows
Non-Executive Director and Chair of Quality Committee

Agenda item:	**COG/11/25ii**
Report:	**People and Culture Committee**
Presented by:	**Dr Rumit Shah, Non-Executive Director and Chair of the People & Culture Committee**
Author:	**Dr Rumit Shah, Non-Executive Director and Chair of the People & Culture Committee**
Action required:	**To note**

1.0 The People and Culture Committee (P&CC) meets bimonthly, with Chair's Assurance Logs from recent meetings provided to the Board of Directors meeting to demonstrate the degree of assurance received on all key matters.

2.0 Care Group Updates

2.1 Since the last report to the Council of Governors, the P&CC has received a presentation from the Senior Management Team from Care Group 2 – Surgery (December).

2.2 Care Group 2 highlighted key updates including the appointment of a new Clinical Director, positive work with Infection, Prevention and Control (IPC) champions, and success in the Florence Nightingale programme. The team has been proactive in addressing high staff turnover rates particularly in sterile services, maximising theatre utilisation, reducing cancellations, and noted the positive feedback from surgeons on the changes in train. The nursing team has been actively engaged with the changes and needs of the service with daily staffing reviews and rostering to ensure patient safety with consideration to the financial challenges. The Committee noted the positive work in progress by the Care Group and welcomed the honest approach to the challenges it faces and the actions it is undertaking.

3.0 Job Planning

3.1 The committee has had regular sight of the Job Planning position within the Trust, which is key for efficient allocation of staff resource, defining individual responsibilities, and ultimately contributing to better patient outcomes and a sustainable workforce.

3.2 The Committee recognised and commended the significant progress made with November reporting 76% sign off of all job plans for the financial year 2024/25, noting the 18% increase month on month, and the successful move to a new software system. The Committee did also acknowledge that there is further to go in order to achieve the 95% target.

4.0 Medical Education Report and GMC Training Survey

4.1 The Committee welcomed the new report, which was also presented to the Board of Directors in January, as a positive move towards improving the working lives of doctors in training and an example of how the Trust could work towards Teaching Hospital status.

4.2 The report summarised the areas needing improvement, such as the training facilities and noted the concerns of sexual safety from the survey, which triangulated with the annual Trust-wide Staff Survey and would align with the action plan developed and in progress.

5.0 Guardian of Safe Working Hours

5.1 The committee receive quarterly reports from the independent Guardian of Safe Working Hours.

5.2 The Committee noted the report, recognising that the Acute Medical Unit (AMU) in particular had been experiencing some long standing issues due to additional capacity, however there were a number of proactive actions that had been put in place, such as listening events and more communication, and these were gaining traction with input from General Managers, doctors and Heads of Nursing.

6.0 Board Assurance Framework (BAF) and Risk Register

6.1 The BAF (Board Assurance Framework) continues to be monitored monthly, with meetings taking place with the relevant Executive Directors, and the updated BAF is presented to the Committee.

6.2 The Risk Management report included details on all approved risks that were aligned with the committee, for further oversight and accountability for Care Groups and Executives. This allowed for more depth of discussions and consideration of contributing factors and horizon scanning, developing a mature approach to risk management.

Dr Rumit Shah
Non-Executive Director and Chair of the People & Culture Committee

COUNCIL OF GOVERNORS MEETING: 12 February 2025

Agenda item:	**COG/11/25iii**
Report:	**Finance and Performance Committee (FPC)**
Author and Presented by:	**Martin Temple, Chair of FPC**
Action required:	**To note**

1.0 FPC continues to meet monthly, with Chair's Assurance Logs from recent meetings provided to the Board of Directors at their meeting to demonstrate the degree of assurance received on all key matters.

2.0 Care Group Updates

2.1 Since the last report to the Council of Governors, the FPC have received a presentation from the Senior Management Teams from Care Group 2 (November) and Care Group 3 (December). There was no presentation at the January 2025 Committee.

2.2 The Committee reviewed the presentation from Care Group 2, highlighting financial challenges due to staff sickness, increased pay costs, and overspend on medical supplies. Recovery actions were underway, including a large coding review and efforts to reduce agency spend. Despite these issues, there have been improvements in specific areas, such as ophthalmology and the MEOC, and there were no 65-week waiters. The Care Group continues to address theatre and anaesthetic staffing issues and is focused on long-term solutions and quality patient care.

2.3 The presentation from Care Group 3 gave key updates on financial and operational performance. Financial challenges were outlined, particularly with the Cost Improvement Plan (CIP), but controls were in place to address the deficit. Operationally, there was over-delivery on day cases and electives, but RTT performance was below target, particularly in Gynaecology. The Child Development Centre (CDC) had received funding to address a backlog which was a positive step forward and pharmacy optimisation and care group governance were also discussed. The committee was assured by the presentation, despite ongoing challenges with CIP and RTT targets.

3.0 Integrated Financial Performance Report

3.1 The monthly financial reports that the Committee receives provide an honest representation of the current financial position to understand what is happening and to identify the risks.

3.2 At the December meeting, the positives were highlighted including the initiatives around counting and coding that had been successful and made a big impact in terms of elective recovery, the deliberately planned and measured release of

reserves, and that whilst the capital position was behind, the cash position was ahead of plan.

3.3 The committee also had oversight of the planning for 2025/26, with updates on engagement with key stakeholders to identify key areas of risk as well as opportunities.

3.4 Whilst there are still significant challenges to achieve the financial plan, the committee were aware of the actions in place and the collaborative culture involved to ensure each Care Group and services were pulling in the right direction and pushing to achieve the individual, as well as Trust-wide, trajectories.

4.0 Operational Priorities

4.1 There were three operational priorities aligned to the Finance & Performance Committee in 2024/25 – Cancer, Emergency Care and Elective Care – and the Committee receives an update on each one on a quarterly basis.

4.2 An update on Elective Care was received in December and the report highlighted the stabilization of referral demand due to clinical triage improvements and also the mutual aid provided to Sheffield and Doncaster. The Trust successfully eliminated 65-week breaches, although 52-week wait challenges persist due to operational pressures. Improvements in RTT 18-week standards were noted, especially in cardiology, with support measures in place for more challenged specialties. The Trust was selected to be part of the national Further Faster programme which gives enhanced support to keys areas and services and will help to inform and develop the Trusts transformational programmes. The committee was assured of the ongoing efforts and progress.

4.3 On Emergency Care, it was reported to the committee that there were increased attendances, particularly in the UECC, and there were discussions on the Winter Plan for managing demand with a temporary workforce. The 4-Hour Standard performance was below target, but improvements were noted in non-admitted patient care and ambulance handover times. The Trust received £7m external capital funding for building work at the front end of the hospital and there would be reconfiguration of Medical and Surgical SDECs. The committee was assured of the progress towards targets.

5.0 Board Assurance Framework and Risk Register

5.1 The Committee continued to consider the Board Assurance Framework (BAF) and risk register at each meeting. The Risk Register includes risks rated 12 and above aligned to the committee, for horizon scanning.

5.2 For the BAF, the committee considered the significant and continuing increased patient demand and increased the score for BAF Risk D5 from 12 to 15. BAF Risk D8 score of 20 was maintained due to the level of uncertainty.

5.3 The Risk Register was presented to the committee in a new format to allow for further triangulation with reports and accountability from Care Groups and

Executives. It was highlighted the importance of a mature risk management process particularly when finances are under increased pressure.

6. Emergency Preparedness, Resilience and Response (EPRR) Core Standards

6.1 The Committee acknowledged the progress made here and the report in November outlined the compliance rate of 65%, the Core Standards template, statement of compliance and improvement plan. The continued improvement was emphasised alongside the continued collaboration with other South Yorkshire trusts.

6.2 In accordance with the approved Reservation of Powers to the Board and Schedule of Delegation, the Committee approved the Final Submission EPRR Report.

Martin Temple
Non- Executive Director, Chair of Finance and Performance Committee

COUNCIL OF GOVERNORS MEETING: 12 February 2025

Agenda item: **COG/11/25iii**

Report: **Finance Report**

Presented by: **Steve Hackett, Director of Finance**
Author(s): **As above**

Action required: For noting

This detailed report provides the Council of Governors with an update on:

- Section 1 – Financial Summary for November 2024 (Month 8 2024/25):
    - A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management.
    - The Trust was notified in September that it would receive £5,718K of national deficit funding. The overall impact is the requirement to improve the 2024/25 planned deficit from £6,302K to £584K
- Section 2 – Income & Expenditure Account for November 2024 (Month 8 2024/25:
    - Financial results for November 2024.
        - A control total surplus to plan of £788K in month and £1,915K deficit to plan year to date;
        - NHS England measures the Trust's I&E performance against its control total having adjusted for depreciation on donated assets, impairments and accounting for Private Finance Initiatives under IFRS 16 – Leases (total of £523K).
- Section 3 – Income and Expenditure Account Forecast Out-Turn
    - A forecast out-turn deficit to the planned control total, for the year ending 31st March 2025, of £9,490K.
    - At this point the Trust will be reporting externally to the ICB and NHSE that it will be delivering its planned deficit as actions are being taken to recover this position, and the use of reserves will enable the Trust to deliver its plan.
- Section 4 – Capital Expenditure for November 2024 (Month 8 2024/25)
    - Results for November 2024 show expenditure of £815K in month and £4,315K year to date against a budget of £5,999K, an under-spend of £1,684K (28%). Schemes are progressing and it is expected that the Trust will spend its full capital allocation.
- Section 5 – Cash Flow 2024/25

- A cash flow graph showing actual cash movements between April 2023 and November 2024. A month-end cash value as at 30th November 2024 of £10,145K, which is £4,159K favourable to plan.

1. Key Financial Headlines

1.1 The key financial metrics for the Trust are shown in the table below. These are:

- Performance against the monthly income and expenditure plan;
- Capital expenditure;
- Cash management.

Key Headlines	Month			Year to date			Forecast	Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	FV £000s
I&E Performance (Actual)	(284)	500	784	(715)	(2,661)	(1,946)	(9,522)	(12,372)
I&E Performance (Control Total)	(223)	565	788	(223)	(2,138)	(1,915)	(9,490)	(12,343)
Capital Expenditure	1,060	815	245	5,999	4,315	1,684	0	0
Cash Balance	(671)	(3,491)	(2,820)	5,986	10,145	4,159	0	0

1.2 The Trust has under-spent against its I&E control total in November 2024 by £788K and year to date it has over-spent by £1,915K. NHS England measures the Trust's I&E performance against its control total having adjusted for depreciation on donated assets, impairments and accounting for Private Finance Initiatives under IFRS 16 - Leases.

1.3 These figures include an under performance on elective recovery activity of £1,358K year to date, it is expected that this will be recovered through additional targeted schemes and from a review to provide assurance that the activity is appropriately recorded and captured.

1.4 The Trust was notified of deficit funding of £5,718K in September 2024, which improves the overall planned deficit for 2024/25 from £6,302K to £584K. Deficit funding has been phased into the plan from September 2024.

1.5 Capital expenditure is behind plan in month and year to date, with cumulative spend of £4,315K against a budget of £5,999K. Approval to spend capital funding, across the Trust's priorities, has been agreed and the forecast is to fully deliver against plan. The capital programme is continuing to be monitored by the Capital Monitoring Group chaired by the Director of Finance.

1.6 The cash position at the end of November 2024 is £10,145K and is favourable to plan by £4,159K. This is due to the receipts (year to date) for deficit funding, and incremental capital funding.

2. Income & Expenditure Account for November 2024 (Month 8 2024/25)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered a surplus to plan in November 2024 of £788K and a deficit to plan of £1,915K year to date.

Summary Income and Expenditure Position	Annual plan	Month			Year to date			2024/2025
		Plan	Actual	Variance	Plan	Actual	Variance	Monthly Trend /
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	Variance
Clinical Income	347,420	29,719	31,634	1,915	233,293	236,529	3,236	
Other Operating Income	24,984	2,237	2,634	398	16,826	18,596	1,770	
Pay	(243,715)	(21,994)	(23,272)	(1,278)	(163,558)	(173,930)	(10,372)	
Non Pay	(101,538)	(8,920)	(10,338)	(1,417)	(72,111)	(77,992)	(5,881)	
Non Operating Costs	(4,995)	(338)	(323)	14	(2,912)	(2,554)	358	
Reserves	(24,104)	(988)	164	1,153	(12,253)	(3,311)	8,941	
Retained Surplus/ (Deficit)	(1,949)	(284)	500	784	(715)	(2,661)	(1,946)	
Adjustments	1,365	61	65	3	492	523	31	
Control Total Surplus/ (Deficit)	(584)	(223)	565	788	(223)	(2,138)	(1,915)	

2.2 Clinical Income is ahead of plan year to date largely due to the true up position on the 2023/24 ERF of £1,250K, consultants pay reform £800K, Industrial Action funding £604K and Community Diagnostic Centre (CDC) income of £890K. These figures include an adverse year to date position on ERF in 2024/25 of £1,358K. The overall ERF target for South Yorkshire ICB and the Trust is 103% of 19/20's activity (priced at current tariff), for variable activity the plan is based on 2023/24 outturn uplifted for 2024/25 tariff.

2.3 Other Operating Income is ahead of plan in month and year to date with increased income from staff recharges (£803K), which will be an offset to the pay over-spend, and increased research, education and training income (£1,027K).

2.4 Pay costs are over-spending by £10,372K year to date. Bank and agency expenditure is not currently being maintained within the gross establishment budget, and contributing to this is £2,541K under-delivery against the planned cost improvements.

2.5 Non Pay costs are over-spending by £5,881K year to date. The overspend is largely related to Drugs and Clinical Supplies £3,965K, Premises £531K, and under-delivery against cost improvement plans of £1,101K which are offset by under-spends for clinical negligence £306K.

2.6 The positive performance in Non-Operating Costs is due to interest receivable on cash balances being better than planned.

2.7 £8,941K has already been released from Reserves year to date, this is to cover the under-delivery of CIP, additional capacity over and above funded bed capacity and Industrial Action impact on ERF.

3 Forecast Out-Turn Performance to 31st March 2025

3.1 The table below shows the forecast out-turn position for the financial year 2024/25. The Trust is forecasting to deliver a £9,490K deficit to plan.

Summary Income and Expenditure Position	Annual plan	Forecast outturn (Full Year)	Forecast Variance (Full Year)	Actual Variance (YTD)	Forecast Variance	Total Variance	2024/2025 Monthly Trend /
	£000s	£000s	£000s	£000s	£000s	£000s	Variance
Clinical Income	347,420	351,424	4,005	3,236	768	4,005	
Other Operating Income	24,984	27,753	2,769	1,770	999	2,769	
Pay	(243,715)	(260,284)	(16,569)	(10,372)	(6,197)	(16,569)	
Non Pay	(101,538)	(110,752)	(9,214)	(5,881)	(3,324)	(9,205)	
Non Operating Costs	(4,995)	(4,450)	545	358	178	536	
Reserves	(24,104)	(15,162)	8,941	8,941	0	8,941	
Retained Surplus/ (Deficit)	(1,949)	(11,471)	(9,522)	(1,946)	(7,576)	(9,522)	
Adjustments	1,365	1,397	32	31	(1)	32	
Control Total Surplus/ (Deficit)	(584)	(10,074)	(9,490)	(1,915)	(7,576)	(9,490)	

3.2 Within Clinical Income, the estimated ERF YTD under delivery against divisional targets is reflected of £1,358K. No further under or over delivery of ERF is forecast. It also includes the true up of 2023/24's ERF £1,250K, variable income, and income relating to the consultants pay reform which was notified of post plan submission and CDC income of £890K.

3.3 Other Operating Income is forecasting increases in income from research, development, education & training (£1,601K) and staff recharges (£1,404K). This additional income will equally be offset by further increases in pay and non-pay expenditure.

3.4 Pay is showing a significant deterioration in performance but this does include, as yet, undelivered annual CIP budget of £4,238K and premium agency cost FOT variance of £4,505K. Pay is not being managed within budgeted establishment.

3.5 Non Pay costs are similarly showing a significant deterioration in performance linked to continued increasing costs most notably within premises £987K, undelivered CIPs £2,330K, and drugs and clinical supplies £5,885K, which are partly offset by forecast underspends in clinical negligence £452K.

3.6 Non-Operating Costs reflect increased income from interest receivable on money deposited with Government banking services.

3.7 The Trust will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE. It assumes that with appropriate management action and the use of reserves, these will enable the Trust to deliver its overall plan by 31st March 2025, a year end deficit of £584K. This position assumes that the Elective Recovery Fund and Efficiency targets will be met, and actions are taken with regards additional capacity.

3.9 Cost reduction and CIP delivery are key to improving the forecast outturn position, and are required to be proactively managed across all services, and for action plans to be implemented. This remains a significant risk to the Trust delivering against its overall plan. Financial recovery meetings are being held monthly with Senior Leaders and Executive Directors to address the financial and operational challenges, and to identify solutions.

4. Capital Programme

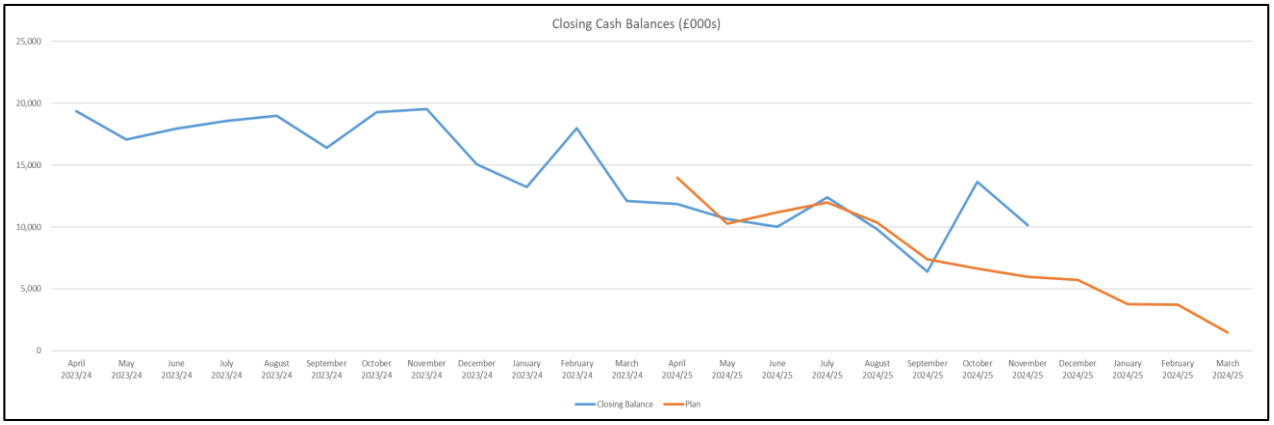
4.1 During November 2024 the Trust incurred capital expenditure of £815K, and year to date it is £4,315K. Schemes are progressing and it is expected that the Trust will spend its full capital allocation.

Capital Expenditure	Month			Year to date			Forecast	Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	Forecast Variance £000s
Estates Strategy	368	195	173	1,977	1,470	507	0	0
Estates Maintenance	474	519	(45)	2,287	1,147	1,140	0	0
Information Technology	171	11	160	1,327	991	336	0	0
Medical & Other Equipment	88	89	(1)	582	707	(125)	0	0
Other	(41)	0	(41)	(174)	0	(174)	0	0
TOTAL	1,060	815	245	5,999	4,315	1,684	**0**	**0**

4.2 The planned capital spend for the year is £11,180K. This includes an additional £30K of capital PDC which has been agreed since the plan submission.

5. Cash Management

5.1 The cash position at the end of November is £10,145K and is favourable to plan by £4,159K. This has allowed the Trust to earn interest on its daily cash balances of £574K year to date.



Steve Hackett
Director of Finance
10 December 2024

COUNCIL OF GOVERNORS MEETING: 12 February 2025

Agenda item: **COG/11/25iv**

Report: **Report from Audit and Risk Committee (ARC)**

Presented by: **Mr Kamran Malik, Non-Executive Director and Chair of Audit & Risk Committee**

Author(s): **as above**

Action required: **To note**

1.0 The Audit and Risk Committee met in January 2025, with the Chair's Assurance Log produced for the Board of Directors to demonstrate the degree of assurance received on all key matters.

2.0 Risk Management Report

2.1 The Committee received the latest risk register report including in depth information in regard to Trust-wide approved risks with additional scrutiny on action plans.

2.2 The Committee recognised the increased focus and work and improvement of the risk management process. They agreed that consideration was now required as to the next step for risk management to take it to the next level, with dynamic risk assessments, joined up actions across different risks and the importance of consistency when grading risk ratings across the different Care Groups and Corporate Services.

2.3 The Committee welcomed the advice from 360 Assure and Forvis Mazars that they have started using elements of the Trust's risk management process as a good example to other trust in the region.

3.0 Board Assurance Framework (BAF)

3.1 The Committee noted that risks R2 and OP3 are now owned by the new Managing Director who is undertaking a full review of the risks. The risks are also to be aligned to one of the Assurance Committees for strategic oversight.

4.0 Standards of Business Conduct

4.1 The Committee recognised the improving compliance of staff with the annual declaration of conflicts of interest to the December 2024 position of 67.85% compared to the November 2024 position of 56.23%.

4.2 The Committee noted the work undertaken in order to provide the data for this item and the further actions being taken in conjunction with the Medical Director's office and Communications to further improve compliance.

5.0 Internal Audit

5.1 The Committee received the Internal Audit Progress Report. Significant Assurance was given to Budget setting, reporting and monitoring.

5.2 A split significant/moderate Assurance opinion was also given for Bank and agency spend.

5.3 Significant Assurance opinion was also given on Board Assurance Framework (BAF).

Mr Kamran Malik
Non-Executive Director, Chair of Audit Committee

COUNCIL OF GOVERNORS MEETING: 12 February 2025

Agenda item: **COG/11/25v**

Report: **Charitable Funds Committee (CFC) Chair's Report**

Presented by: **Heather Craven, Chair, Charitable Funds Committee**
Author(s): **as above**

Action required: **To note**

1.0 The Charitable Funds Committee continues to meet on a bi-monthly basis with Chair's Reports from recent meetings provided to the Corporate Trustee to demonstrate the degree of assurance received on all key matters.

2.0 Charity Strategy

2.1 The Charity Strategy 2022-2025 comes to an end at the end of March and it was reported that some objectives from this last year covered by the strategy would carry over into the next year, the first year of the new three year strategy. The charity has been very proactive in fundraising and some areas such as business engagement have developed faster than anticipated which due to limited resource has impacted on the ability to complete all objectives. It was acknowledged that all objectives had been partially addressed or considered, however the successful fundraising and over-delivery in other areas had been the rationale behind the non-delivery.

2.2 The Rotherham Hospital and Community Charity Strategy for 2025-2028 was presented and supported by the committee, subject to some final amendments and would be submitted to the Corporate Trustee for final approval. The strategy was a culmination of discussions and feedback sought from the committee and put forward a step change for the charity. Core themes were financial sustainability of the charity, community engagement and supporting work to address health inequalities, as well as supporting education which would tie into the Trust objective around Teaching Hospital status.

3.0 Finance Report

3.1 The charity continues to be in a good financial position, reporting Month 8 cumulative position for income (excluding Legacies, Gift Aid and NHS Charities Together income) at £154.4k compared with £106.1k and £51.3k for the years 23/24 and 22/23 respectively.

3.2 It was reported that the individual fund balances remain consistent and there is need to ensure funds are turned over as best as possible, and to maintain the focus here for Funds Stewards (Care Group General Managers).

4.0 Charity Appeals and Fundraising

4.1 The Committee receive updates on a number of appeals and fundraising initiatives currently taking place or planned for the future.

4.2 The Committee were updated that November and December had been brilliant months of activity and the reporting could not convey the joy the events had brought which was evident at the recent choir singing at Meadowhall, with the reactions of the crowds and volunteers.

4.3 The charity ambassadors were highlighted who are really engaged to promote and support the charity.

4.4 The next big appeal that has been launched is the Dementia Appeal, which aims to enhance ward areas for patients with dementia. Feedback on the promotional material had been positive and once the specifics and scalability have been finalised, there will be significant push for further donations and grants with booklets and other promotional material.

4.5 The charity held another successful Business Breakfast event in January with key note speakers including Penny Fisher from the Trust (General Manager of Care Group 4) and James Beighton, Development Manager at Skills Street.

5.0 Charity Awards

5.1 The charity and volunteers were nominated for two awards: UnLTD Business Awards and Voluntary Action Rotherham Awards, which reflected the engagement and boosted profile with the local and business community.

6.0 Risk Information

6.1 The committee continues to review all charity risks on a regular basis, linking with the strategic objectives and monitoring all risks and mitigating actions.

Heather Craven
Non-Executive Director and Chair of Charitable Funds Committee

COUNCIL OF GOVERNORS MEETING: 12 February 2025

Agenda item: **COG/12/25**

Report: **Integrated Performance Report**

Presented by: **Bob Kirton, Managing Director**
Author(s): **As above**

Action required: **For noting**

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 November 2024, 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.

Council of Governors Meeting

Integrated Performance Report - November 2024

Trust Dashboard

The Rotherham NHS Foundation Trust

Strategic Update

Providing high quality care improving the experience of our patients	• Ward accreditation process complete for all Adult ward, plans in place for Maternity and Paediatrics. • Engagement has started on developing our Quality Priorities for 25/26 • Actions plans have commenced for those areas that show room for improvement in our most recent CQC surveys
Engaging with our people & improving the organisational culture	• The Trust has received its Staff Survey management report and Picker are now processing the remaining reports. National reports remain embargoed until mid-February 2025. • Occupational health services are vital for supporting staff and reducing sickness absence; the trust is currently re-tendering this contract.
Becoming a financially sustainable & productive organisation	• Significant new development approved for UECC £5.5m with MOU due to be signed imminently • While National planning guidance has been delayed, internal service level Demand & Capacity Planning continues to be progressed for 2025/26.
Focus on our operational delivery and improving access to care	• Improvement noted in the RRT position, and the Trust continues to have 0 waits over 65 weeks. • Full review of the existing transformation programme, enabling us to go further faster with a key focus on ENT paediatrics, orthopaedics, gynaecology specialties from January 2025

Patient and Staff Experience

- CQC's 2024 inpatient surveys for Urgent & Emergency Care, and Maternity Service have been published, with positive results.
- Areas in the UECC survey where the Trust scores well in comparison to others; include communicating with patients & families about results, information upon arrival; support after leaving UECC. Maternity Service results were also positive
- Comments from FFT and Complaints are informing future actions plans in those areas where there is room for improvement.

Combined Positivity Score (95.0%)

93.8 ☒

Complaints Rate (8.0)

10.1 ☒

Quality and Safety

SHMI (*As Expected*/100.0)

As Expected ☑

Care Hours per Patient Day (7.3)

6.6 ☒

Patient Falls per 1k Bed Days (0.19)

0.16 ☑

People and Culture

Sickness Absence (4.8%)

6.5 ☒

MAST (85.0%)

90.0 ☑

Appraisal Season Rate (90%)

79.8 ☒

Turnover (8.0-9.5%)

8.6 ☑

Capital Investments

Capital Expenditure (YTD)

£4.3m (plan £5.9m)

- Current spend is £1.6m behind plan but forecast to spend all capital allocation by year end
- Significant new development approved for UECC £5.5m with MOU due to be signed imminently

Finance (YTD, £000s)

Indicator	Plan	Actual
I&E	(223)	(2,138)
CIP	7,201	3,571
Cash balance	5,986	10,145

Operational Performance

A&E 4 Hour Standard (78%)

62.1 ☒

RTT 18 Week Standard (92%)

62.6 ☒

65 Week Waits (0)

0 ☑

DM01 6-Week Standard (1%)

1.0 ☑

Cancer Faster Diagnosis (77%)

80.2 ☑

Cancer 62 Day Standard (70%)

74.6 ☑

For more information on how to interpret SPC summary icons click here.

Performance Matrix Summary

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • Urgent 2 Hour Response • Mean LoS (Elective) • Turnover (12 month rolling)	**GOOD: CELEBRATE AND UNDERSTAND** • Readmissions • OP to PIFU • 31 Day Treatment Standard	**CONCERNING: CELEBRATE BUT TAKE ACTION** • 1:1 Care in Labour • 65+ weeks • RTT • Appraisal Rates
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • SHMI • MAST – Job Specific • Vacancy Rate (total)	**STATIC: INVESTIGATE AND UNDERSTAND** • Care Hours per Patient Day • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Patient Falls (Moderate and above) • Medication Incidents (Moderate and above) – Acute and Community • C. diff infections • Waiting List Size • OP to PIFU • Overdue Followups • DM01 • FDS • 62 Day Treatment Standard • >12 hours in A&E • 12 hour Trolley Waits • Bed Occupancy • LoS >21 Days • Date of Discharge = Discharge Ready Date • Patients on Virtual Ward • First Outpatients (%Plan) • Inpatients (%Plan) • Daycases (%Plan) • LoS >7 Days • Mean LoS (Non-Elective) • A&E Attendances from Care Homes	**CONCERNING: INVESTIGATE & TAKE ACTION** • Breast milk first feed • 4 Hour Performance • Ambulance Handovers >30min • Average time to be Seen • Criteria to Reside is No • Admissions from Care Homes • Clinic Utilisation • Capped Theatres Utilisation • Did Not Attend • Discharged <5pm • Sickness Rates (12 month rolling) • Sickness Rates • Appraisal Rates (12 month rolling)
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • Stillbirth rate • MAST - Core	**CONCERNING:INVESTIGATE & TAKE ACTION** • VTE Risk Assessments • Combined Positivity Score • Pressure Ulcers (Cat 3 and above) – Acute and Community	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • 52+ weeks

Performance Matrix Summary - Quality

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE**	**GOOD: CELEBRATE AND UNDERSTAND** • Readmissions	**CONCERNING: CELEBRATE BUT TAKE ACTION** • 1:1 Care in Labour
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • SHMI	**STATIC: INVESTIGATE AND UNDERSTAND** • Care Hours per Patient Day • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Patient Falls (Moderate and above) • Medication Incidents (Moderate and above) – Acute and Community • C. diff infections	**CONCERNING: INVESTIGATE & TAKE ACTION** • Breast milk first feed
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • Stillbirth rate	**CONCERNING:INVESTIGATE & TAKE ACTION** • VTE Risk Assessments • Combined Positivity Score • Pressure Ulcers (Cat 3 and above) – Acute and Community	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

How to read the ICONs in this report:

Have we achieved in month?

Are we consistently passing(P)/failing (F) or is it hit and miss (?)

Are we significantly Improving /deteriorating or is there no significant change?

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	-	30,402	Feb-24	-	-			C
Number of 52+ Weeks	200	678	Feb-24					VC
Number of 65+ Weeks	37	74	Feb-24					S

Quality

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
SHMI	"As expected"	"As expected" (104.0)	**Jun-24**	N/A	P		-	G
Readmissions (%)	-	6.2	Oct-24	-	-	L		GI
VTE Risk Assessments (%)	95.0	94.0	Nov-24	☒	?	L		C
Care Hours per Patient Day	7.3	6.6	Nov-24	☒	?			S
Combined Positivity Score (%)	95.0	93.8	Nov-24	☒	?	L	-	C
Complaints (per 10k Contacts)	8.0	10.1	Nov-24	☒	?		-	S
Patient Safety Incident Investigations	3	4	**Oct-24**	☒	?		-	S
Patients Falls (Moderate and Above per 1000 bed days)	0.19	0.16	Nov-24	☑	?		-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 1000 bed days - Acute	0.77	1.32	Nov-24	☒	?	H	-	C
Pressure Ulcers Cat 3/4/STDI and Unstageable per 100 contacts - Community	0.06	0.13	Nov-24	☒	?	H	-	C
Medication Incidents - Moderate and Above per 1000 bed days – Acute	0.05	0.16	Nov-24	☒	?		-	S
Medication Incidents - Moderate and Above per 100 contacts - Community	0.00	0.00	Nov-24	☑	?		-	S
C. difficile Infections	<4	5	**Oct-24**	☒	?			S

*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

SHMI: Summary Hospital-Level Mortality Indicator

Data, Context and Explanation

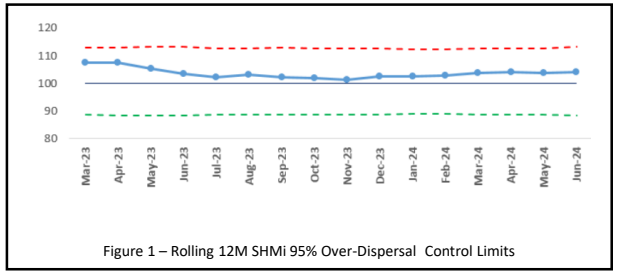


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

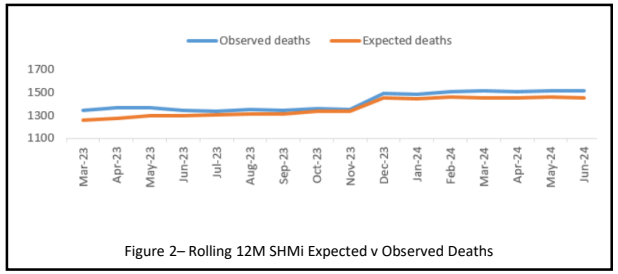


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

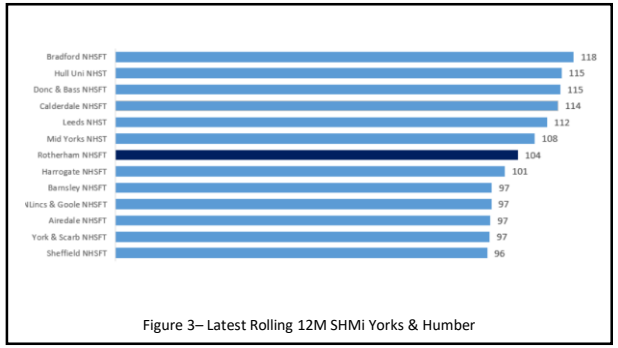


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

TRFT's SHMI remains in the 'As Expected Band'

Covid activity was added back into the SHMI data Dec 2023

- The SHMI reports on mortality at trust level across the NHS in England using a standard methodology. It is produced and published monthly as a National Statistic by NHS Digital
- The SHMI is the ratio between the observed number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated
- The SHMI acts as a 'smoke alarm' to prompt Trusts to consider investigating areas of potential area of concern where more deaths are observed than expected
- Approximately 50% of England's Trusts will be above 100 and 50% below
- There are 3 SHMI banding, As Expected, Higher or Lower. TRFT's SHMI has consistently been As Expected, since July 2021
- SHMI Bandings are calculated for the Trust overall and 10 diagnostic groups

Metric	Current	Target	Exec Owner	Organisational Lead
Latest Rolling 12 Month SHMI -Jun 24	104.0	-	Jo Beahan	John Taylor
Expected Deaths	1455	-		
Observed Deaths	1515	-		
Trust Banding	Expected	-		

What actions are planned?

- To highlight when SHMI values are in the higher than expected band (95% Over-dispersion Control Limit)
- The Trust Mortality Group will decide on any required investigations/reviews based on the Investigation Pyramid
- This may lead to changes/improvements in practice

What is the expected impact?

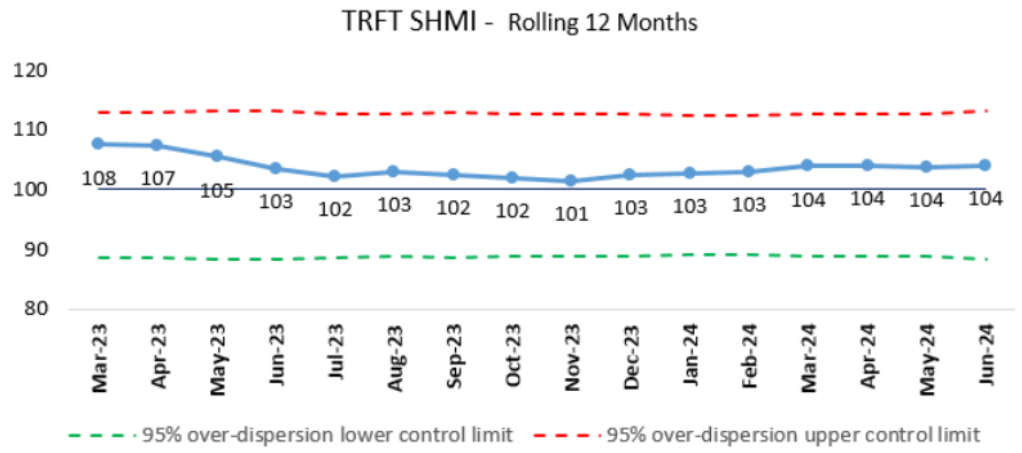
- Investigations or reviews resulting from SHMI investigations will give the Trust Assurance when there are significantly more deaths observed than expected
- Intelligence from SHMi investigations/reviews may lead to changes/improvements in practice

Potential risks to improvement?

- The SHMI isn't monitored and reported on routinely & correctly
- The Trust Mortality Group's response to areas of concern isn't robust and the correct investigations aren't requested/completed
- That intelligence from any investigations/reviews isn't acted upon

SHMI: Summary Hospital-Level Mortality Indicator

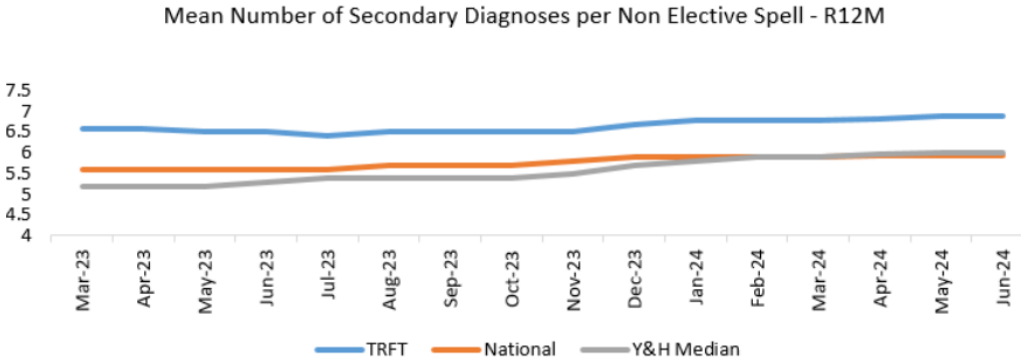
SHMI Update



This chart shows that TRFT has consistency been in the As Expected band. The trend pattern shows Common Cause Variation, within this band.

Interpretation Guidance NHS England June 2024

'Where a trust has an 'as expected' SHMI, it is inappropriate to conclude that their SHMI is lower or higher than the national baseline, even if the number of observed deaths is smaller or larger than the number of expected deaths. This is because the trust has been placed in the 'as expected' range because any variation from the number of expected deaths is not statistically significant



The depth of co-morbidity coding is important for the SHMI because its effects the calculated expected risk of death % for each inpatient admission.

This chart shows that TRFT's depth of coding for non elective spells has been consistently higher than the National figure and the Yorkshire & Humber median.

TRFT's higher rate is either down to TRFT's casemix having a higher prevalence of co-morbidities or better capture of these co-morbidities.

SHMI: Coding & Alerts

SHMI - Diagnostic Group Alerts

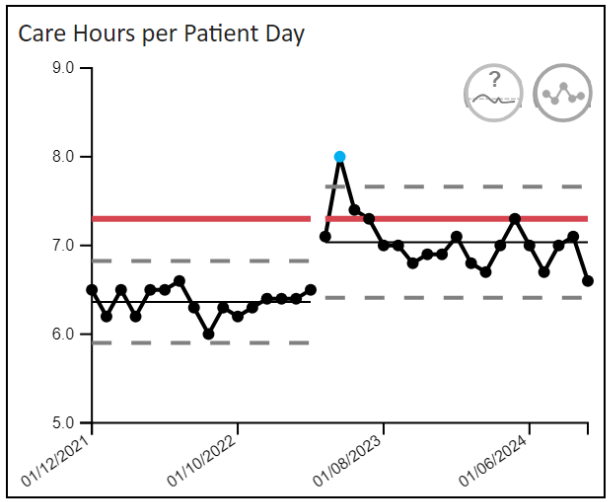
TRFT currently has no alerts for its diagnostic groups.

SHMI Changes – Methodology, Process or Specification

No new changes

Subtheme: Care hours per patient day

Data, Context and Explanation



- Care Hours Per Patient Day (CHPPD) is the formal, principal measure of workforce deployment in ward-based settings.
- CHPPD forms an integral part of a ward/unit/trust review and oversight of quality and performance indicators to inform quality of care, patient outcomes, people productivity and financial sustainably.
- CHPPD should be used alongside clinical quality and safety outcome measures to understand and reduce unwarranted variation, and support delivery of high quality, efficient patient care.
- Focus on percentage of fill rate against funded establishment.
- CHPPD for November was 6.8 against planned 7.1
- Fill rates for nights is good and for HCSW 113% above planned
- Fill rates for days RN is the lowest but there are more members of the multi-professional team to support patient safety and experience.

Metric	Value	Target	Exec Lead	Ops Lead
Care Hours per Patient Day	6.6	7.3	Helen Dobson	Cindy Storer

What actions are planned?

- Continued roll out of the Exemplar Accreditation programme. This programme is underpinned by monthly Quality dashboards
- All the September/October NRN are in post and most have ended their supernumerary period.
- Recruitment of 24 NRN for January-March has started with offer letters sent.

What is the expected impact?

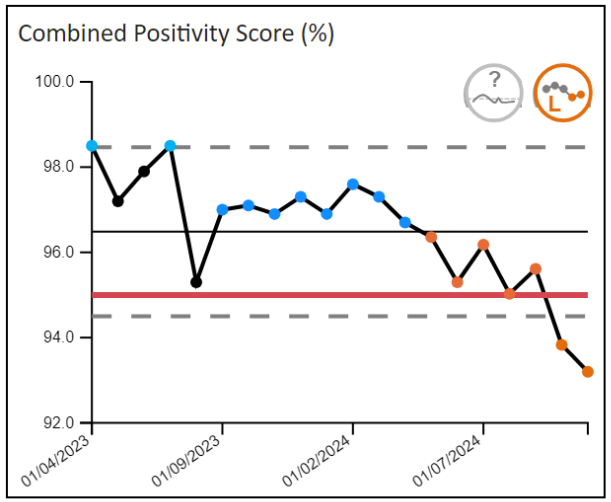
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.

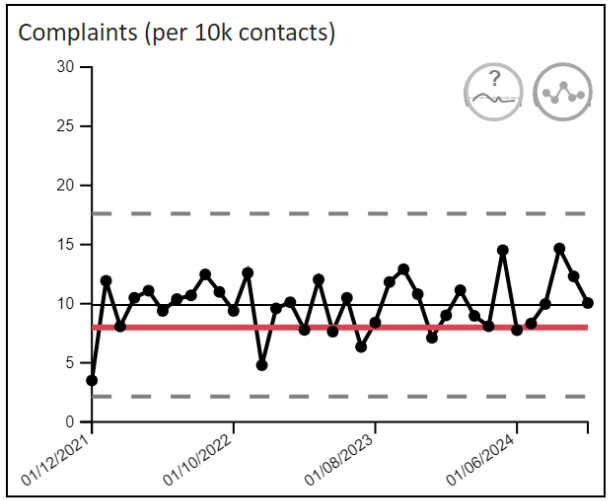
Potential risks to improvement?

- Needing to open additional beds using existing establishments and temporary NHS staff
- Roster KPI not being met
- Turnover of Nurses, Midwives and HCSW

Subtheme: Patient Experience

Data, Context and Explanation





- The Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
- The FFT asks people if they would recommend the services they have used. Our Combined Positivity Score dipped in October to 93.8% with an increase in negative responses in UECC and IP wards.
- Patients can complain about any aspect of NHS care, treatment or service and this is written into the NHS Constitution.
- The number of complaints continues to be monitored. There has been a consistent rate of written complaints per month over the last three years, despite the rising numbers of patients being seen.
- Deterioration in FFT in UECC is impacting on the overall Trust score. Actions are planned to meet the team to understand the change in feedback scores.

Metric	Value	Target	Exec Lead	Ops Lead
Combined Positivity Score (%)	93.2	95.0	Helen Dobson	Cindy Storer
Complaints (per 10k contacts)	10.1	8.0	Helen Dobson	Cindy Storer

What actions are planned?

- Meeting with UECC teams to discuss deterioration in position.
- Front line resolution through the new PALS resulting in positive compliments
- Training through new Monopoly board continues and is well received
- Patient experience improvement plan for 2024/5 delivered

What is the expected impact?

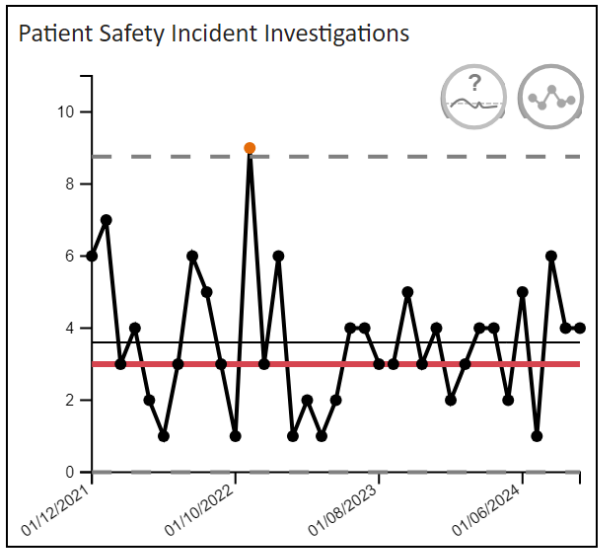
- FFT Positivity score above 95
- The PALS service aims to promote local resolutions to concerns earlier in the process leading to a reduction in concerns being raised. Themes from PALS are around outpatient appointments and discharge.

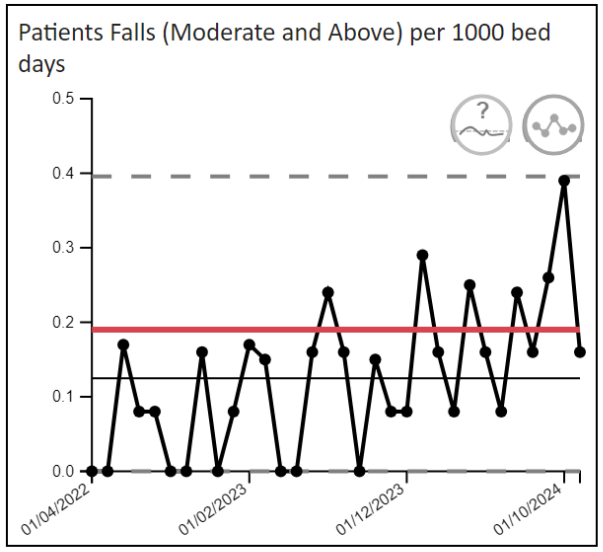
Potential risks to improvement?

- None – all patient experience improvement plans now delivered for 2024/5

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 PSI remain consistent per month.
- The number of patient falls at moderate harm is remaining consistent at present, at times achieving the 0.19 per 1000 bed days target, and has achieved in month

Metric	Value	Target	Exec Lead	Ops Lead
Patient Safety Incident Investigations	4	3	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.31	0.19	Helen Dobson	Victoria Hazeldine

What actions are planned?

- A Falls Prevention Lead is proposed for the Trust to help reduce the total number of all falls and moderate harm falls through Qi projects and education
- The Patient Safety Incident Response Plan has been updated and will be published by December 2024

What is the expected impact?

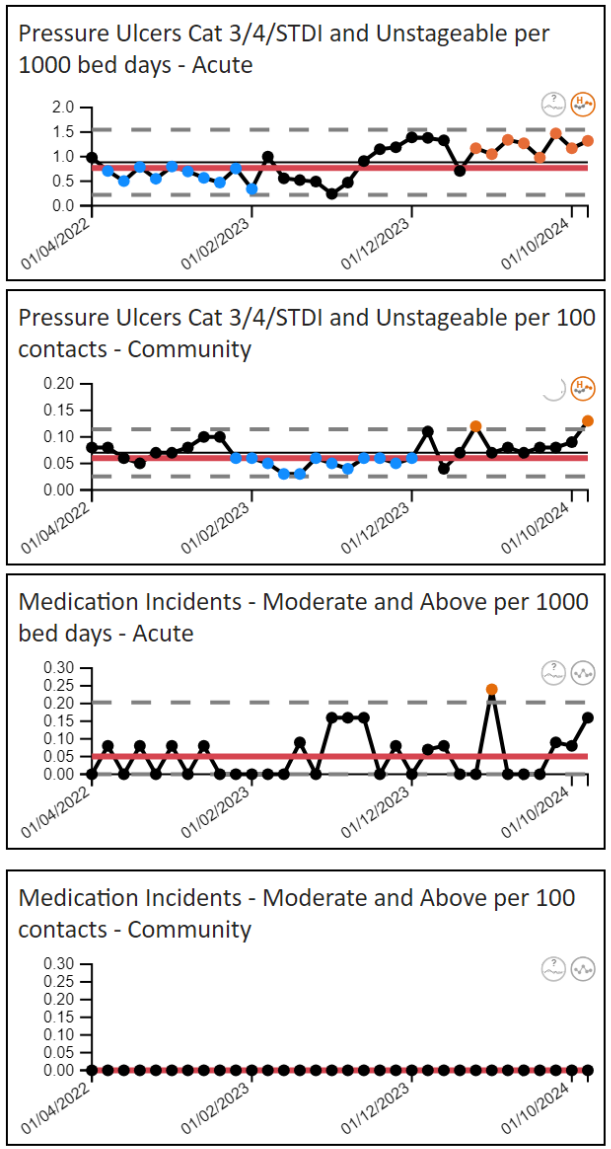
- Stabilisation of PSII's with adequate evidence of shared learning
- Reduction in the total number of falls
- Clear guidance on the use of PSII's against alternative investigation methodology

Potential risks to improvement?

- Increase in the number of patients admitted to acute Trust with complex health problems and additional bed capacity, resulting in reduced nursing and medical ratios
- The lack of a falls lead practitioner to complete work across acute and community to ensure the Trust is compliant with NAIF and Qi initiatives

Subtheme: Care Incidents (2)

Data, Context and Explanation



- 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. This equates to 0.8% increase on previous months. September's figure is 0.53%. there are no themes/trends identified for this increase.
- The reported Cat 3 and 4, SDTI's and unstageable damage are all reviewed and graded by Tissue Viability, some are downgraded when assessed even though this assessment work has shown an improvement in initial grading by the community staff.
- Medication incidents in both Community and Acute remain in common cause, although Community the rate persists at 0 whilst in Acute it fluctuates with a mean of 0.05.

Metric	Value	Target	Exec Lead	Ops Lead
Pressure Ulcers Cat 3/4/STDI and Unstagea...	1.48	0.77	Helen Dobson	Victoria Hazeldine
Pressure Ulcers Cat 3/4/STDI and Unstagea...	0.11	0.06	Helen Dobson	Victoria Hazeldine
Medication Incidents - Moderate and Abov...	0.16	0.05	Jo Beahan	Victoria Hazeldine
Medication Incidents - Moderate and Abov...	0.00	0.00	Jo Beahan	Victoria Hazeldine

What actions are planned?

- The metric for medication incidents has now been set for moderate harms and above. This has taken into account the past 2 years data to provide a reasonable target score.
- Pressure Ulcer Investigation Tool completion and presentation at Harm Free panel is working well with action plans developed and worked through where further learning has been identified. Staff report that the process is helpful to them.

What is the expected impact?

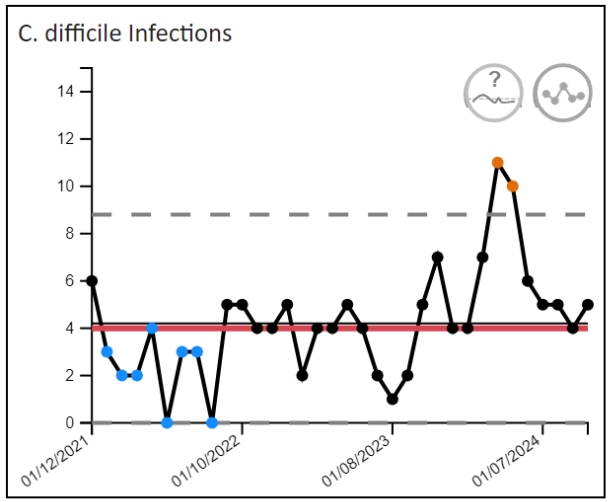
- Reduction in the number of moderate and above medication incidents.
- Reduction in the number of CAT 3/4/SDTI and unstageable pressure ulcers
- Clearer understanding of where the highest area of risk in between community and acute

Potential risks to improvement?

- Increase in the number of patients admitted to acute Trust with complex health problems and additional bed capacity, resulting in reduced nursing and medical ratios

Subtheme: Infection Prevention & Control

Data, Context and Explanation



- Clostridium difficile (C. diff) is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It can usually be treated with a different type of antibiotic.
- The first two months of 24/25 showed significantly higher than expected rates. This is also in line with increased national rates of C. diff.
- Learning from harm is reviewed monthly at Harm Free Care panels and the emerging themes linked to antimicrobial stewardship and prescribing practices. Action are in place to address (see planned action box). It is noticeable that, at present, we will continue to see infections higher than target.
- Nationally there is a trend for increasing rates of C. diff with a renewed focus on AMR. Rates per 100,000 bed days from UKHSA have been published for Q1 highlighting the Trust as an outlier for that period.

Metric	Value	Target	Exec Lead	Ops Lead
C. difficile Infections	5	4	Helen Dobson	Jen Hilton

What actions are planned?

- Harm Free panel continues with continued themes on antibiotic prescribing identified.
- National Standards of Healthcare Cleanliness (2021) have been re-launched.
- New microbiologist appointed and started 18 November
- Antimicrobial pharmacist to consider using EPMA to set a stop date for antibiotics and introduce a process where antibiotics have permission codes issued to allow prescribing

What is the expected impact?

- A Reduction in case of C. diff and associated per 100,000 bed day rate

Potential risks to improvement?

- Heavy promotion of Sepsis pathway and common prescribing of co-amoxiclav within the pathway resulting in use of antibiotics without proven bacterial infection

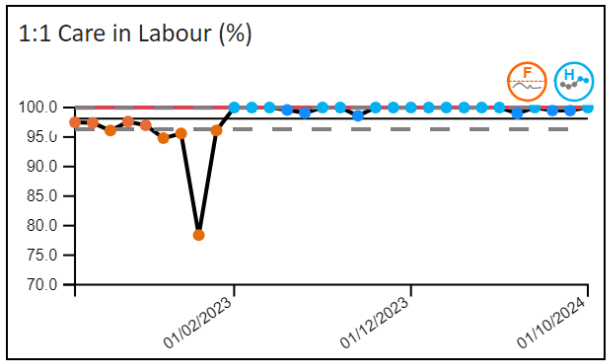
Maternity

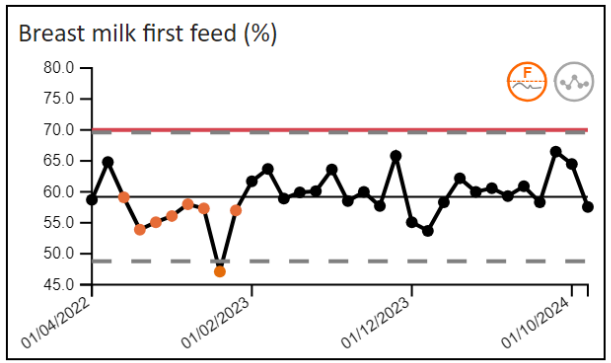
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	100	Sep-24	✗	F	H	-	CI
Breast milk first feed (%)	70.0	57.6	**Oct-24**	✗	F			C
Stillbirth rate (per 1000 births)	4.66	4.0	**Oct-24**	✓	P	H	-	C

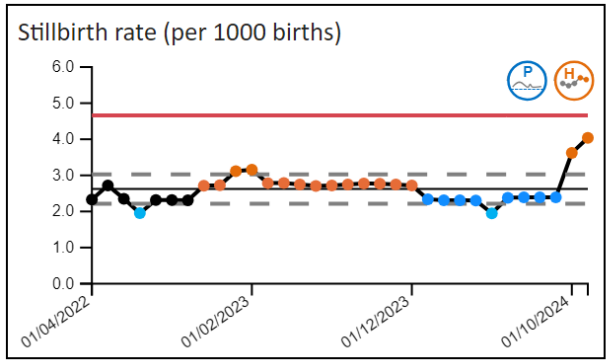
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Maternity

Data, Context and Explanation







- 1:1 care in labour remains at a high performance level, This data is monitored through the Maternity Birth Rate plus Acuity tool to provide assurance for Maternity incentive scheme. Performance on the tool is 100% for August.
- Breast Milk First Feed % continues to be below the Trust target, with an average of 59.9 % against a Trust target of 66%.
- Work is ongoing to educate and support families regarding the benefits of breast milk. TRFT Maternity services are working with partners to support this supporting the Unicef Baby Friendly (BFI) infant feeding standards.
- In September/ October and November the Maternity service reported 5 stillbirths over a 5 week period. This has increased the adjusted stillbirth rate to 3.62 per 1000.

Metric	Value	Target	Exec Lead	Ops Lead
1:1 Care in Labour (%)	100.0	100.0	Helen Dobson	Sarah Petty
Breast milk first feed (%)	57.6	70.0	Helen Dobson	Sarah Petty
Stillbirth rate (per 1000 births)	4.0	4.66	Helen Dobson	Sarah Petty

What actions are planned?

- 1:1 care in labour is a standard for CNST, birth rate plus data is monitored through maternity and neonatal safety paper to monitor compliance. This is to ensure that all women in labour on labour ward receive 1:1 care.
- Breast milk first feed: Unicef Baby Friendly action plan to achieve standards for BFI, working in collaboration with RMBC and 0-19. Actions have included High standards of parent information and education on breast feeding, working with partners in Family hubs to improve infant feeding support.
- Stillbirth rate: Due to the cluster of stillbirths seen over a 5 week period a thematic review has been undertaken. The Local Maternity and Neonatal System have been invited to undertake an independent review of the stillbirths. This is scheduled for the 29th November 2024.

What is the expected impact?

- Performance to be maintained supporting safe staffing as detailed in the bi annual staffing paper/escalation policy for TRFT.
- Achieving BFI accreditation ensures that TRFT meet the required standards to support infant feeding standards across the service. The Three year delivery plan recommends that this is achieved by March 27
- The thematic review undertaken by TRFT did not identify any immediate learning, the themes identified were deprivation and mental health, we are awaiting the LMNS external review for further assurance .

Potential risks to improvement?

- Maintain birth rate plus establishment setting requirements and backfilling maternity leave and gaps above headroom supports safe staffing on every shift
- Infrastructure and support to gain BFI including training. To maintain partnership working with RMBC.
- The cluster of 5 stillbirths together will impact on the rolling stillbirth figure for the next 12 months.

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 • Mean LoS (Elective)	**GOOD: CELEBRATE AND UNDERSTAND** • OP to PIFU • 31 Day Treatment Standard	**CONCERNING: CELEBRATE BUT TAKE ACTION** • 65+ weeks • RTT
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND**	**STATIC: INVESTIGATE AND UNDERSTAND** • Waiting List Size • OP to PIFU • Overdue Followups • DM01 • FDS • 62 Day Treatment Standard • >12 hours in A&E • 12 hour Trolley Waits • Bed Occupancy • LoS >21 Days • Date of Discharge = Discharge Ready Date • Patients on Virtual Ward • First Outpatients (%Plan) • Inpatients (%Plan) • Daycases (%Plan) • LoS >7 Days • Mean LoS (Non-Elective) • A&E Attendances from Care Homes	**CONCERNING: INVESTIGATE & TAKE ACTION** • 4 Hour Performance • Ambulance Handovers >30min • Average time to be Seen • Criteria to Reside is No • Admissions from Care Homes • Clinic Utilisation • Capped Theatres Utilisation • Did Not Attend • Discharged <5pm
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • 52+ weeks

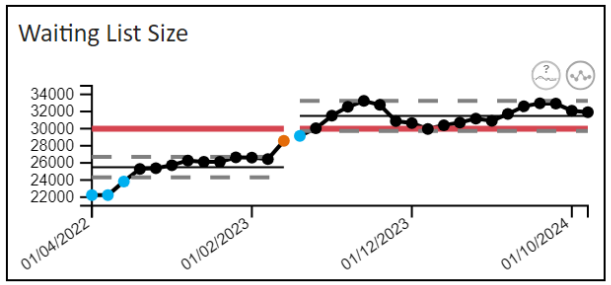
Elective Care and Cancer

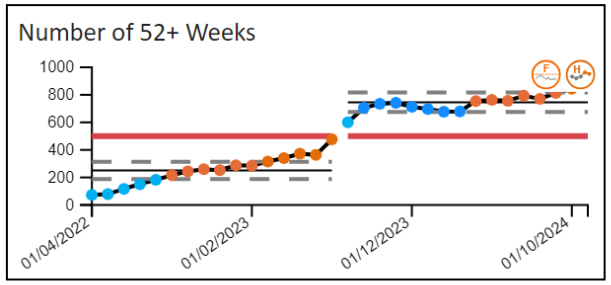
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	30,000	31,925	Nov-24	✗	?			S
Number of 52+ Weeks	500	890	Nov-24	✗	F	H		VC
Number of 65+ Weeks	0	0	Nov-24	✓	F	L		CI
Referral To Treatment (%)	92.0	62.6	Nov-24	✗	F	H		CI
OP Activity moved or Discharged to PIFU (%)	2.5	2.8	**Oct-24**	✓	?			S
Overdue Follow-ups	-	16,308	Nov-24	-	-		-	S
DM01 (%)	1.0	1.0	**Oct-24**	✓	?			S
Faster Diagnosis Standard (%)	77.0	80.2	Oct-24	✓	?			S
31 Day Treatment Standard (%)	96.0	99.1	Oct-24	✓	?	H		G
62 Day Treatment Standard (%)	70.0	74.6	Oct-24	✓	?			S

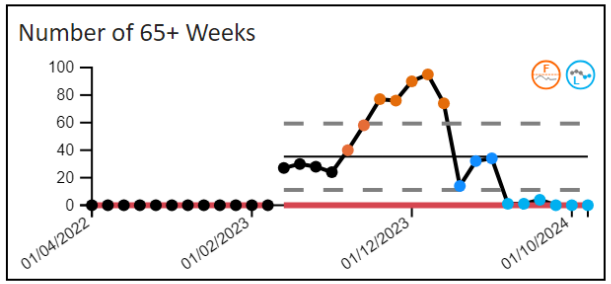
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

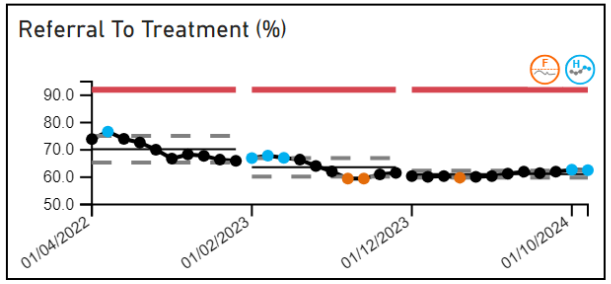
Subtheme: Long Waiters

Data, Context and Explanation









- The number of patients on our RRT waiting list continues to be within normal variation, with a slight in month reduction being seen.
- The Trust had committed to reducing the number of patients waiting over 52 weeks by 50% by March from 755 to 500. We are currently seeing an impact on elective orthopaedic capacity due to an increase trauma, and delivery of this ambition remains challenging.
- 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 achieved 0 breaches in Sept-24 and have maintained this through to Nov-24. We continue to focus on sustaining this position.
- A review of the existing transformation programme, supported by GIRFT Further Faster 20 is progressing at pace. This work aims to see us reach our Trust ambition to achieve RTT performance of 92% in a minimum of 5 specialties. Rheumatology, Stroke, and Geriatric Medicine are now achieving compliance with the RTT standard, however, Respiratory were just short at 91% in Nov-24.
- The last 5 months have begun to show increased performance levels, with November's RTT performance being significantly better than the preceding months.

Metric	Value	Target	Exec Lead	Ops Lead
Waiting List Size	31,925	30,000	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks	890	500	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	0	0	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	62.6	92.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Roll out light-touch electronic triage for low-risk patients, improve processes for shutting down underutilised lists, and develop clear booking guidelines for theatres
•Conduct validation of booked theatre lists using PowerBI, finalise theatre SOPs, and install TVs in theatre reception to display real-time flow data
•External reviews planned in December as part of the FF20 programme to review Theatre/Anaesthetic processes

What is the expected impact?

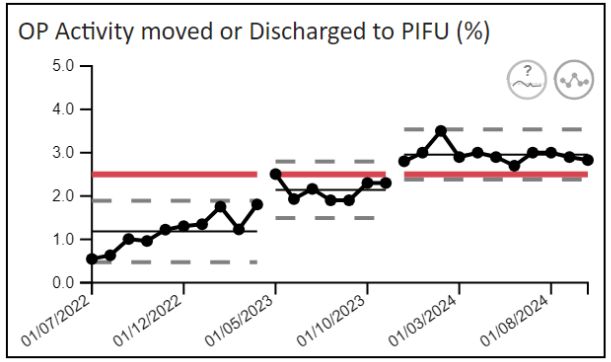
•Optimised booking and triage workflows to reduce delays and improve patient outcomes, with full impact anticipated by March 2025
•Increased theatre efficiency and reduced cancellations, with visible improvements by January 2025
•Full review of the existing transformation programme, enabling us to go further faster with a key focus on ENT paediatrics, orthopaedics, gynaecology specialties from January 2025

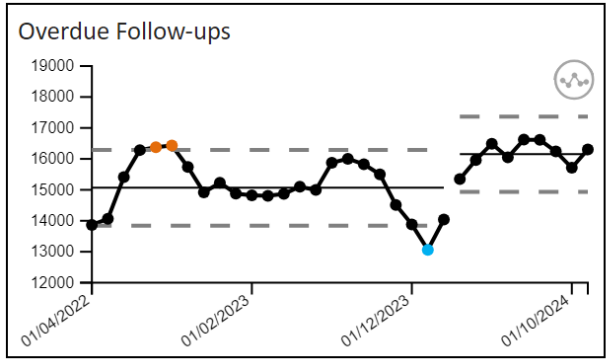
Potential risks to improvement?

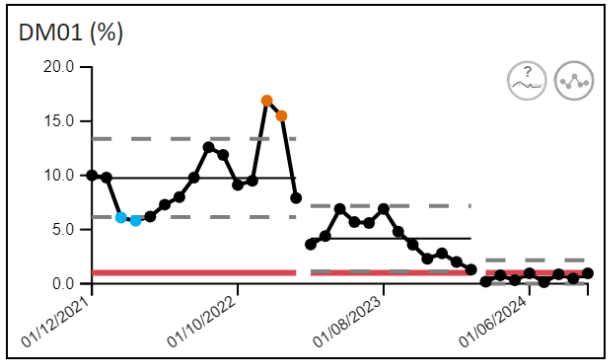
- Operational pressures could divert resources and delay the implementation of planned actions i.e. HDU capacity, elective activity
- Limited staff availability, high sickness rates, and change fatigue may impact the adoption of new processes and technologies
- Availability of financial resource to support additional activity
- Risk of identification of long waits through enhanced validation of waiting list.

Subtheme: Diagnostics & Follow-ups

Data, Context and Explanation







•The 2024/25 national planning guidance set an objective to continue to implement outpatient transformation approaches, including patient-initiated follow-up (PIFU).

•The Trust set the objective to ensure 1.5% of patients waiting for an outpatient follow-up appointment is moved or discharged to PIFU, by Mar-25. We have seen significant improvement in this area from Dec-23, which is currently holding steady around 2.5%

• The last 8 months have seen a step change in the average number of overdue follow ups, with notable increases seen in Ophthalmology, Respiratory, Dermatology, ENT and Rheumatology. This does look to be reducing in recent months.

•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 met this standard, so set an internal ambition to maintain performance at 99% for 24/25. The Trust has maintained this achievement since Mar-24.

Metric	Value	Target	Exec Lead	Ops Lead
OP Activity moved or Discharged to PIFU (%)	2.8	2.5	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	16,308	-	Sally Kilgariff	Andrea Squires
DM01 (%)	1.0	1.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Roll out PIFU SOP across all services, incorporating specialty-specific clinical protocols
•Train healthcare assistants in additional tasks, review outpatient clinic utilisation data to identify opportunities, and ensure consistent room booking practices across outpatient areas
•Demand & Capacity Planning continues to be progressed for 2025/26
•Mutual aid continues to be accessed to support Endoscopy capacity following the addition of surveillance patients to the active DM01 wait list in September 2024

What is the expected impact?

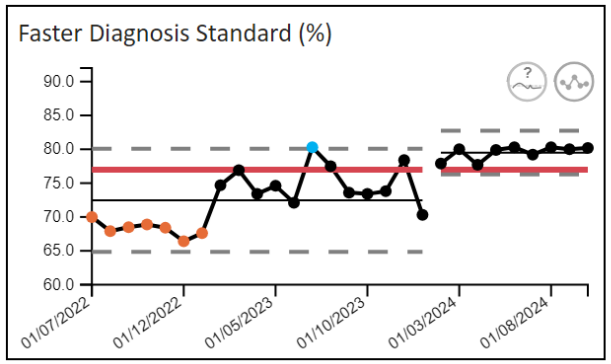
Streamlined follow-up processes and improved patient engagement, with measurable outcomes expected by January 2025
• Better clinic utilisation and expanded service capacity, with progress expected by February 2025
•Services will identify gaps in service provision and develop 'closing the gap' plans to support 2025/26 planning cycle for submission on 16 December 2024
•Sustainability of DM01 performance through to March 2025

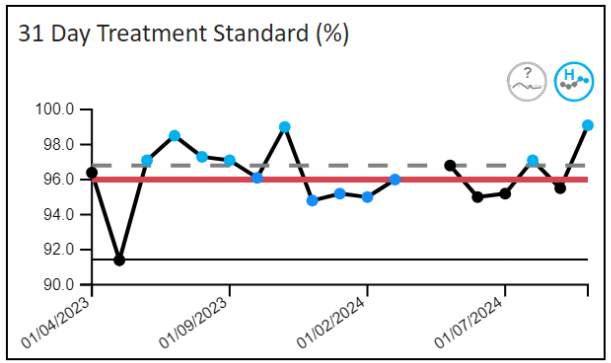
Potential risks to improvement?

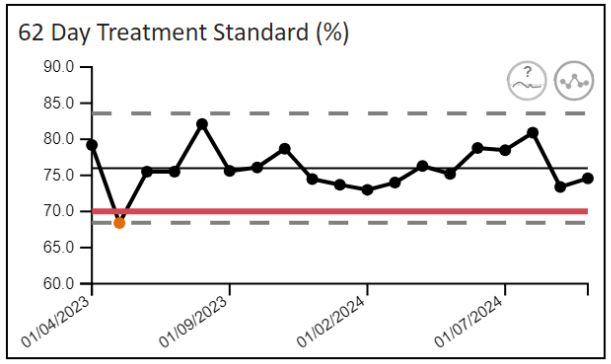
- Addition of overdue surveillance patients in endoscopy to DM01 from September 2024 requiring additional capacity may impact on DM01 performance
- Availability of financial resource to support additional activity.
- Impact of the transfer of long waits in DM01 as part of any mutual aid agreements across the system.
- Limited staff availability, high sickness rates, and change fatigue may impact the adoption of new processes and technologies

Subtheme: Cancer

Data, Context and Explanation







•In 2024/25, the national planning guidance set an objective to improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025. 8 out of the last 9 months have achieved the national target, with average performance at 79% since Feb 24. We continue to work towards consistently achieving this standard and have set a further ambition to improve performance to 80% by March 2025.

•The 31-day standard continues to show normal variation patterns. The Cancer Improvement Team are focusing support in Skin to improve this standard.

•The national planning guidance also sets the objective to improve the 62-day Referral-to-Treatment performance to 70% by Mar-25.

• As the Trust is consistently achieving this standard, we have set a further ambition to improve performance to 77% by March 2025. The trust continues to meet this target, and current variation/process indicates that it is extremely unlikely that performance will fall below target levels, however it is not impossible.

Metric	Value	Target	Exec Lead	Ops Lead
Faster Diagnosis Standard (%)	80.2	77.0	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	99.1	96.0	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	74.6	70.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Implement targeted interventions to improve performance and reduce breaches in urology.
•Ensure sustained delivery of the 77% national 62 Day target through focused operational improvements
•Investigate deviations around the 96% 31 Day target to identify root causes and develop corrective actions
•Continue monitoring the impact of previous interventions and refine strategies to sustain the local FDS stretch target of 80%

What is the expected impact?

•Reduce urology breaches through enhanced scheduling and capacity improvements, with initial impact expected by February 2025
•Ensure timely diagnostics and treatments to sustain compliance with the 77% 62 Day target, with improvements visible by February 2025
•Address root causes of variability in 31 Day pathway to achieve more consistent performance, with significant progress by February 2025
•Sustain the 80% FDS stretch target by March 2025

Potential risks to improvement?

•Lack of capacity in key areas such as diagnostics, clinics, or staffing to accommodate additional workload for targeted interventions, particularly in urology
•Ongoing operational demands and emergency cases could divert resources and delay the implementation of planned actions i.e. HDU capacity for LGI
Resistance from clinical and operational teams to adopt new processes or prioritise changes due to change fatigue or competing priorities

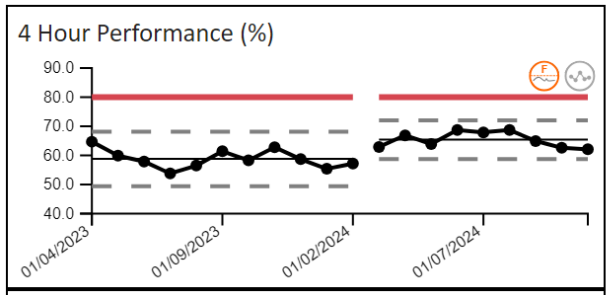
Non-elective and Flow

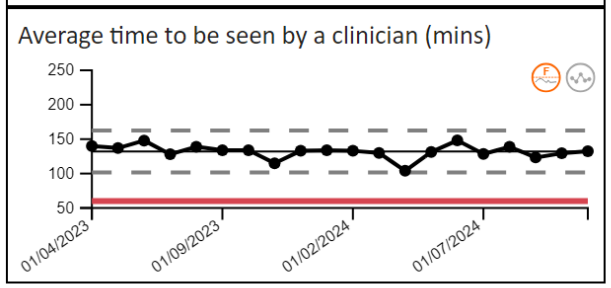
Metric	Trust Target	Latest Data	Period	Achieved (in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	80.0	62.1	Nov-24	☒	F			C
Ambulance Handover Times >30 mins (%)	0.0	18.9	Nov-24	☒	F			C
Average time to be seen by a clinician (mins)	60.0	132.3	Nov-24	☒	F		-	C
Patients spending >12 hours in A&E from time of arrival (%)	2.0	4.6	Nov-24	☒	?			S
12hr Trolley Waits	0	16	Nov-24	☒	?		-	S
Bed Occupancy (%)	92.0	90.4	Nov-24	☑	?			S
Length of Stay over 21 Days	64	49	Nov-24	☑	?		-	S
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	83.1	Aug-24	☒	?		-	S
Criteria to Reside is No (%)	10.0	20.4	Nov-24	☒	F		-	C

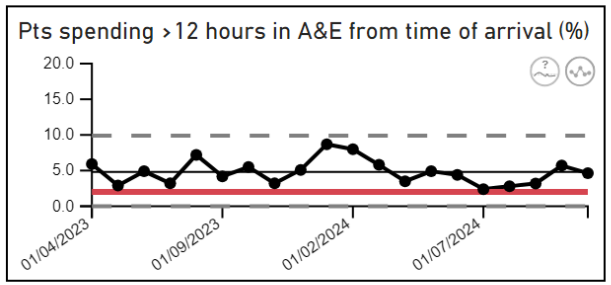
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

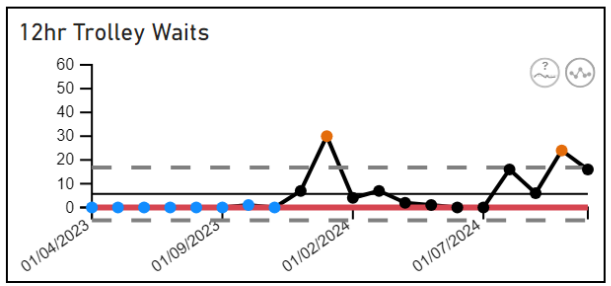
Subtheme: Emergency Care - Waiting Times

Data, Context and Explanation









- National guidance set an objective for all Trusts to achieve the 4 hour performance standard of 78% by March 2025. While performance falls below this standard, there is sustained improvement in this area, which is now performing at a stable average of 67%.
- Average time to see a clinician remains in a natural variation pattern. The consistent increase in demand continues to challenge further improvements.
- The number of patients spending more than 12 hours in the department is a key national focus. This is increasing month on month which is further compounded by the increase in UECC attendances and increased waits for admission.
- The Trust has set a standard to achieve zero trolley waits in line with national guidance, this had been seen recently but hard to maintain over the last few month due to ongoing challenges with patient flow across the trust footprint. The ringfencing and protecting of SDEC from inpatients has resulted in some trolley waits in the short term, but improved patient flow overall.

Metric	Value	Target	Exec Lead	Ops Lead
4 Hour Performance (%)	62.1	80.0	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	132.3	60.0	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	4.6	2.0	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	16	0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Work continues to develop SDEC Pathways and improve efficiency within SDEC's
- Continued focus on 'live' SDEC dashboard
- Expansion of Radiology tracker to improve visibility of reporting (CT/MRIs)
- Additional validation by senior operational team of 4 hour breaches
- Recruitment to Clinical Vacancies (medical/ENP)
- Escalation SOP to be approved for Paediatrics although is currently in use

What is the expected impact?

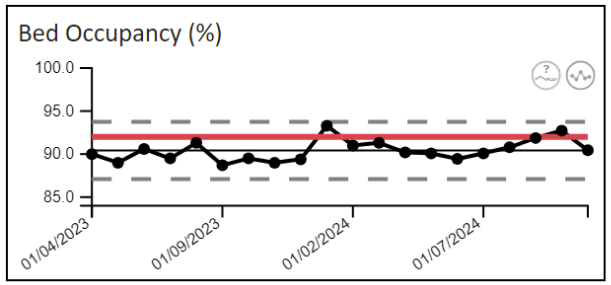
•Non-admitted performance for Primary Care, Minor Injuries will improve by March 2025
•Visibility of all SDEC area via the new dashboard, to improve flow and support SDECs to remain open even at times of high demand by January 2025
•Improvement in the total time patients spend in the department by March 2025
•Improved time to be seen by a clinician by January 2025

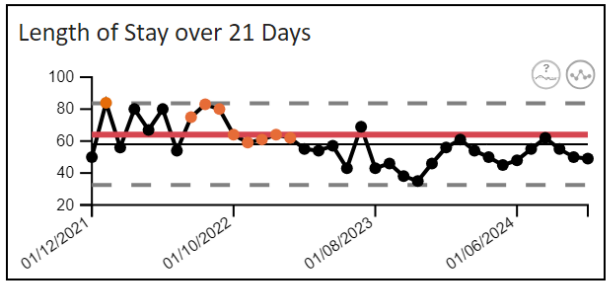
Potential risks to improvement?

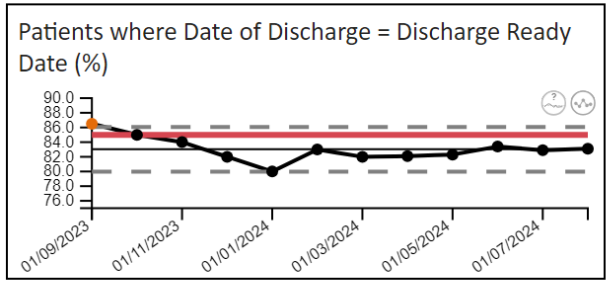
- Significant increases in demand will significantly impact the Trust ability to achieve the 4 hour performance standards.
- Medical workforce staffing through December into January particularly at Tier 4 level

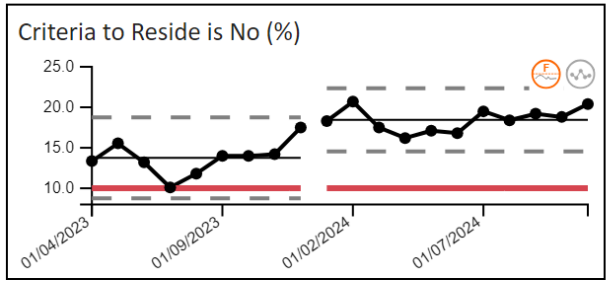
Subtheme: Inpatient Flow

Data, Context and Explanation









- Bed Occupancy for November was 90.4% this includes both core bed capacity as well as escalation capacity in line with national definition. 90.4% for Adult G&A. If we were to exclude the “escalation beds” on B5, Rockingham and SU we would be at 92.6% for Adult G&A. (B5 would be 101.7%, Rockingham would be 90.3% and SU would be 111.3%.)
- 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 holds steady below target at around 83%.
- Criteria to Reside continues to fluctuate, showing natural variation between 22% and 14%, consistently not achieving the target of below 10%. Due to challenges experienced across all discharge pathways, more focused work is planned to take place to achieve the Trust standard of 10%.

Metric	Value	Target	Exec Lead	Ops Lead
Bed Occupancy (%)	90.4	92.0	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	49	64	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	83.1	85.0	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	20.4	10.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Roll out of discharge tracker across the trust
- Length of Stay meetings changed and more focus on patients not known to IDT
- Focus on criteria to reside and internal delays
- Clear repatriation policy at place and in the trust
- Board round standardisation across medical wards

What is the expected impact?

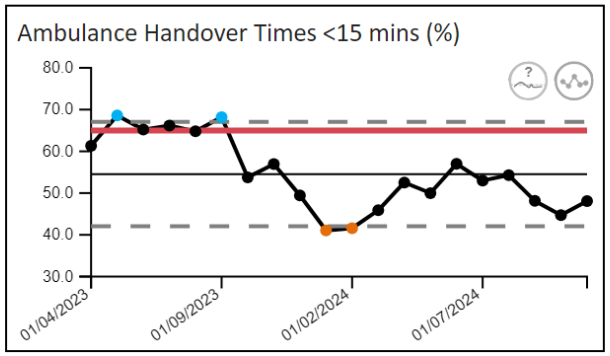
- Patients discharged on discharge ready date to reach target by March 2025
- Continued reduction in patients in hospital over 21 days by January 2025
- Reduction in those patients that have been an inpatient over 7 days by January 2025
- Reduction in numbers of patients that are Out of Areas and an increased LOS by January 2025
- Reduction in internal delays for patients waiting discharge by January 2025

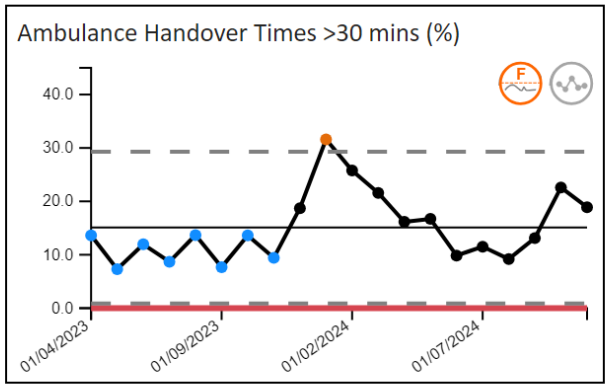
Potential risks to improvement?

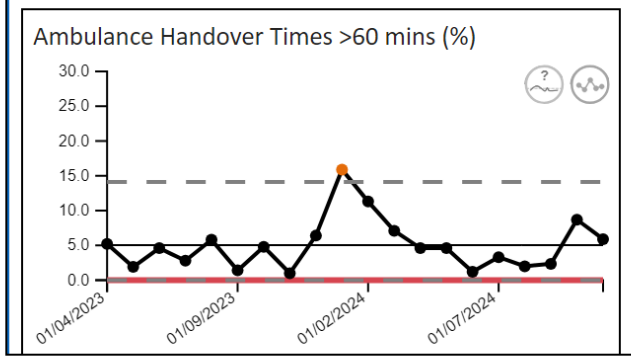
•Increase demand through UECC sustained
•De-escalation of inpatient beds not possible due to ongoing pressures
• Increased demand fails to reduce bed occupancy and additional beds will need to remain open

Subtheme: Emergency Care - Ambulance

Data, Context and Explanation







- The Operational Planning Guidance set an objective to achieve an average of 30 minutes to handover by March 2025.
- Achievement of this standard is dependent on compliance with two other standards; patients wait less than 15 minutes for handover and patients must not wait over 60 minutes for handover.
- The Trust compliance with Ambulance handover times <15 minutes remains below the standard of 65%. There is a month on month deterioration in the ability to handover within 15mins due to capacity restraints.
- For handover times >30mins, average times appeared to be falling but recent months have seen continued growth in this area due to capacity restraints within UECC at times of peak demand.
- Ambulance handover times >60 did not meet the standard of 0%. Performance levels indicate that we should expect an average of 5%, while some months may achieve 0%, the data indicates the process is not currently sustainable.
- YAS has identified the Trust as benchmarking positively.

Metric	Value	Target	Exec Lead	Ops Lead
Ambulance Handover Times <15 mins (%)	48.1	65.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >30 mins (%)	18.9	0.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	5.9	0.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- YAS and CHAT colleagues piloting new approach to support patients who have fallen and utilising community UCR
- 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

What is the expected impact?

•There will be an improvement in ambulance handover times and TRFT sustained high levels of performance by January 2025
•Pilots will support reduction in conveyance to ensure all pathways in and out of hospital are utilised by March 2025

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
• Potential increase in IPC during the winter which will require off load direct to cubicles

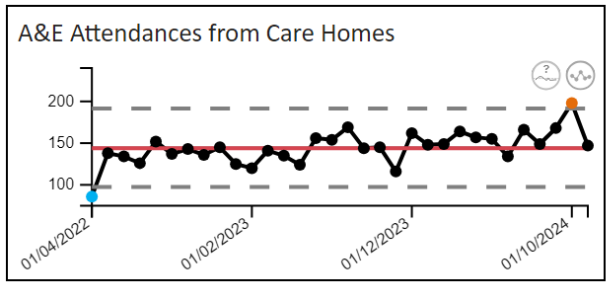
Community

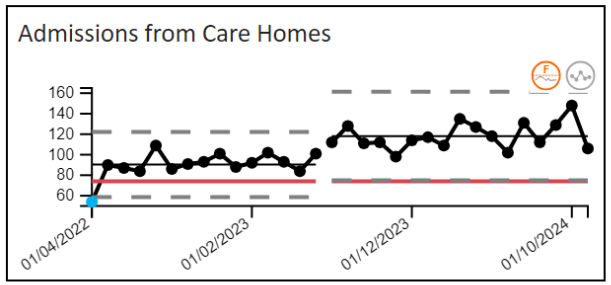
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	144	147	Nov-24	✗	?		-	S
Admissions from Care Homes	74	106	Nov-24	✗	F		-	C
Number of Patients on Virtual Ward	80	72	Nov-24	✗	?		-	S
Urgent 2 Hour Community Response (%)	70.0	79.0	Sep-24	✓	P	H	-	VG

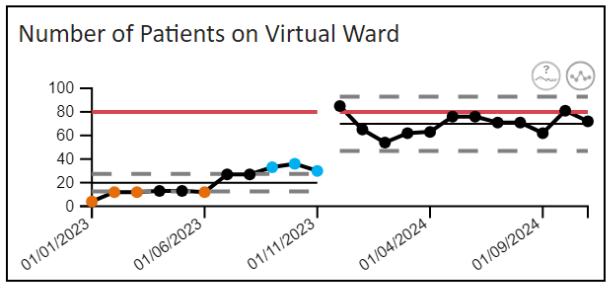
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

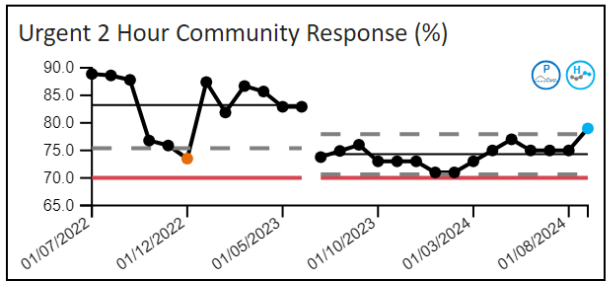
Subtheme: Community

Data, Context and Explanation









- The Community Teams, including the Trusted Assessors, continue to in reach into the Acute setting to facilitate early supported discharges for care homes residents. The Trusted Assessors also continue to build relationships with Care Home staff to ensure community pathways are considered prior to calling 999.
- Community Teams continue to work with YAS regarding the support community colleagues can provide.
- All care homes attendances and admissions are analysis each month to highlights any potential training requirements or concerns within care homes

- The number of patients on Virtual Ward has decreased in month. In November there was an average of 63 patients being cared for against a Trust standard of 80. Occupancy reached a peak of 78 on the 1 November and 73 on 30 November. Capacity was impacted by sickness in month.

- The National standard for the 2 hour urgent community response is 70% of appropriate referrals. The trust is consistently meeting this target, and recent performance indicated this is now at a level where is can sustainably met the standard. The forecast position for October 77%, November 78%

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances from Care Homes	147	144	Sally Kilgariff	Penny Fisher
Admissions from Care Homes	106	74	Sally Kilgariff	Penny Fisher
Number of Patients on Virtual Ward	72	80	Sally Kilgariff	Penny Fisher
Urgent 2 Hour Community Response (%)	79.0	70.0	Sally Kilgariff	Penny Fisher

What actions are planned?

- Continue to embed the role of Trusted Assessors and monitor impact.
- Monitor the Virtual Ward Heart Failure pathway.
- Test remote technology with a small number of heart failure patients
- Ongoing review of specialist planned nursing activity to identify any UCR activity, including a review of the Directory of Service and Data quality.

What is the expected impact?

- Reduce conveyance from Care Homes to UECC and admission from Care Homes
- Increased offer to patients and increased referrals to Virtual Ward, thereby increasing our Virtual Ward bed utilisation.
- Improved categorisation of patients into three general acuity levels
- Continue to increase patient volumes and improved systems and processes, along with staff well-being.

Potential risks to improvement?

- Resource availability may impact on the ability to deliver improvement work.
- Workforce retention and wellbeing may impact on the ability to deliver improvement work

Productivity Priorities

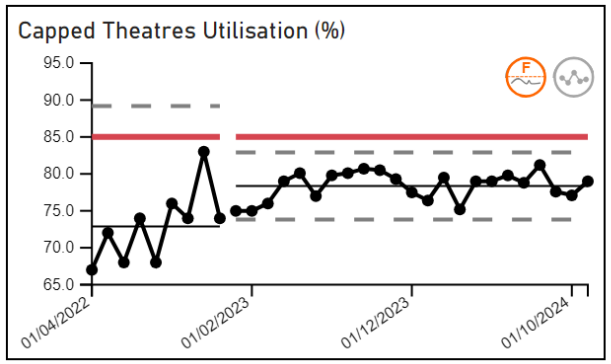
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%)	85.0	78.2	Nov-24	✗	F		-	C
Capped Theatres Utilisation (%)	85.0	79.0	Nov-24	✗	F			C
Did Not Attend (%)	7.0	7.4	Nov-24	✗	F			C
First Outpatients (% of Plan)	100.0	102.0	Nov-24	✓	?			S
Inpatients (% of Plan)	100.0	101.0	Nov-24	✓	?		-	S
Daycases (% of Plan)	100.0	107.0	Nov-24	✓	?		-	S
Length of Stay over 7 days	-	187	Nov-24	-	-		-	S
Mean Length of Stay (Non-elective)	-	5.2	Nov-24	-	-			S
Mean Length of Stay (Elective excluding Daycases)	-	2.2	Nov-24	-	-	L		GI
Discharged before 5pm (%)	70.0	62.9	Nov-24	✗	F			C

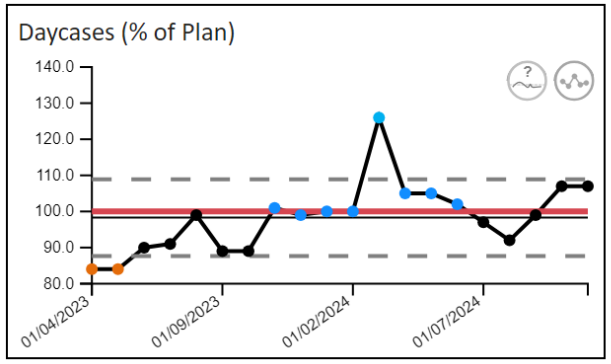
Plan is 19/20 + 3% i.e. *103% of 19/20*, therefore 100% achievement against Plan is 103% of 19/20

*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 consistent, with current utilisation at 79% against the 85% standard.
- Day case activity had been achieving plan for a number of months. Work continues across a variety of targeted specialties.

Metric	Value	Target	Exec Lead	Ops Lead
Capped Theatres Utilisation (%)	79.0	85.0	Sally Kilgariff	Jodie Roberts
Daycases (% of Plan)	107.0	100.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increased pre-op assessment sessions have been agreed to support scheduling
- Increased focus on T&O day cases
- Enhanced analysis of work that has been transferred to MEOC
- Improved utilisation of MEOC for simple cases
- Roll out of increased cases per list in Ophthalmology
- Validation of patients that are not fit for surgery

What is the expected impact?

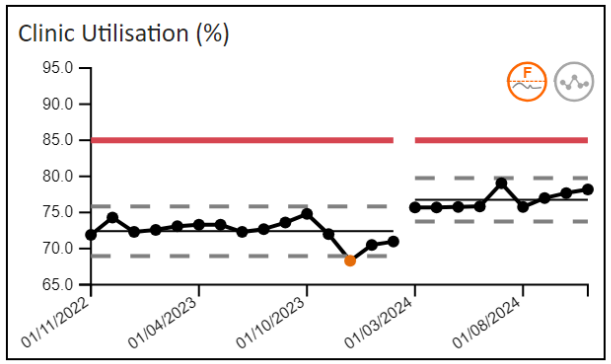
- Improvement in theatre utilisation
- Improved overall scheduling
- Increase in use of day cases theatres from T&O
- Increased day case rate in Ophthalmology
- Improvement in forward view and reducing on the day cancellations.
- Positive impact on data quality

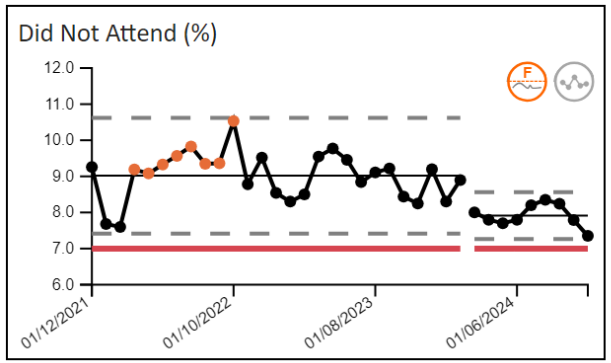
Potential risks to improvement?

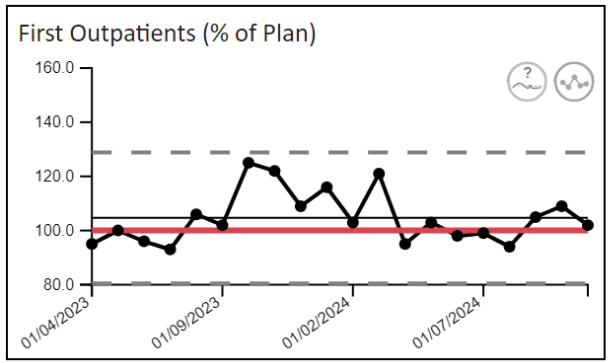
- Anaesthetic rotas may continue to impact on the ability to run theatre activity which significantly impacts on T&O in particular
- Capacity to deliver pre-op assessment may impact on patients available and fit for surgery
- High levels of theatre staff absence impacting on lists been used
- Theatre staffing remains a concern

Subtheme: Outpatients

Data, Context and Explanation







- Clinic Utilisation is key to productivity and underutilised clinics is a key focus for the Trust this year. A 4% improvement step change has been noted since Mar 24, and further incremental improvements with further work still to do to achieve the standard of 85%.
- Trust DNA rates have shown sustained reductions, holding steady around 8%, with more to do to get to the 7% target. Work is focused on meeting the needs of our local population when attending for outpatient appointments to improve attendance via digital reminders and targeted patient engagement.
- Outpatient productivity provides the organisation with the opportunity to increase activity levels and improve outcomes for patients. The last two months have performed in excess to plan, although sustained change is not yet seen.
- The Further Faster programme (GIRFT) supports each speciality in addressing their own specific productivity challenges in relation to outpatients in line with the GIRFT handbooks.

Metric	Value	Target	Exec Lead	Ops Lead
Clinic Utilisation (%)	78.2	85.0	Sally Kilgariff	Jodie Roberts
Did Not Attend (%)	7.4	7.0	Sally Kilgariff	Jodie Roberts
First Outpatients (% of Plan)	102.0	100.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increased capacity to deliver first outpatient appointments across numerous specialities to support activity levels are on-going. Funded via ERF.
- Development of PIFU module on Patient Hub to support management of patients in PIFU.
- Review Utilisation capacity and understand un-booked slots.
- Review data on discharged at first appointment to understand where triage may have biggest impact.
- Triage process being improved to enable clinicians to discharge with Advice and Guidance
- Clinic templates review on going to standardise in line with GIRFT action

What is the expected impact?

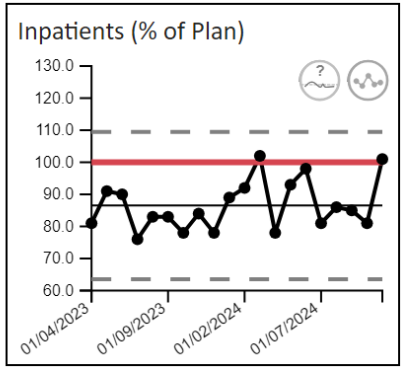
- Increase in clinic utilisation by 5% by Q3 2024/25.
- Reduction in patients that DNA to 7% by Q4 2024/25
- Increase in outpatient activity by 2% by Q3 2024/25

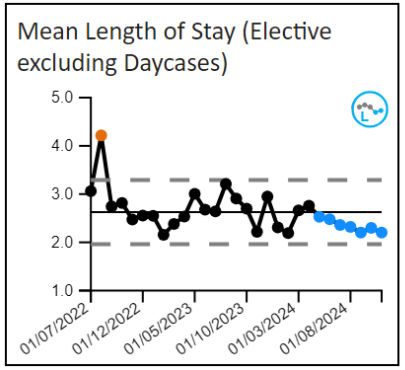
Potential risks to improvement?

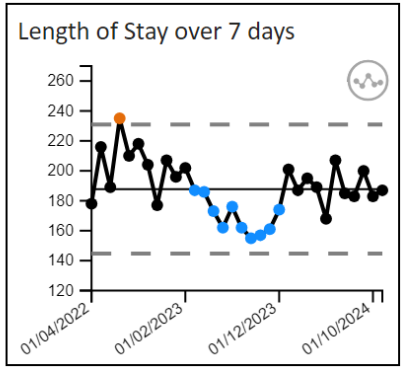
- Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
- Patient availability may impact on the ability to improve clinic utilisation, particularly short notice backfilled appointments.
- GP collective action and impact on referrals to specialities and use of advice and guidance

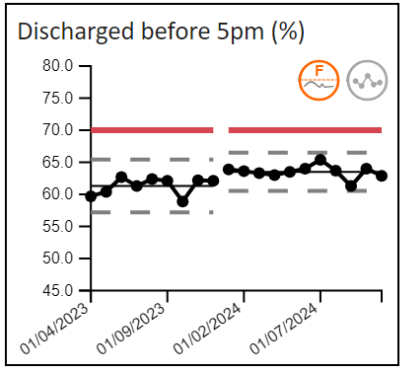
Subtheme: Inpatients

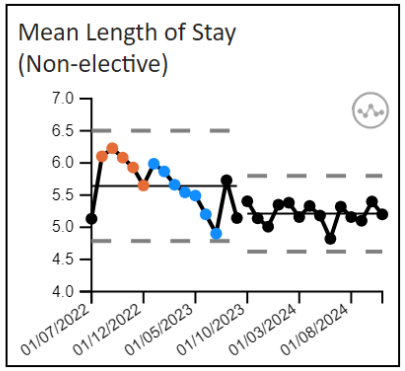
Data, Context and Explanation











- Inpatient have performed to plan for the first time in 7 months, while this remains in normal variation it is a marked in month improvement.
- Mean length of stay for **elective** patients is showing a continued downward trend over the last 6 months. Focused work to decreasing length of stay on surgical wards is imperative to support the elective recovery programme.
- Mean length of stay for **Non-elective** patients has remained stable under 5.5 days over the last 12-18 months.
- The number of patients with a LoS of 7+ days has remained static . Work continues to focus on getting patients to the right place and follow the home first approach.
- Patients discharged before 5pm has showed sustained improvement since Jan 24, although dips in current months have been noted. Work continues to focus on improving discharge rates earlier in the day. With a new discharge tracker implemented across the trust.

Metric	Value	Target	Exec Lead	Ops Lead
Inpatients (% of Plan)	101.0	100.0	Sally Kilgariff	Jodie Roberts
Length of Stay over 7 days	187	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	5.2	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	2.2	-	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	62.9	70.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increase daily numbers through the discharge lounge by 5 further patients.
- Ongoing LLOS reviews focusing on patients not known to IDT
- Focus on Internal delays to reduce patients with no criteria to reside
- Focus on LOS in surgical specialities
- Focus on patients waiting over 7 days to reduce LOS overall
- Opening of Community Ready Unit on Sundays through Winter to support earlier discharges

What is the expected impact?

- Increase number of patients discharged before 5pm to 70% by Q3 2024.
- Reduction of 7 day LOS patients by 10%
- Continued reduction in average LOS for elective inpatients
- Increased number of discharges earlier in the day supported by CRU opening on a Sunday

Potential risks to improvement?

- Increased complexity of patients and a reliance on out of hospital care
- Increased number of beds open to deal with demand and thorough discharge planning ahead of time, with no additional resource to support both internally and externally
- Ability for the CRU to manage significant increase in numbers and transport to support earlier discharge (peaks and troughs in demand)
- Additional beds and demand on medical and nursing workforce

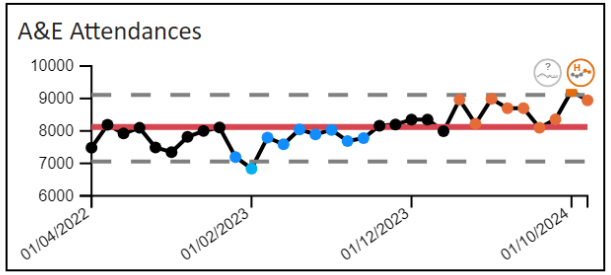
Activity

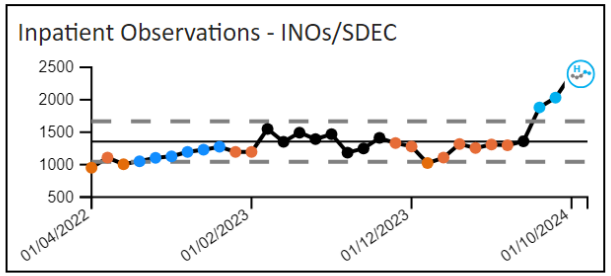
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances [Block]	8,124	8,946	Nov-24	☒	?	H	-	C
Inpatient Observations – INOs/SDEC [Block]	-	2,262	Nov-24	-	-	H	-	G
Non-Elective Inpatients [Block]	-	2,554	Nov-24	-	-	H	-	C
Outpatients Follow Up - Attendances [Block]	14,699	15,545	Nov-24	☒	?		-	S
Daycases [ERF]	1,999	2,139	Nov-24	☑	?		-	S
Inpatients - Electives [ERF]	352	354	Nov-24	☑	?		-	S
Outpatients New - Attendances [ERF]	6,049	6,170	Nov-24	☑	?		-	S
Outpatient Procedures - New and Follow Up [ERF]	4,767	4,817	Nov-24	☑	?		-	S
Referrals [Outpatient Demand]	-	8,203	Nov-24	-	-		-	S
2ww Referrals [Outpatient Demand]	-	1,166	Nov-24	-	-		-	S

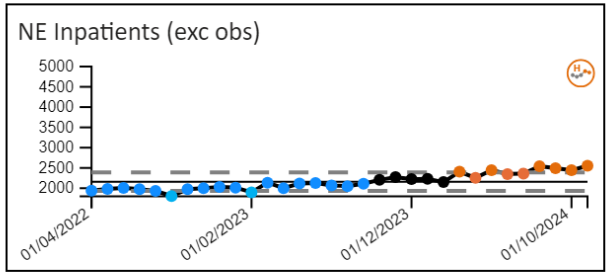
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

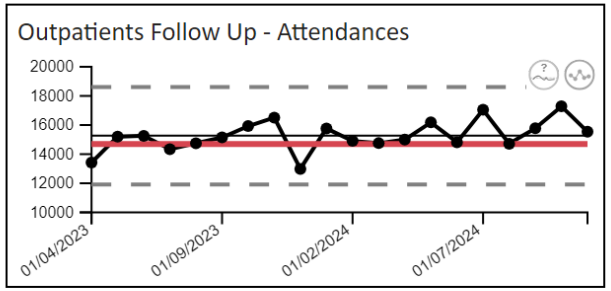
Subtheme: Block

Data, Context and Explanation









- Key activity lines on block contract are based on 23/24 M10 forecast outturn (block funding will not directly reflect activity)
- Block contracts do not allow additional income generation where activity lines are over performing
- A&E attendances are above plan both in-month (+13%) and year-to-date (10%).
- Non-Elective admissions (excluding obs/SDEC) have been increasing month on month.
- Outpatient Follow-ups continue to significantly over perform both in-month (and year-to-date) however some of these are expected to convert to Procedures when the activity recording issues are resolved. It is anticipated there will be a reduction in follow-up activity as a consequence.
- The Trust has significant follow-up backlogs therefore over performance is expect to continue/increase whilst we look to clear these.

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances	8,946	8,124	Sally Kilgariff	Jodie Roberts
Inpatient Observations - INOs/SDEC	2,262	-	Sally Kilgariff	Jodie Roberts
NE Inpatients (exc obs)	2,554	-	Sally Kilgariff	Jodie Roberts
Outpatients Follow Up - Attendances	15,545	14,699	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Reconciliation of SDEC activity against Non-Elective under performance
- 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
- Identify any areas of correlation between non-elective pressures and reduction in elective procedures (impacting ERF)

What is the expected impact?

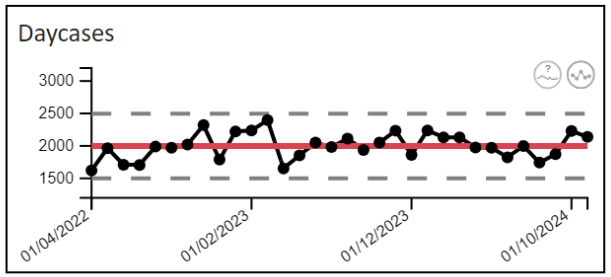
- Confirm SDEC/NEL activity is accurately being reflect in the data submission/contract monitoring. Fully understand the impact of EDS4.
- Ensure accurate record keeping for A&E attendances (should the contract mechanism change in the future this could potentially impact any re-basing)
- Identify areas of above national/peer average new to follow-up ratios and initiate further review to understand why

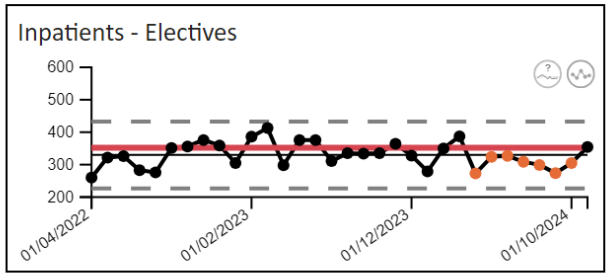
Potential risks to improvement?

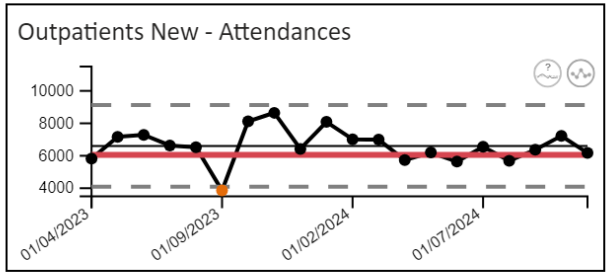
- Despite being on block, all key lines require scrutiny to ensure the Trust a) understands how this is impacting on financial performance b) we maintain an accurate position to safeguard changes to future contracting models
- Continuing increase in non elective demand, which is unfunded due to block contract.
- Switches of activity to SDEC could impact on any future re-basing (contract team aware)

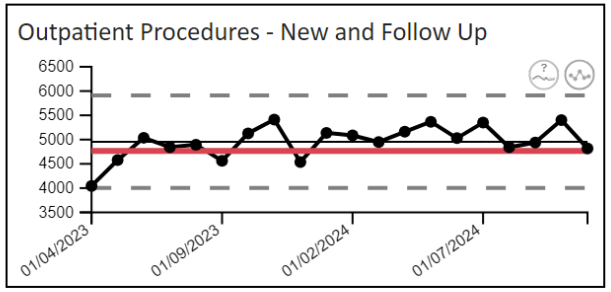
Subtheme: ERF

Data, Context and Explanation









- ERF contracted activity targets are based on 19/20 actuals + 3% (24/25 plans include the 3% increase)
- ERF lines operate on a cost and volume basis as per National Planning Guidance
- In October the new tariff price uplifts for the pay award have been transacted on both plan and actuals
- In-month Daycase activity is 264 above planned activity levels. Casemix has seen a significantly improvement at October flex position and in-month 8 is only £13k below plan. Ophthalmology, General Surgery, T&O, OMFS are the biggest contributors to the year-to-date under performance but improvements are being made
- In-month Elective is 3 above activity plan and £29k above income plan. General Surgery, T&O, Urology are the biggest contributors to the year-to-date under performance but improvements are being made
- In-month Outpatient New Attendances are 121 above planned levels with income at £59k above plan.
- In-month Outpatient Procedures are 50 above activity plan and £59k above income plan.

Metric	Value	Target	Exec Lead	Ops Lead
Daycases	2,139	1,999	Sally Kilgariff	Jodie Roberts
Inpatients - Electives	354	352	Sally Kilgariff	Jodie Roberts
Outpatients New - Attendances	6,170	6,049	Sally Kilgariff	Jodie Roberts
Outpatient Procedures - New and Follow Up	4,817	4,767	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Additional sessions to increase Elective, Day case and Outpatient first activity from September 2024
- Outsourcing of T&O EL/DC activity has been agreed
- Activity recording issues continue to be addressed and corrected
- Issues with an external/internal system synchronisation continue to be identified and urgently addressed
- Analysis of Day Case activity by HRG

What is the expected impact?

- Internal additional sessions and insourcing/outsourcing schemes will support delivery against the 24/25 ERF target and contribute to improving the income position.
- Correction of activity recording issues will ensure activity is correctly aligned and the appropriate income is received.
- Agreement of waiting list initiative payments is likely to increase uptake of additional sessions by internal staff therefore reducing the need for ongoing external resource and reducing costs associated with theatre staff insourcing

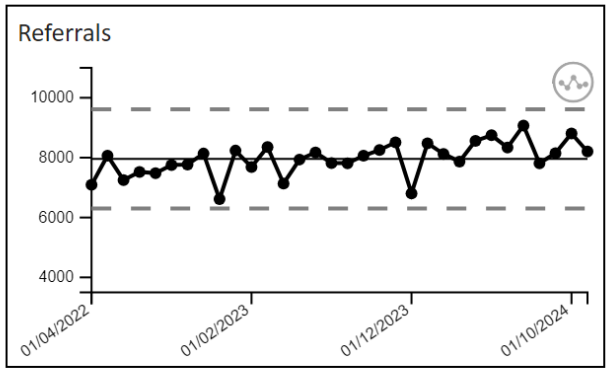
Potential risks to improvement?

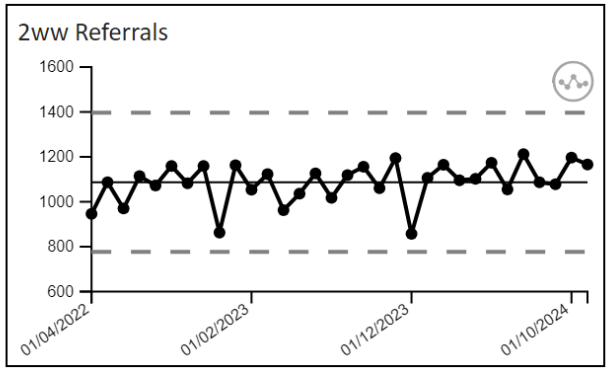
- Internal workforce (consultant and wider) to support additional sessions
- Efficient utilisation of core capacity (e.g. if core lists are stood-down or consistently underutilised, any additional sessions/insourcing will be replacing that loss of activity as opposed to delivering additional capacity)
- Work to correct the Outpatient procedure recording is much more complex than originally anticipated – however there remains a significant income opportunity
- Timely rectification of IT system data mapping issues

Subtheme: OP Demand

Metric	Value	Target	Exec Lead	Ops Lead
Referrals	8,203	-	Sally Kilgariff	Jodie Roberts
2ww Referrals	1,166	-	Sally Kilgariff	Jodie Roberts

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

What actions are planned?

- A more detailed review of referrals by specialty will be introduced into monthly Contract Compliance meetings held with Care Groups
- Identify whether duplicate referrals are being made to a range of services (often due to long waits)
- Identify appropriateness of 2WW referrals
- Review of capacity and demand to support 25/26 planning
- Increasing use of Advice & Guidance by GPs
- Capacity and Demand planning

What is the expected impact?

- Greater understanding of referral patterns internally
- Determine what discussions to have with Commissioners to identify potential solutions and work with Primary Care to ensure clinical referral protocols are being adhered to
- Agree approaches for Demand Management with Commissioners
- Communicate any new systems/processes
- Greater visibility on gaps to meet demand / activity plans based on Capacity and Demand planning

Potential risks to improvement?

- Analysis does not identify any inappropriate referrals (i.e. demand has genuinely increased)
- Analysis demonstrates sustained decreases in demand with no impact on waiting times or waiting list reductions
- Lack of engagement from Commissioners/Primary Care
- Nationally mandated targets which are non negotiable

Finance

Apr 24 to Nov 24

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)	(284)	500	784	(715)	(2,661)	(1,946)	(9,522)	(12,372)
I&E Performance (Control Total)	(223)	565	788	(223)	(2,138)	(1,915)	(9,490)	(12,343)
Efficiency Programme (CIP)	1,193	688	(505)	7,201	3,571	(3,630)	(4,063)	(4,957)
Capital Expenditure	1,060	815	245	5,999	4,315	1,684	0	0
Cash Balance	(671)	(3,491)	(2,820)	5,986	10,145	4,159	0	0

Performance Matrix Summary – People and Culture

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**EXCELLENT: LEARN AND CELEBRATE** • Turnover (12 month rolling)	**GOOD: CELEBRATE AND UNDERSTAND**	**CONCERNING: CELEBRATE BUT TAKE ACTION** • Appraisal Rates
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • MAST – Job Specific • Vacancy Rate (total)	**STATIC: INVESTIGATE AND UNDERSTAND**	**CONCERNING: INVESTIGATE & TAKE ACTION** • Sickness Rates (12 month rolling) • Sickness Rates • Appraisal Rates (12 month rolling)
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • MAST - Core	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

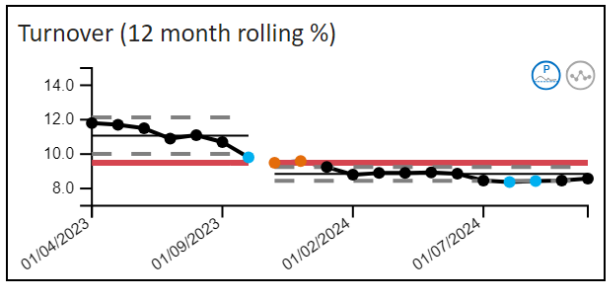
People and Culture

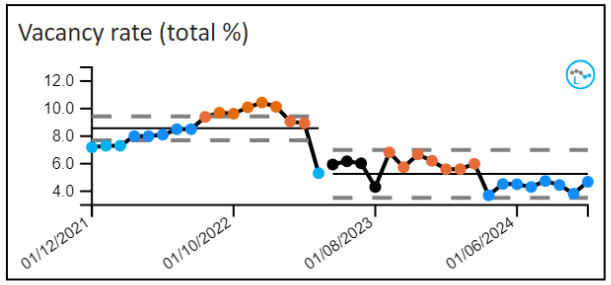
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	8.6	Nov-24	☑	P	L		VG
Vacancy Rate (total %)	-	4.7	Nov-24	-	-	L	-	G
Sickness Rates (12 month rolling %)	4.8	5.9	Nov-24	☒	F		-	C
Sickness Rates (%)	4.8	6.5	Nov-24	☒	F			C
Appraisal Rates (12 month rolling %)	90.0	80.9	Nov-24	☒	F		-	C
Appraisals Season Rates (%)	90.0	79.8	Nov-24	☒	F	H	-	CI
MAST – Core (%)	85.0	90.0	Nov-24	☑	P	L	-	C
MAST – Job Specific (%)	85.0	87.6	Nov-24	☑	P		-	G

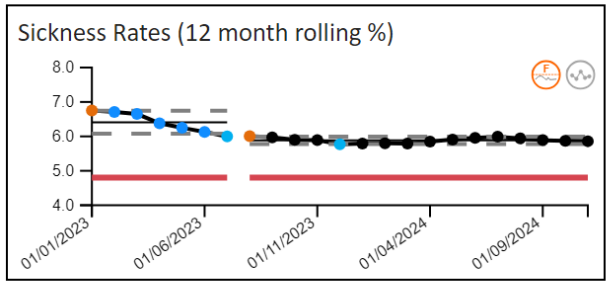
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

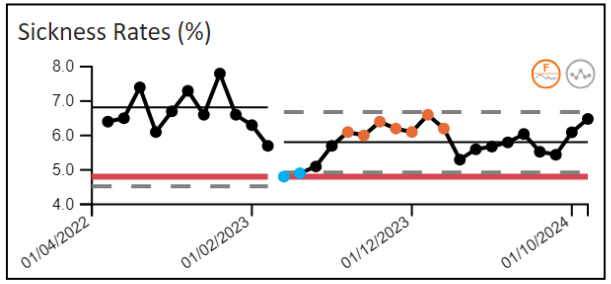
Subtheme: People

Data, Context and Explanation









- Retention performance continues to be strong and in within our target range for 2024/25 of 8-9.5%. Care Groups are all within a healthy range with more detailed breakdowns provided as part of operational management information for action where appropriate.
- Vacancy rate is in a strong position with strong recruitment campaigns for newly qualified nurses and midwives attracting success.
- Sickness absence rate performance, especially the rolling 12 month measure is now static following improvement during 2023/24 and as a result a cause for concern.
- The rate of sickness absence is been driven primarily by long term sickness absence. Links between deprivation, population health and the health and wellbeing of our people are also relevant here.

Metric	Value	Target	Exec Lead	Ops Lead
Turnover (12 month rolling %)	8.6	9.5	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	4.7	-	Daniel Hartley	Paul Ferrie
Sickness Rates (12 month rolling %)	5.9	4.8	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	6.5	4.8	Daniel Hartley	Paul Ferrie

What actions are planned?

- Continued emphasis on delivering our People and Culture strategy – 'We said, we did' action plans to drive engagement and improvement to maintain and strengthen retention and vacancy rate performance
- Comprehensive work on Health Wellbeing and Attendance including a full review of the Trust's approaches to this informed by; evidence based tools; best practice and audit work as per People and Culture Strategy
- Currently out to tender for Occupational Health Service with an emphasis in specification for more support to operational managers

What is the expected impact?

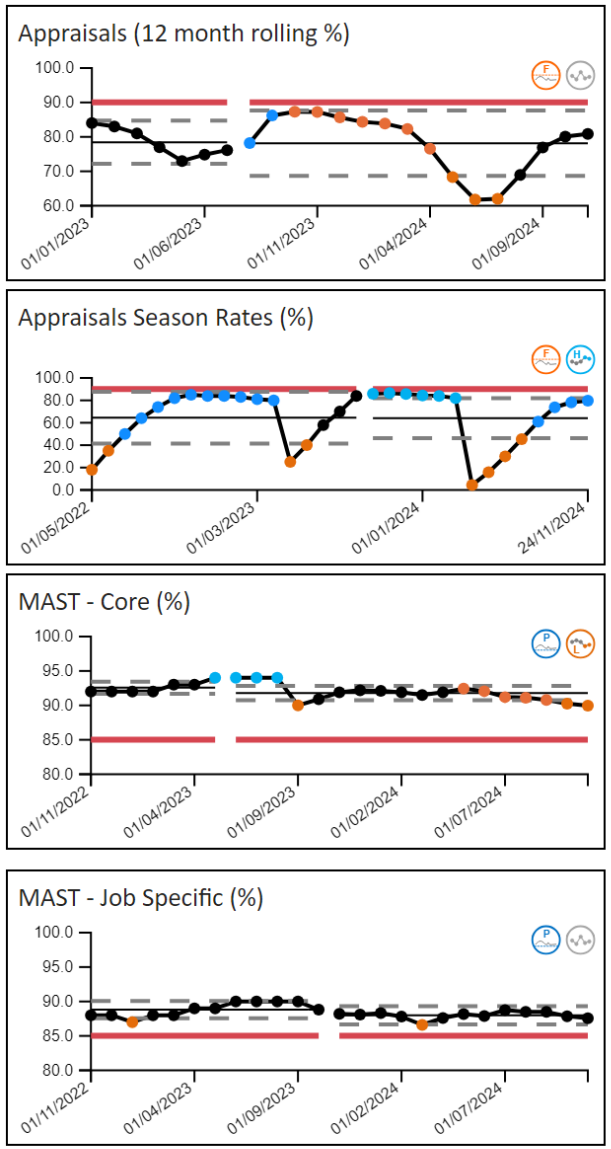
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

Potential risks to improvement?

- Continued impact of ill-health of staff on attendance

Subtheme: MAST & Appraisals

Data, Context and Explanation



- Rolling 12 month appraisal performance has begun to show an improvement as the appraisal season comes to a conclusion.
- New seasons appraisal completion rate performance is 79.8%, rolling 12 months 80.9% and is expected to improve further over the coming weeks as final appraisals are recorded onto ESR.
- 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	Value	Target	Exec Lead	Ops Lead
Appraisals (12 month rolling %)	80.9	90.0	Daniel Hartley	Paul Ferrie
Appraisals Season Rates (%)	79.8	90.0	Daniel Hartley	Paul Ferrie
MAST - Core (%)	90.0	85.0	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	87.6	85.0	Daniel Hartley	Paul Ferrie

What actions are planned?

- Focus on continued roll out and cascade of appraisals for this year using new suite of appraisal documentation which was improved based on feedback.
- Emphasis on senior leader accountability for Appraisal and MAST compliance
- Review of new national guidance around MAST, expected during 2025/26

What is the expected impact?

- Improvement in appraisal completion rates both in month and rolling 12 months
- Improvement in MAST Core and Job Specific completion rates

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

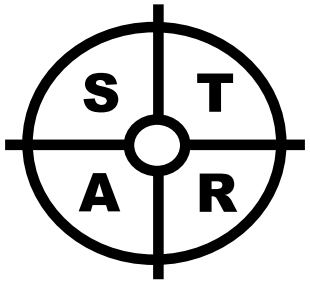
Assurance Icons

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 in the month	Local	80	
Urgent 2 Hour Community Response (%)	Proportion of standard Urgent 2 Hour Community Response (UCR) referrals seen within 2hrs.	Local	70.0	
Clinic Utilisation (%)	Proportion of Outpatient clinic slots that are utilised	Local	85.0	
Capped Theatres Utilisation (%)	Proportion of time spent operating in theatres, within the planned session time only.	National	85.0	
Model Hospital Daycase Rate (%)	The total number of Day Cases done on patients over 17 where the admission method is elective and the episode is "pre-planned with day surgery intent"	Local	85.0	
Did Not Attend (%)	Proportion of Outpatient clinic slots where the outcome was Did Not Attend	Local	7.0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
First Outpatients (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	103.0	
Inpatients (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	103.0	
Daycases (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	103.0	
Length of Stay over 7 days	Snapshot of number of Inpatients with a current LOS of 7 days or more as at month end.	Local	-	
Mean Length of Stay (Non-elective)	Average LOS for all discharged patients where the admission method is non-elective, 0 LOS are excluded and Observations are excluded.	Local	-	
Mean Length of Stay (Elective excluding Daycases)	Average LOS for all discharged patients where the admission method is elective, 0 LOS are excluded and Daycases are excluded.	Local	-	
Discharged before 5pm (%)	Proportion of patients discharged before 5pm - includes transfers to discharge lounge.	Local	70.0	

COUNCIL OF GOVERNORS MEETING: 12 February 2025

Agenda item: **COG/13/25**

Report: **Exemplar Accreditation Programme**

Presented by: **Victoria Hazeldine, Deputy Chief Nurse**
Author(s): **As above**

Action required: **For noting**

Exemplar Accreditation has now completed for year one. The program of work will continue into Year two where we hope to see more ward areas achieve Bronze Accreditation and maybe even a few Silvers.

There has been some positive improvements made and we hope that you can start to envisage how our Trust are showing the quality of care our patients receive.

TRFT Exemplar Accreditation

Presented by:
Victoria Hazeldine- Deputy Chief Nurse
Beccy Vallance- Head of Qi

WHAT IS EXEMPLAR ACCREDITATION?

- The development of a set of standards so that areas for improvement can be identified and areas of excellence celebrated.
- A comprehensive assessment on the quality of care at ward, unit and department levels; bringing key measures together into a single overarching framework.

BENEFITS

- Reduces unwanted variation; evidence based standardises approach to supporting delivery of care and improving quality.
- Drive continuous improvement in patient outcomes.
- Increase patient satisfaction.
- Improve staff experiences, which in turn can improve staff retention.
- Provides ward to board assurance.
- Creates a culture of pride and accomplishment.
- Encourages collective leadership.

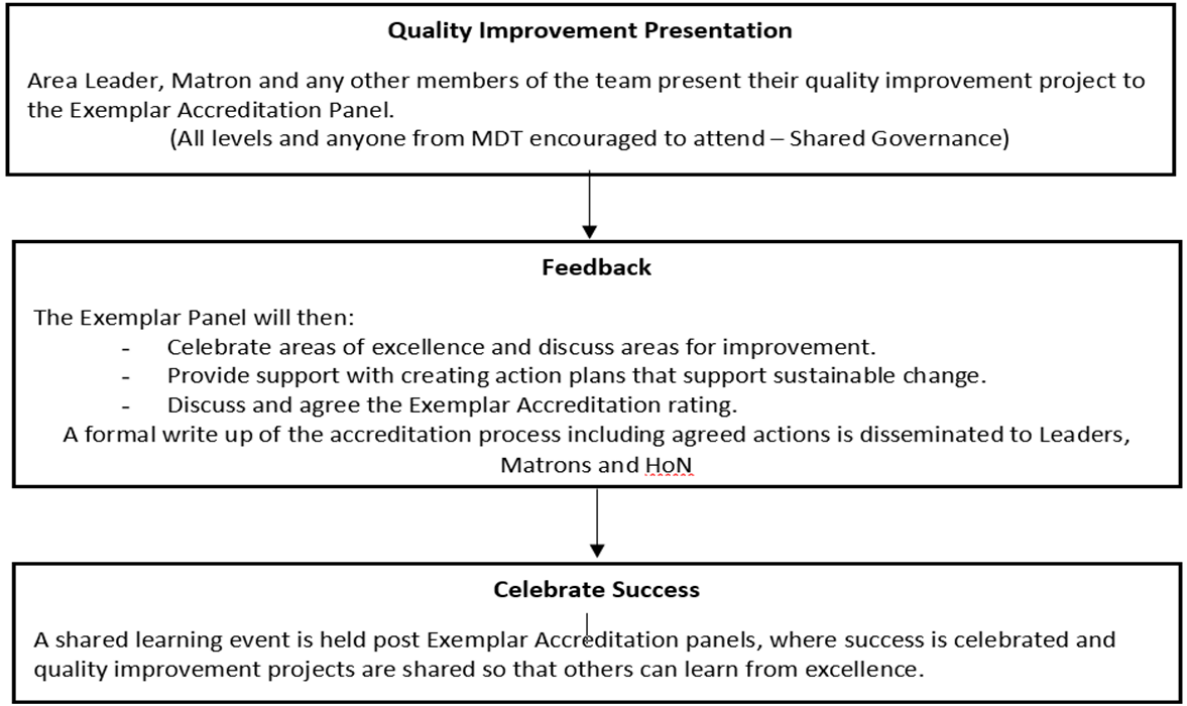
Exemplar Accreditation domains

Quality and Safety	Efficiency	Patient Experience	Staff Experience	Quality Improvement
1. Patients receive harm free care and lessons are learned from incidents. 2. Patients receive evidenced based personalised care. 3. The area environment is managed to provide safety. 4. Quality indicators are maintained to demonstrate safety.	1. Patients receive the right care, in the right place, at the right time. 2. There are appropriate numbers of staff to receive patients needs. 3. The area team uses resources efficiently.	1. All patients receive timely, holistic, individualised care. 2. The area is a welcoming and welcoming place to be. 3. Patients feel listened to and understand the care they receive.	1. All staff are engaged, empowered and enjoy working in that area. 2. Staff have to most up-to-date skills and knowledge to do their job. 3. The is an open culture that makes staff feel safe.	1. Creating a culture for improvement. 2. Use of improvement methodology. 3. Using data to drive improvement. 4. Sharing and learning to encourage spread.
SAFE	EFFICIENT	CARING	WELL LED	RESPONSIVE

How do we assess against these standards?

- Exemplar Information Pack
- Staff Survey
- Patient Survey
- Exemplar Data Analysis Pack

What does the process look like?



How do we score?

Rating	Descriptors	Accredited	Scrutiny (Reassessment and Review)	Next Steps
GOLD Exemplar area	Significantly exceeds the Trust standard expectation	Yes	Must Have: • No white standards. • 60% or more of the standard are gold. • Must have achieved gold standards for Safeguarding, Infection Control, Falls, Incidents of HAPU and Appraisals* • Must have evidence of action planning and reassessment*	Improvement plan required for Bronze measures as appropriate. Bi-annual monitoring
SILVER Excellent Care	Greatly exceeds the Trust standard expectation. Some measures require improvement	Yes	Must Have: • 20% or less white standards. • 50% or more of the standard are gold. • Must have evidence of action planning and reassessment*	Improvement plan required for white measures. Bi-annual monitoring
BRONZE Highly Commended-Aspiring and Improving	Exceeds the satisfactory Trust standard expectation. Some measures require improvement	Yes	Must Have: • 20% or less white standards. • Must have evidence of action planning and reassessment*	Improvement plan required for white measures. Bi-annual monitoring
WORKING TOWARDS ACCREDITATION Efficient and safe- On the pathway to excellence	Minimum standard expected at the Trust. Measures require improvement	No	Must Have: • 30% or less white standards.	Improvement plan required for white measures. Bi-annual monitoring
Learning and Improving	Below the minimum standard expected at the Trust. Measures require improvement and regular monitoring	No	Must Have: • More than 30% of the standards are white.	Improvement plan required for white measures. Regular support by Accreditation team. Quarterley monitoring

Where are we now?

Ward Accreditation - Year 1

Round 1					
DATE	TIME	VENUE	AREA	WARD MANAGER	LEVEL ACCREDITED TO
10/04/2024	3pm - 5pm	Boardroom	A5	Terri Taylor	White
11/04/2024	9am - 11am	Boardroom	B10	Lauren Hugill	Bronze
11/04/2024	11.15am - 1.15pm	Boardroom	Rockingham	Richard Drury	White
11/04/2024	2pm - 4pm	B10 Seminar Room	A7	Ria Saunby	White

Round 2					
DATE	TIME	VENUE	AREA	WARD MANAGER	LEVEL ACCREDITED TO
06/06/2024	9am - 10.30am	Boardroom	B11	Annabel Vella	White
06/06/2024	10.30am - 12.00pm	Boardroom	CCU	Paula Perry	Bronze
10/06/2024	2pm - 3.30pm	Boardroom	A3	Alison Phillips	White
12/06/2024	2pm - 3.30pm	B10 Seminar Room	Fitzwilliam	Neil Brittain	Bronze
13/06/2024	9am - 10.30am	Boardroom	A1	Sally Hooper	Bronze

Round 3					
DATE	TIME	VENUE	AREA	WARD MANAGER	LEVEL ACCREDITED TO
05/08/2024	10am - 11.30am	Boardroom	A2	Melissa Nuttall	White
06/08/2024	3pm - 4.30pm	Boardroom	ASU	Sam Burgin	Bronze
07/08/2024	3pm - 4.30pm	Boardroom	Stroke Unit	Claire Murray	White
21/08/2024	10am - 11.30am	Boardroom	AMU	Natalie Zuber	White

Round 4					
DATE	TIME	VENUE	AREA	WARD MANAGER	LEVEL ACCREDITED TO
16/10/2024	2pm - 3.30pm	Boardroom	Sitwell	Megan Parker	Green
16/10/2024	3.30pm - 5.00pm	Boardroom	A4	Jackie Bibby	White
17/10/2024	2pm - 3.30pm	3B Seminar Room, D Level	B5	Kerry Smith	Green
24/10/2024	2pm - 3.30pm	3B Seminar Room, D Level	Short Stay Unit	Jordon Hammond	Green

Round 5					
DATE	TIME	VENUE	AREA	WARD MANAGER	LEVEL ACCREDITED TO
04/12/2024	9am-10am	Boardroom	Childrens ward/CAU	Jenny Newbold	Green
04/12/2024	10am-11am	Boardroom	Neonatal Unit	Kathryn Parke	Green
10/12/2024	08:45am-09:45am	Listerdale Room	Labour Ward	Alexa Birks	Green
10/12/2024	09:45am-10:45am	Listerdale Room	Wharncliffe	Kerry Arnold	White

Themes

- Discharges before 5pm
- End of life care
- Closure of outstanding Datix
- Use of SBAR
- Pressure Ulcer prevention
- Qi training and use of the AMAT system
- Fluid balance and Food charts
- Use of Tendable

Actions

- There is now a ‘virtual waiting area’ in Sepia for patients who are discharged and awaiting TTOs

- Work for End of Life care is picked up through National Audit. There has been an overall improvement in compliance in the last quarter

- Datix now has a cascade of reminders, facilitated by the QGA team and the total number of overdue Datix events have reduced

- It was recognised that not all areas were aware of their responsibility to complete the SBAR tool at handover, how to utilise in meditech and how to appropriately record on Tendable. Areas of good practice were buddied up with those with lower scores. Impact is still to be tested.

- The Purpose T tool has been implemented and shown increasing compliance. There is evidence to support that areas have improving compliance with the SSKIN bundle but there is no significant impact currently in the reduction of Pressure Ulcers

- ILSY training continues and there has been an increase in the number of projects registered. Impact is measured through the Qi team.

- There were at least 2 areas that showed outstanding practice and a Qi project with excellent results. These ward managers then led a piece of work to implement across the Trust. Improving Tendable results have been identified.

- Full review of Tendable questions to ensure the risk of NA is now removed where possible

Continuous Monitoring

Quality Insights - Ward Dashboard

Ward: B10

The Rotherham NHS Foundation Trust

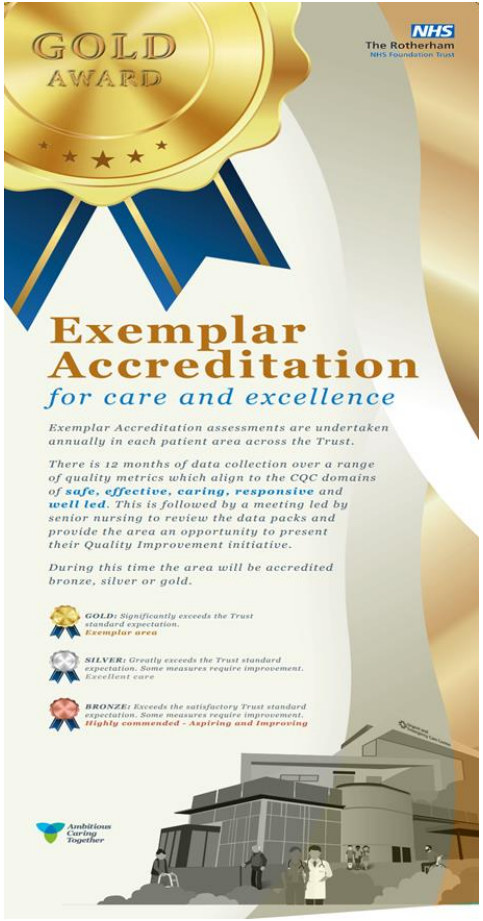
Dates: 01/01/2024 – 31/12/2024

Ward: B10

Well Led | Staffing | Safety | Experience | Infection | Tendable

4 Weekly Metrics	26/02/2024	25/03/2024	22/04/2024	20/05/2024	17/06/2024	15/07/2024	09/09/2024	07/10/2024	04/11/2024	02/12/2024
Well-Led										
E-roster Approval Compliance	45	45	43	48	46	42	42	47	45	42
Roster KPI Compliance - Safety - Unfilled	7.4%	8.5%	7.3%	8.1%	7.1%	8.6%	9.0%	8.1%	8.5%	10.6%
Roster KPI Compliance - Annual Leave	18.6%	13.5%	8.6%	12.6%	12.6%	13.3%	11.2%	10.9%	11.6%	15.2%
Roster KPI Compliance - Sickness	4.8%	0.8%	4.7%	3.5%	3.5%	2.6%	7.9%	3.0%	2.6%	6.0%
Roster KPI Compliance - Study Day	1.7%	1.0%	4.2%	2.3%	2.2%	2.5%	1.7%	2.3%	4.0%	2.3%
Roster KPI Compliance - Other Leave	0.7%	0.7%	0.1%	0.5%	1.0%	0.9%	0.3%	0.7%	0.4%	0.7%
Roster KPI Compliance - Parenting	10.4%	8.9%	7.0%	7.0%	8.7%	6.1%	6.5%	4.8%	0.0%	0.0%
Roster KPI Compliance - Working Day	1.3%	3.2%	5.4%	3.8%	2.4%	0.6%	1.0%	5.6%	6.7%	0.2%
Roster KPI Compliance - Total Unavailability	37.5%	28.0%	30.1%	29.6%	30.3%	26.0%	28.7%	27.3%	25.4%	24.4%
Roster KPI Compliance - Effectiveness - Staff Over NET Hours	3.5%	2.8%	3.1%	2.6%	1.9%	1.7%	1.2%	1.2%	0.9%	0.6%
Roster KPI Compliance - Effectiveness - Under NET Hours	1.2%	1.4%	1.2%	1.0%	0.7%	1.2%	1.1%	1.0%	1.3%	1.8%
Roster KPI - Effectiveness Additional Duty Hours	11	245	19	69	15	77	287	28	122	135

Monthly Metrics	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Well-Led												
Core MAST	97.7%	97.4%	97.1%	98.2%	98.8%	99.0%	98.8%	98.7%	98.7%	97.3%	96.6%	96.0%
Role Specific MAST	92.5%	92.3%	94.4%	98.2%	98.1%	98.2%	97.2%	94.6%	94.6%	93.2%	95.6%	93.7%
Personal Development Review - 12mths rolling	88.9%	96.6%	93.3%	93.6%	66.7%	80.7%	87.5%	96.6%	100.0%	90.6%	90.3%	90.3%
Finalisation Achieved	1	1	1	1	1	1	1	0	1	1	1	1
CHPPD In Month	5.58	6.33	5.83	6.36	5.91	6.01	5.95	10.56	6.5	5.75	5.95	5.92


GOLD
AWARD
NHS
The Rotherham
NHS Foundation Trust
Exemplar Accreditation
for care and excellence
Exemplar Accreditation assessments are undertaken annually in each patient area across the Trust.
There is 12 months of data collection over a range of quality metrics which align to the CQC domains of safe, effective, caring, responsive and well led. This is followed by a meeting led by senior nursing to review the data packs and provide the area an opportunity to present their Quality Improvement initiative.
During this time the area will be accredited bronze, silver or gold.
GOLD: Significantly exceeds the Trust standard expectation.
Exemplar area
SILVER: Greatly exceeds the Trust standard expectation. Some measures require improvement.
Excellent care
BRONZE: Exceeds the satisfactory Trust standard expectation. Some measures require improvement.
Highly commended - Aspiring and Improving
Ambitious Caring Together


BRONZE
AWARD
Exemplar Accreditation
NHS
The Rotherham
NHS Foundation Trust
CONGRATULATIONS
This is to certify that
has received a bronze award
SIGNED
DATE
Ambitious Caring Together


BRONZE
AWARD
Exemplar
Accreditation
for care and excellence


Any Questions

COUNCIL OF GOVERNORS MEETING: 12 February 2025

Agenda item: **COG/14/25**

Report: **Chairs Update from Governors Membership Engagement Group (GME)**

Author and Presented by: **Geoffrey Berry, Lead Governor and Chair of GME**

Action required: **To note**

1.0 The GME continues to meet on a quarterly basis, with the last meeting held on 17th December 2024.

2.0 Membership Engagement

2.1 The group received the position of the Trust membership which was:

Rotherham Wide	8731
Rest of England	1365
Staff	3575
Total	**13,671**

2.2 For staff membership, there is work ongoing to raise awareness and the staff Governors had given several ideas to increase their visibility and promote membership. This could also apply to or be replicated by the public governors.

2.3 For public membership, governors were in contact with school governors and looking into promoting the membership and role of governors to parents at schools.

3.0 Governors Surgery

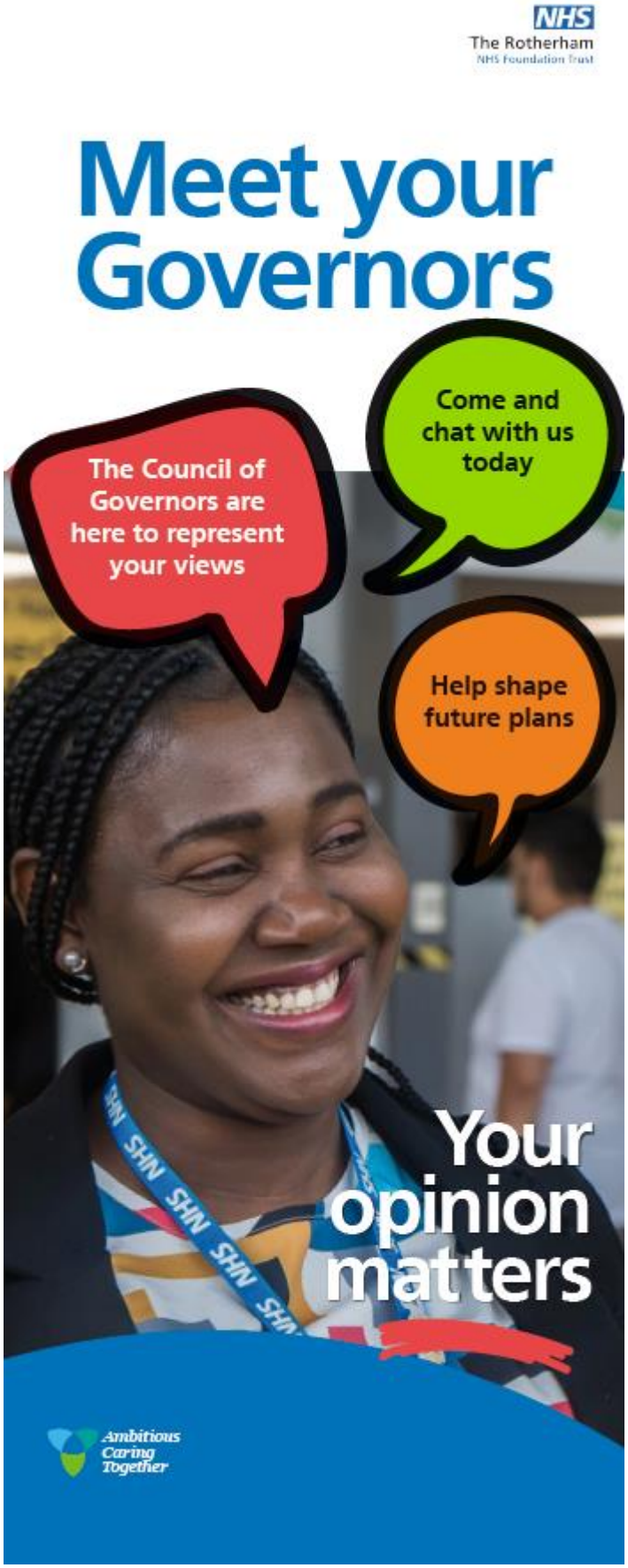
3.1 The group were presented with the re-brand for the Governor Surgery banner (see Appendix 1) and the branding that would flow through to other governor and membership promotional material. The next step is to finalise posters to be placed in public areas to raise awareness and give opportunity for members to give feedback via the QR code or email address listed.

4.0 Forward look to 2025 Elections

4.1 The group took note of the report in relation to the upcoming elections this year and the proactive steps and suggestions to bolster engagement and membership in advance of the election period.

Geoffrey Berry
Lead Governor
Chair of Governors Membership Engagement Group

Appendix 1 – Governor Banner



COUNCIL OF GOVERNORS MEETING: 12 February 2025

Agenda item: **COG/15/25**

Report: **Staff Governors Lunchtime Lecture**

Presented by: **Matthew White & Rachel Bell – Staff Governors**
Authors: **All Staff Governors**

Action required: **To note**

1.0 On 28th January 2025, the staff governors presented their own lunchtime lecture on the role of a staff governor with a focus on engaging with staff members. They were introduced and supported by Dr Mike Richmond, Trust Chairman.

2.0 The lecture had a good turnout and there were multiple questions and suggestions from attendees for governors to take forward.

3.0 The presentation used is attached for information.

Staff Governors:

Staff What?

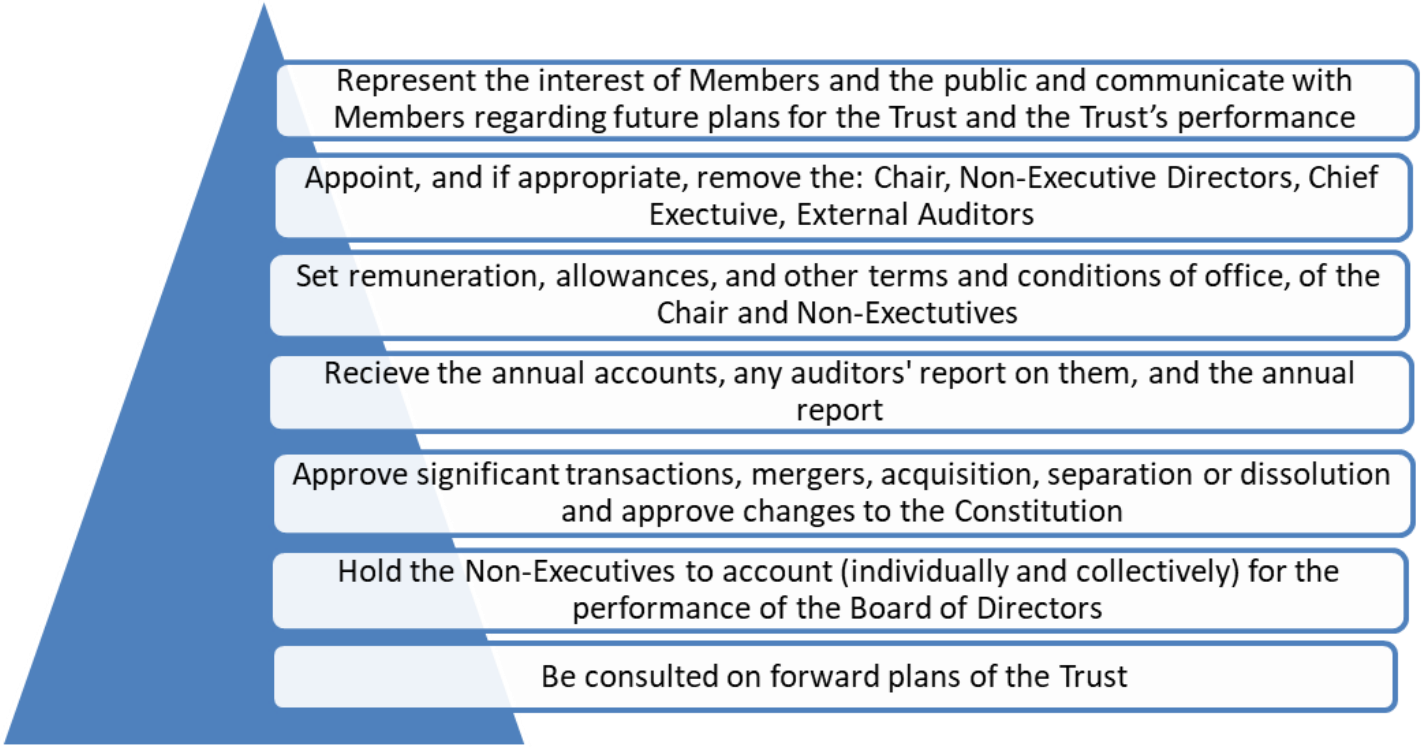
Presented by
Rachel Bell, Sammy Nordkil, Kerry Smith, Sarah Hayhurst and Matthew White
Staff Governors
2025

Introduction by
Dr Mike Richmond
Chairman
2025

What is a Governor?

- NHS foundation trust governors are the direct representatives of local communities. Governors do not manage the operations of the trusts; rather, they challenge the board of directors and hold the non- executive directors to account for the performance of the board.

What Do Governors Do?



So, What is a Staff Governor?

- Staff Governors are current members of TRFT Staff who put themselves forward to be elected by the **Members** of the Trust to serve on the Council of Governors

- As well as representing patients and the public in general, we also represent staff
  - Raise concerns
  - Ask questions in forums normally inaccessible to staff

Who can become a Staff Governor?

- Any member of TRFT staff
  - Regardless of job banding
  - Regardless of job role (in fact a wider array of job roles is arguably better)
  - Regardless of whether someone is clinical or non-clinical in their profession
- Only condition is that the individual is (or happy to become) a Member of The Rotherham NHS Foundation Trust

We have Members?

- An individual who feels that they have a vested interest in the working and activity of a Foundation Trust can become a member
- Foundation trusts are NHS organisations that have been structured and organised in such a way that allows them to make better and more flexible use of their money. This helps to plan for future investments, support developments, and improving local services.
- Foundation Trusts are accountable to the public through their **membership**. Members are represented by **Governors**.
- Staff are **not** automatically members – Opting in is needed when you join the Trust or you can join later (it's **free**).
- Anyone can become a member so long as they are at least 16 years old.

More on membership...

- Members can put themselves forward to be elected as a Staff Governor
- Only registered members can vote in Staff Governor elections
- You can give feedback to your Governors on areas or services important to you or your friends and family
- Through members and the Council of Governors, the organisation responds to the views of local patients, visitors and staff
- Members receive updates on Trust news, Public meetings and Public Panels

Who are the Staff Governors?

- Short answer = Us
- There are five staff governors at full complement
- At present we represent a reasonable spread of different professional backgrounds

Who are the Staff Governors?

Rachel Bell

Day Job: Professional Lead for Medical Imaging, Physics and Illustration

Where You'll Usually Find Me:

I am based in Radiology on B level of the main trust site.

If you see me stop and say hello, I would love to meet you

Why did I decide to become a governor?

Who are the Staff Governors?

Sammy Nordkil

Day Job: Senior Physiotherapist

Where You'll Usually Find Me:

I am based in the Therapy Department on C level.

I work on a range of different wards so if you catch me in passing please say hello.

Why did I decide to become a governor?

Who are the Staff Governors?

Matthew White

Day Job: Principal Audiologist / Hearing Therapist

Where You'll Usually Find Me:

- Rotherham Community Health Centre (RCHC) - Audiology is on the 1st Floor in the Green Area.
- Rotherham Hospital – Audiology in on Level C in Main Outpatients.

Why did I decide to become a governor?

Who are the Staff Governors?

Kerry Smith

Day Job: Ward Manager

Where You'll Usually Find Me: can be found on war
B5, pop in and say hello

Why did I decide to become a governor?

Who are the Staff Governors?

Sarah Hayhurst

Day Job: Project Manager – Delivery & Improvement

Where You'll Usually Find Me:

Delivery & Improvement office on the management corridor, level D

Why did I decide to become a governor?

How to Contact Us?

Email: rgh-tr.staffgovernors@nhs.net

Scan the QR code

Talk to us if you see us: We're nice people (Honest)

Become a member of the Trust

You can also find the link via the Trust website – see 'Get Involved'


We want to know your ideas!
How can we best work with you?
Is there a best time to visit your area?
Is there an issue you think we should be taking upwards?
We are keen to get stuck in and be more visible on your behalf

Calendar of Business for Council of Governors 2025

REPORT - ORDER		2025			
		Feb	May	Sep	Nov
		12	21	03	19
Procedural items					
Welcome and announcements	Chair	/	/	/	/
Apologies and quoracy check	Chair	/	/	/	/
Declaration of Interest	Chair	/	/	/	/
Minutes of the previous meeting	Chair	/	/	/	/
Matters arising and action log	Chair	/	/	/	/
Chairman's report	Chair	/	/	/	/
Report from the Non-Executive Chairs of Board Committees					
Report from Audit & Risk Committee	NED Chair	/	/	/	/
Report from Finance and Performance Committee (inc. Finance Report)	NED Chair	/	/	/	/
Report from Quality Committee	NED Chair	/	/	/	/
Report from People & Culture Committee	NED Chair	/	/	/	/
Report from Charitable Funds Committee	CFC Chair	/	/	/	/
Integrated Performance Report (for information)	Man. Dir.	/	/	/	/
Progress Report (for information)	Man. Dir.	/	/	/	/
Partnership Working	Man. Dir.			/	
Organisational Priorities	CEO		/		
Five Year Strategy Update (every 6 months)	CEO		/		/
Quality Priorities	CN		/		
Quality Account	CN		/		
Annual Report (through Annual Members Meeting)	DoCA			/	
Annual Accounts (through Annual Members Meeting)	DoF			/	
Financial Plan	DoF				/
Governor Regulatory and Statutory Requirements					
Governance Report	DoCA	/	/	/	/
Constitution – formal review Last review February 2023	DoCA				/
Constitution – Partner Governors	DoCA				/
Governors Standing Orders (linked to Constitution review) To be reviewed every 3 years as a minimum or in conjunction with any changes to Constitution. Last review October 2018	DoCA				/
Appointment of Vice Chair (as needed)	DoCA				
Appointment of Senior Independent Director (as needed)	DoCA				
Appointment / Reappointment of NED's (as needed)	NomComm				
Appointment/Reappointment of Chair (as needed)	NomComm				
Outcome of Chair and NED Appraisals	NomComm			/	
External Auditors (contract renewal) Contract with Mazars LLP effective from 2024 for 3 years	DoCA				

Key:

DoCA (Director of Corporate Affairs) MD (Medical Director) NED (Non-Executive Director)
DoF (Director of Finance) CEO (Chief Executive)
NomComm (Nominations Committee) CN (Chief Nurse)

Calendar of Business for Council of Governors 2025

External Auditors Engagement report to CoG following closure of annual audit	DoCA				/
Lead Governor Appointment (Annual)	DoCA		/		
Deputy Lead Governor Appointment	DoCA		/		
Governor Elections (part of Governance Report or Member Engagement Group Report)	DoCA	/	/	/	/
Council of Governors Annual Review of Effectiveness	DoCA				/
Sub Groups of the Council of Governors					
Member Engagement Group Report/Chairs Log	Group Chair	/	/	/	/
Member Engagement Group Terms of Reference	Group Chair				/
Audit & Risk Committee Terms of Reference Annual Review	Chair				/

Key:

DoCA (Director of Corporate Affairs)
DoF (Director of Finance)
NomComm (Nominations Committee)
MD (Medical Director)
CEO (Chief Executive)
CN (Chief Nurse)
NED (Non-Executive Director)

Calendar of Business for Council of Governors 2025

CONFIDENTIAL

REPORT - ORDER		2024			
		Feb	May	Sept	Nov
		21	15	10	20
Procedural items					
Nomination & Remuneration Committee Report (if held)	Chair	/	/	/	/
Nomination & Remuneration Committee Approved Minutes (if held)	Chair	/	/	/	/
Nomination & Remuneration Committee Terms of Reference	Chair			/	

Key:

DoCA (Director of Corporate Affairs)
DoF (Director of Finance)
NomComm (Nominations Committee)
MD (Medical Director)
CEO (Chief Executive)
CN (Chief Nurse)
NED (Non-Executive Director)