The Rotherham NHS Foundation Trust

Council of Governors

The Rotherham NHS Foundation Trust

Schedule	Wednesday 14 May 2025, 5:00 PM — 6:45 PM BST
Venue	Board Room, Level D
Organiser	Peter Walsh

Agenda

5:00 PM	PROCEDURAL ITEMS	
	COG/20/25.	Chairman's Welcome and announcements - Verbal For Noting - Presented by Dr Mike Richmond
	COG/21/25.	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/22/25.	Declarations of Interest - Verbal For Noting - Presented by Dr Mike Richmond
	COG/23/25.	Minutes of the previous meeting held on 12th February 2025 For Approval - Presented by Dr Mike Richmond
	COG/24/25.	Matters arising from the previous minutes (not covered elsewhere on the agenda) - Verbal For Discussion - Presented by Dr Mike Richmond
	COG/25/25.	Action Log For Decision - Presented by Dr Mike Richmond

5:10 PM	OVERVIEW AND CONTEXT For Noting	
	COG/26/25.	Chair's Report - Verbal For Noting - Presented by Dr Mike Richmond
	COG/27/25.	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
5:55 PM	STRATEGY, PLANNING AND PERFORMANCE	
	COG/28/25.	Integrated Performance Report (IPR) For Noting - Presented by Bob Kirton
	COG/29/25.	TRFT Five Year Strategy - 6 month review For Noting - Presented by Bob Kirton
	COG/30/25.	National, Integrated Care Board and Rotherham Place Update For Noting - Presented by Bob Kirton
6:25 PM	SUB GROUPS OF THE COUNCIL OF GOVERNORS	
	COG/31/25.	Governor Membership Engagement Group Chairs Report presented by Geoffrey Berry, Lead Governor For Noting

6:35 PM	COMMITTEE GOVERNANCE	
	COG/32/25.	Constitution - Partner Governors For Approval - Presented by Peter Walsh
	COG/33/25.	Issues to be escalated to Board of Directors - Verbal For Approval
	COG/34/25.	Calendar of Business for Council of Governors 2025 For Information - Presented by Dr Mike Richmond
	COG/35/25.	Any Other Business For Discussion - Presented by Dr Mike Richmond
	COG/36/25.	Next meeting to be held on 03 September 2025 For Noting
	CLOSE OF MEETING	

Draft until approved at May 2025 Council of Governors meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON WEDNESDAY 12 FEBRUARY 2025 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 (via Teams)
Mr M Skelding, Public Governor Rotherham Wide
Mrs M Gambles, Public Governor Rotherham Wide
Mr F Kler, Public Governor Rest of England
Ms V Ball, Public Governor Rotherham Wide
Ms I Ogbolu, Public Governor Rotherham Wide
Mr A A Zaidi, Public Governor Rotherham Wide

Staff Governors: Ms R Bell, Staff Governor
Mr S Nordkil, Staff Governor
Mr M White, 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
Prof. Shirely Congdon, Non-Executive Director
Dr R Shah, Non-Executive Director
Mr M Temple, Non-Executive Director
Mrs H Craven, Non-Executive Director
Dr R Jenkins, Chief Executive
Mr B Kirton, Managing Director
Mr S Hackett, Director of Finance
Ms A Wendzicha, Director of Corporate Affairs
Mr A Wolfe, Deputy Director of Corporate Affairs
Ms C Rimmer, Corporate Governance Manager (minutes)
Mrs J Roberts, Director of Operations/Deputy Chief Operating Officer (for item 8/25)
Mr T Nield, Head of Nursing (for item 8/25)
Mr B Gray, Deputy Director: Strategy and Delivery (for item 9/25)

Apologies: Mr R Taylor, Public Governor Rotherham Wide
Ms H Watson, Non-Executive Director
Mr A Mondon, Associate Non-Executive Director
Ms J Mallinder, Partner Governor Voluntary Action Rotherham
Mrs K Smith, Staff Governor
Mr M Ayub, Public Governor Rotherham Wide
Ms S Hayhurst, Staff Governor

Mr S Goodwin, Public Governor Rotherham Wide
Mr M Ramzan, Public Governor Rotherham Wide

ITEM	PROCEDURAL ITEMS	ACTION
COG/1/25	**CHAIRMAN'S WELCOME AND ANNOUNCEMENTS** Dr Richmond welcomed all those present, and those attending virtually.	
COG/2/25	**APOLOGIES FOR ABSENCE & QUORACY CHECK** The apologies were noted and the meeting was confirmed to be quorate.	
COG/3/25	**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/4/25	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting held 20th November 2024 were agreed as a correct record.	
COG/5/25	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting held on 10th September 2024 were ratified as a correct record.	
COG/6/25	**MATTERS ARISING FROM PREVIOUS MINUTES (NOT COVERED ELSEWHERE IN THE AGENDA)** No matters were raised.	
COG/7/25	**ACTION LOG** Nil by return.	
COG/8/25	**UECC CAPITAL BUILD** The Council welcomed Mrs Roberts and Mr Nield to the meeting who gave a presentation on the UECC Capital Build. Mrs Roberts introduced the presentation and gave an overview of the programme governance structure and timelines. Mrs Roberts updated the Council on the funding and bid process, the £7mil received and the wider positive impact on services outside of the front door footprint. There had been key enablers to progress the	

	programme and Mrs Robert commended the work of staff to relocate services during the building works. Mr Nield updated the Council on the thirty five teams involved and six hundred staff, and referred to the governance around the project, effective risk management, cash flow and the key delivery points against the plan. Mr Nield highlighted that the project is focused on UECC pathways and workforce workstreams, looking at pathways and departments, with conversion rates as one of the measurements of success. There had been partnership working with a number of other sites visited for further assurance on the plans and delivery. Mr Neild presented the floor plans of the project and outlined the transfigurations and timelines. The Pre-op area would be completed first, and Mr Neild acknowledged the challenges of the tight timelines and the need to minimise disruption to staff and patients, emphasising the importance of careful planning and coordination to ensure smooth transitions and continued patient care. Mr Neild summarised that there would be significant estates and building work over the next six months with multiple office and department moves. There has been positive support and engagement and although there will be challenges, the final outcome would be positive. Dr Richmond raised that on the last CQC visit in 2021, the report was critical on parts of the UECC and Dr Jenkins acknowledged that the project will help here but that the CQC are already impressed with the progress of the Trust in many areas. The CQC have not re-inspected and Dr Jenkins noted that it was disappointing due to the work done and improvements made, such as UECC performance and new consultant leadership. Dr Jenkins also highlighted the enrichment for staff as part of the project and the departmental gain. Ms Bell queried whether the work flows into UECC will be reviewed and Mrs Roberts confirmed they would be working through the main workstreams and giving this key focus following the moves. Mrs Gambles questioned how patients and the public are being informed of the project and the reasons behind relocations of services and appointments. Mrs Roberts explained that they had been restricted by NHSE what could be publicised, but authority had been granted and the communications teams would go ahead with their plans to share the news and there would be print outs available on PALS. Mr Nield detailed that there is a designated workstream around patient experience and this would pick up feedback regularly.	

	Dr Richmond suggested there is opportunity for governors to visit the project site in due course.	**TN/ Comte. Sec.**
COG/9/25	**PLANNING GUIDANCE 2025/26** The Council welcomed Mr Gray to the meeting who provided an overview of the planning guidance, which sets out the priorities for the NHS over the next 12 months and focuses on reducing waiting times for elective care, improving cancer performance, and meeting A&E waiting time targets. The guidance included simplified priorities, reflecting on previous years, and clarified the roles of ICBs. Mr Gray highlighted the financial challenges facing the NHS and the emphasis on living within budgets, improving productivity and making tough decisions about services. The delivery targets reflected a clear drive around reform, development in neighbourhoods, improving productivity, whilst maintaining safety and quality in the services provided. Mr Kirton added that there is a clear focus on the simplified guidance issued, in order to support a very challenging position. Dr Jenkins commented on the financial challenges ahead and the reductions in funding. There will be more investment in community and neighbourhoods, shifting to more to preventative care, rather than reactive; this is supported but the transition will be challenging. There is also need to explore ways to bolster productivity and efficiency, working collaboratively with our partners. Mr Hackett outlined that the financial challenge is still emerging, with allocations in progress and further work needed to understand and translate into contracts. There will also be significant change in electives with a cap in place. Mr White reflected that, from a staff perspective, it has felt that certain services have had extra capacity yet the flow to other services and subsequent influx had not been considered. Mr White questioned what is being done to engage with staff on the ground and on the greater efficiencies needed, what is being done to support implementing changes that are being delayed by governance arrangements. Mr Kirton acknowledged that there is pressure on staff to deliver and detailed that they were briefing Care Group leaders this week to share the information and plans to move forward. The Communications team will also be active in sharing the information and updates with colleagues. Regarding to change implementation, Mr Kirton outlined the intent to simplify the	

	business case process and pilot a 'give it a go' week to help progress in this area and support productivity and innovation. Mr Hackett reflected that acute sites sometimes struggle with variation and acknowledged the challenges and pressures in specialities but raised that activity levels overall are lower; there is need to work harder at patient flow over the next year. Dr Richmond acknowledged the issues raised regarding barriers to change and permissiveness was needed in micro systems to move forward.	
COG/10/25	**CHAIR'S REPORT - Verbal** Following on from the planning guidance, Dr Richmond added that a key challenge will be the constrained financial envelope at ICB level and the financial position for the Trust should not be underestimated. There is need to actively collaborate to move forward, looking at economies of scale and being adaptive to the dynamic situation. As the Council of Governance and also the Board, we have to horizon scan and utilise our resources effectively as possible, with collaboration at the forefront. Dr Richmond updated the governors on the recent Board to Board meeting with Barnsley and the Joint Strategic Partnership Group, and reflected that initial partnerships had been based on necessities and building trust, but there is now a shift to maximise the skill set of each Trust. The joint meetings had strengthened understanding and engagement as well as shared working and attitudes. Members were able to derive the benefits of collective and collaborative working, looking to find further opportunities for efficiencies, productivity and innovation. Dr Richmond summarised that, although much is being asked of the Trusts, there is confidence to find the right paths with a focused mind set.	
COG/11/25	**REPORT FROM NON EXECUTIVE DIRECTOR CHAIRS OF BOARD COMMITTEES** i. Quality Committee Ms Burrows updated the council on the regular Care Group presentations received, noting the impressive innovation in Care Group 4 with the portable X-ray project, and the importance of patient awareness and choice for Virtual Ward. For the Quality Priorities, Ms Burrows reported good progress and the outline of the priorities for the next year. There would be a continuation of Diabetes Management, following a beneficial exploration stage and expanded scope, a focus on Antimicrobial Stewardship linking with the IPR and C Difficile peaks and lastly,	

	Delayed Diagnosis for which Ms Burrows was pleased to see focus on health inequalities in this wide ranging priority. On Maternity and Neonates, Ms Burrows reported the cluster of still births and the oversight by the committee on the internal and external reviews. Ms Burrows also acknowledged the CNST sign off and the value of the Executive check and challenge here. Lastly, Ms Burrows detailed the committee's involvement in the Quality Strategy development and the outcome of the recent workshop to shift away from retrospective reporting and into more forward planning and proactive approaches. Ms Bell queried the outcome of the investigations into the stillbirths and whether there were common factors. Ms Burrows detailed that there were some commonalities around deprivation and mental health but stressed that it was not around failures in care. Dr Jenkins added that Rotherham has a high percentage of deprivation and the risks are more prevalent. It is important the Trust does more work in this space and Dr Jenkins raised that the Maternity Service at the Trust was very good. As Maternity Safety Champion, Dr Shah confirmed that information is presented on a monthly basis and there was no regular pattern. The service is seeing patients with more comorbidities and health inequalities play a part in this. Mr White requested that for chairs reports, full Care Group details were added. ii. People and Culture Committee Dr Shah introduced the report and highlighted the presentation received from Care Group 2 (Surgery), linking to the discussions earlier around planning guidance and elective recovery. Another important aspect for the committee Dr Shah raised was the focus on job planning and the improvement in compliance following a system change. This scrutiny would continue with the expectation to meet the 95% target soon. Dr Shah also noted the Medical Education Report and GMC Training Survey received and linked with the NHSE emphasis on improving the lives of resident doctors. The survey highlighted concerns over sexual safety and Dr Shah referred to actions in progress including the Sexual Safety Charter agreed at Board, the work of the Freedom to Speak Up Guardians and the posters around the Trust. iii. Finance and Performance Committee incl. Finance Report	**Cmte. Sec.**

Mr Temple reflected on the report at the last meeting highlighting the sheer volume and reported that it had continued and was sustained. The committee had been trying to establish and gain assurance that the models in place were fit for purpose, and the implications of the volume in relation to finance as well as performance. Mr Temple commended the performance achievements made in the top quartiles, considering the journey, and noted the consistent tracking of financial positions to meet the targets set.

From the chairs report, Mr Temple highlighted the following key items:

- Care Group 2 presentation and financial challenges, but alongside improvements at MEOC
- Care Group 3 CIP challenges, but the achievement in additional funding for the Child Development
- Centre (CDC)
- High demands on emergency care services
- Emergency Preparedness, Resilience and Response (EPRR) standards and 65% compliance

Mr Hackett presented the finance report and drew attention to the continued improvement in financial position month on month as a result of the plans in place and grip and control measures. Mr Hackett outlined that the Trust was on track to deliver to plan, but that it would be a challenge and effective grip and control must continue.

Mr Nordkil queried how the governors could be assured that the £7mil capital funding would assist the Trust to reach the 4 hour targets and would not increase demand on staff. Mr Hackett explained that, as part of the business case submitted, there was a rigorous assurance process through NHSE and challenge around patient experience and operational performance. There will be external focus on the delivery and the Trust will have to be able to demonstrate return via metrics and delivery.

iv. Audit and Risk Committee

Mr Malik presented the Audit and Risk Committee report and updated the Council on the following:

- The committee's focus on Risk Management and the integration throughout the organisation. There had been a focus on policies and frameworks and how this transposes into every day practices. The next step is to review the application of the tools and messaging for consistent decision making and good reporting frameworks
- No concerns raised so far over year-end planning

	- Internal audit assurance opinions and the monitoring moving forwards Mr White queried the reporting of joined up actions of risks and whether this was a prior issue. Mr Malik detailed that it formed part of the consistent approach and framework, referring to the joined up actions across risks and the check and balance through training and governance committees. Ms Wendzicha added that there is now further challenge when actions have been completed and there has been no change to the risk, leading to further reviews or action plans to mitigate the risk. Mr White questioned the compliance rates for declarations of conflicts of interest and Mr Malik concurred that it was raised as a concern but that the improvement in compliance had been a result of a concerted effort. Ms Wendzicha clarified that the declarations related to the policy on business conduct and include decision making staff, Band 8D and above colleagues and any other conflicts of interests that need to be declared. On the split assurance (section 5.2) Mr Malik explained that there was a narrow specific scope of the audit in relation to the ordering process and a control weakness was found. v. Charitable Funds Committee Mrs Craven introduced the report and reflected that the festive period had been a busy time for the charity with a lot of fun and joy from a number of successful events. Partnering with local and national businesses had really come to fruition this year with 800 gifts donated through DuneIm delivering joy campaign, with gifts given to patients in the hospital and out in the community. A key element of the charity strategy had been engaging with the business community and it was going from strength to strength. Mrs Craven highlighted that the charity was coming to the end of its first three year strategy and the successes achieved, such as the first big appeal raising £150k for the neonatal ward. Looking to the future, a new strategy was in development and would move to implementation mode following trustee approval. A key message within will be sustainability, moving into community and how the charity spends its funds. Dr Richmond recognised that the charity had done tremendous work over the past year and Mr Berry commended Mrs Craven and the charity team on their excellent work.	
COG/12/25	**INTEGRATED PERFORMANCE REPORT**	

	Mr Kirton introduced the IPR report drawing attention to the Operational Delivery dashboard and further details within the report. Mr Skelding queried the strategies in place to address high levels of staff sickness and the evidence to back the plans. Mr Kirton detailed that there had been a big focus here and there is dissatisfaction on the progress. Dr Shah commented that it remains a topic of priority for the People & Culture Committee and raised that a considerable factor are wider determinants such as issues at home, financials, bereavements, health inequalities, that are not in the Trust's remit to control. The Health and Wellbeing are active around the Trust and the new Occupational Health procurement will look to be more accessible to support staff. There is compassionate leadership which is looking to pre-empt and prevent and Dr Shah confirmed that trend analysis of sickness is conducted and utilised in the action plans. Mrs Gambles questioned the impact of staffing levels on theatre delivery and Dr Jenkins raised that there is an issue regarding anaesthetics however additional measures have recently been put in place and action taken to equilibrate extra contractual rates. Mr White outlined the importance of mental health and asked whether counselling was in place, as was following the pandemic. Dr Shah explained that it was in place however the utilisation of the service is still to be evaluated.	
COG/13/25	**EXEMPLAR ACCREDITATION PROGRAMME** This item was deferred.	
	SUB GROUPS OF THE COUNCIL OF GOVERNORS	
COG/14/25	**GOVERNOR MEMBERSHIP ENGAGEMENT GROUP CHAIRS REPORT** Mr Berry presented the report and noted that an area of focus was young people due to the current membership statistics and detailed the actions in progress by governors to move forward. Mr Berry raised the importance of input from young people to know their concerns and issues. Mr Berry drew attention to the refresh of the governor banner.	
COG/15/25	**MEMBERSHIP ENGAGEMENT – FEEDBACK FROM THE STAFF GOVERNOR LUNCHTIME LECTURES** Ms Bell and Mr White reported that the staff governors delivered a lunchtime lecture to staff and reflected that it was informal and interactive, encouraging membership and feedback on how best to	

	engage moving forward. The governors also presented on Team Brief and there are plans in place to increase visibility. Dr Richmond commented that it was very well attended with a high level of engagement.	
	COMMITTEE GOVERNANCE	
COG/16/25	**ISSUES TO BE ESCALATED TO BOARD OF DIRECTORS** None were noted.	
COG/17/25	**CALENDAR OF BUSINESS FOR COUNCIL OF GOVERNORS 2025** The Council noted the planner.	
COG/18/25	**ANY OTHER BUSINESS** Mr Zaidi gave feedback from speaking to members of the public around the hospital on the levels of communication and some of the difficulties experienced during appointments. Dr Jenkins noted the need to ensure all staff have good communication skills and encouraged reporting of issues through proper channels to ensure patients can be supported.	
COG/19/25	**NEXT MEETING TO BE HELD ON** Wednesday 14th May 2025	
	CLOSE OF MEETING	

Council of Governors Action Log

Log No	Meeting date	Report/ agenda title	Min Ref	Action	Lead Officer	Time scale	Response	Open/close
	2025							
1	12/02/2025	UECC Capital Build	COG/8/25	Explore the opportunity for governors to visit the project site in due course.	Tom Nield/Committee Secretary	May-25	Depending on building works progression, walkaroud will be scheduled inline with the COG meeting in September.	Rec. to close
2	12/02/2025	Chairs of Board Committee Reports	COG/11/25	Ensure full Care Group details are included in reports.	Committee Secretary	May-25	Full details of Care Groups included in reports.	Rec. to close

Open
Rec to close
Closed

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/27/25i**

Report: **Chairs 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 and the Council of Governors to demonstrate the degree of assurance received on all key matters.

2.0 Since the last presentation to the Council of Governors, the Quality Committee met on:

- Wednesday 26th February 2025
- Wednesday 26th March 2025
- Wednesday 30th April 2025

3.0 The Council of Governors is asked to note the Chair's Logs.

Subject:	**Quality Committee CHAIR'S ASSURANCE LOG** **Quorate: Yes**	Ref:	**QC**

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

Committee / Group: Quality Committee	**Date: 29th January and 26th February 2025**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Integrated Performance Report (IPR)	The Committee noted the decrease in combined positivity scores with additional information to be provided by the Chief Nurse. The committee also requested further specificity on the actions to be taken for the quality elements.	Board of Directors
2	Care Group 4 (Community, Therapies, Dietetics and Radiology, Medical Physics and Medical Illustration) Presentation	The Committee welcomed the positive presentation from Care Group 4, noting the need for more promotion of services to the Rotherham people and also scope for community to do more with a shift of resource approach rather than a stretch.	Board of Directors
3	Draft Quality Priorities 2025/26	The Committee noted the Quality Priorities 2025/26 recommendations, and the Antimicrobial Stewardship which would be linked to Infection Prevention and Control (IPC) reporting around C Difficile.	Board of Directors
4	Patient Safety Committee Report	The Committee were informed of a never event reported and wished to alert the Board. This was regarding a complex patient and a piece of equipment that failed. Due process and investigations would be followed.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
5	Clinical Effectiveness Committee (CEC) Quarterly Report	The Committee agreed that it might be worthwhile to hold a development session for Board on Clinical Effectiveness as it would be an opportunity to develop engagement as a pillar of the Quality Strategy.	Board of Directors
6	Patient Experience Committee Report	Volunteering was raised as a potential opportunity for expansion and that it was worth re-evaluating the model and resources, alongside the benefits and outcomes.	Board of Directors
7	Future Award Opportunities	From the Patient Safety and Patient Experience Committee reporting, the committee raised that there were opportunities to put successful projects and work forward for awards. This included the work on Acute Kidney injury (AKI), Decaffeinated drinks and Acute Pain Management.	Board of Directors
8	Health and Safety Annual Report 2023/24	The Committee received the Annual Report and supported the updates agreed and addendum included, for recommendation to Board of Directors.	Board of Directors
9	Board Assurance Framework (BAF)	Whilst acknowledgement was given to operational pressures and the potential risk to patient safety, triangulating with data and reporting and the overall picture, the Committee agreed for the score of P1 to remain at 8.	Board of Directors
10	Risk Management Report	The Committee welcomed the intention that moving forwards, there would be further triangulation throughout all committee reports with the high level risks. Committee reports should provide further detail on relevant high level risks which would then link back to the main Risk Register Report. Risk details should be acknowledged in each report's Executive Summaries to ensure the triangulation has been considered and included. The Committee agreed that there is need to develop from good papers, to papers that can make a difference, which can change the focus, decisions	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		and possibly the resources of the Trust based on the mature risk information provided to the Committees and Board.	
11	The Medicines and Healthcare products Regulatory Agency (MHRA) Inspection	The committee wished to advise the Board of a recent MHRA inspection at the new Radio-Pharmacy facilities and that there were a significant number of non-conformances noted. There are 3 Major and 7 Other non-conformances. A Major is a significant deviation from Good Manufacturing Practice (GMP) that has a good chance of impacting patient safety, while an Other is a deviation from GMP that isn't as immediately significant to patient safety. There has been a formal letter detailing the non-conformances and assessment and a Trust response will be delivered by the 6th March. This was a pre-inspection and there are currently no patient safety risks. The team are working through the actions and a paper will be submitted to the Executive Team Meeting (ETM).	Board of Directors
12	Quality Strategy Development Session	A proportion of the meeting was reserved for a strategic session to develop the new Quality Strategy. The outcome was good triangulation of overarching themes from the key areas of patient safety, patient experience, clinical effectiveness and quality improvement. The committee will continue to have input on the formulation of the new strategy, linking with the Trust Strategy, as well as the underpinning quality sub-strategies in place.	Board of Directors

Subject:	**Quality Committee CHAIR'S ASSURANCE LOG** **Quorate: Yes**	Ref:	**QC**

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

Committee / Group: Quality Committee	**Date: 26th March 2025**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Care Group 2 (Surgery) Presentation	The Committee received the presentation from Care Group 2 which focused on patients that were waiting and the roads to improvements, linking operational performance with quality outcomes including patient safety and experience. On Mexborough Elective Orthopaedic Centre of Excellence (MEOC), it was reported that patient feedback was extremely positive and the quality metrics were impressive with low numbers of incidents, low Length of Stay, no formal complaints and 100% Friends and Family Test (FFT). The committee recommended that MEOC is put forward for a Board Visit.	Board of Directors
2	Quality Priorities 2025/26	The Committee agreed the Quality Priorities for 2025/26, welcoming the in-depth report and substance behind the priorities. The three priorities for the year are: • Diabetes Management (a continuation of the 2024/25 Quality Priority) • Antimicrobial Stewardship • Reducing delays in Cancer Diagnosis and Treatment	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		Each priority has an Executive Lead, Senior Responsible Owner (SRO), oversight committee and are supported by the Quality Improvement (QI) Team.	
3	Paediatric Audiology Peer Review	The Committee were updated that the Paediatric Audiology team underwent an external peer review and that there is increased scrutiny of paediatric audiology services given the national concerns and patient safety incidents. The feedback was exceptional with only one risk highlighted. Feedback highlighted the positive team culture and leadership and robust local practice. Formal feedback will be received in 2-3 weeks.	Board of Directors
4	Quality Strategy Development	The Committee continued their input into the Quality Strategy and suggested further areas for development, drawing out particular elements such as equitable care, as a key aspect for the quality agenda. Members also noted the importance of local leadership, education and evidenced-based practice to shift the dial on QI for continuous improvement. The Quality Strategy would be presented at Strategic Board in April.	Board of Directors
5	Clinical Effectiveness and Risk Management	From discussions on both the Clinical Effectiveness Committee and Risk Management Report, the Committee considered the Trust-wide culture and ownership towards these aspects. It was suggested that there is clearer expectations on Care Groups attending and presenting to ensure rigour, accountability and triangulation.	Board of Directors
6	Board Assurance Framework (BAF)	The Committee agreed for the score of BAF Risk P1 to increase from 8 to 12, following reflections on the financial constraints and pressures on the front door, the number of risks that are beyond the trusts control due to financial limitations and the number of risks around acuity pressures.	Board of Directors

Subject:	**Quality Committee CHAIR'S ASSURANCE LOG** **Quorate: Yes**	Ref:	**QC**

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

Committee / Group: Quality Committee	**Date: 30th April 2025**	**Chair: Ms Julia Burrows**

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

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
4	Quality Priority: Diabetes Management	As highlighted to the Board previously, the quality priority for Diabetes Management has been continued for another year. It was raised that there had been significant benefit getting the foundations right and would take this learning forward to secure the basics to then push forward with ambition.	Board of Directors
5	Legal Affairs Annual Report	The Committee received the annual report and discussed the increase in the number of inquests and the impact on clinicians due to the demands on their time for statements and attendance at court. This was having an impact on staff wellbeing and morale as well as affecting patients when resource is diverted.	Board of Directors
6	Board Assurance Framework (BAF)	The Committee agreed for the score of BAF Risk P1 to remain at a score of 12. Once the organisational priorities for 2025/26 have been agreed, the BAF will be updated and refreshed to include these objectives.	Board of Directors
7	Maternity and Neonatal Safety Report	This report is presented to Board and the Committee wished to draw attention to the increase in C-section rates, which is reflected nationally, and the emerging impact and risk in terms of resources.	Board of Directors

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/27/25ii**

Report: **Chairs Report from People and Culture Committee (P&CC)**

Author and Presented by: Dr Rumit Shah, Chair of People and Culture Committee

Action required: To note

1.0 The People and Culture Committee (P&CC) continues to meet bi-monthly, with Chair's Assurance Logs from recent meetings provided to the Board of Directors and the Council of Governors to demonstrate the degree of assurance received on all key matters.

2.0 Since the last presentation to the Council of Governors, the People and Culture Committee met on:

- Friday 28th February 2025
- Friday 25th April 2025

3.0 The Council of Governors is asked to note the Chair's Logs.

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

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

Committee / Group: People and Culture Committee	Date: 25th February 2025	Chair: Dr Rumit Shah

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Director of People Report	The Committee acknowledged and recognised the excellent work carried out across the Trust on the band 2 and 3 healthcare assistant review which has now concluded with a number of positive outcomes evident for the colleagues involved, the Trust and for patient care. The Committee also were sighted on the positive impact of the Health and Wellbeing trolleys with sees staff receiving a hot drink and nutritious breakfast pots whilst on the ward. This initiative seeks to give staff 5 minutes to have a drink made for them and provides further opportunity for staff to open up about any issues they might be having and the opportunity for them then to be guided to appropriate help and advice. Executives and other senior managers reported that this feedback has been beneficial. This offering will be extended to support Muslim colleagues breaking their fast for Ramadan and to include trolley rounds during out of hours shifts. An open invitation to committee/Board members was made to take part in a wellbeing trolley round via the Director of People.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
2	Board Assurance Framework	The Committee agreed that the rating should remain at 12.	Board of Directors
3	Risk Register	The Committee welcomed the intention that moving forwards, there would be further triangulation throughout all committee reports with the high level risks. Committee reports should provide further detail on relevant high level risks which would then link back to the main Risk Register Report. Risk details should be acknowledged in each report's Executive Summaries to ensure the triangulation has been considered and included. The Committee agreed that there is need to develop from good papers, to papers that can make a difference, which can change the focus, decisions and possibly the resources of the Trust based on the mature risk information provided to the Committees and Board.	Board of Directors
4	Care Group 1 (UECC and Medicine) Presentation	The Committee received the presentation from Care Group 1 and agreed to advise the Board as to their concerns relating to the current staff sickness rates in line with the increased pressures and demands on the service. There were also concerns over the decrease in Mandatory and Statutory Training (MaST) compliance, particularly for medical staffing and that the Care Group do not have any Freedom to Speak up (FTSU) Guardians, although they are the highest reporting Care Group into the FTSU lead.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		The Committee agreed that this would be followed up in a Confidential People & Culture Committee with the Care Group at the 20th June 2025 Committee.	
5	Trust wide People Performance report	The Committee shared their concerns as to the rolling 12 months sickness absence rate of 6.0% which is a deterioration from 23/24 (5.8%), and significantly above target (4.8%). As part of the wider Health, Wellbeing and Attendance programme which is taking forward a number of actions, a retendered Occupational Health contract is designed to contribute to addressing this which is currently being finalised. The committee agreed a deep dive into Health, Wellbeing and Attendance at its next meeting.	Board of Directors
6	Gender Pay Gap	The Committee received the Gender Pay Gap report and recommended it to the Board for approval.	Board of Directors
7	Staff Survey Report	The Committee received the embargoed staff survey report which is presented in Confidential Board and will come to Public Board in May 2025.	Board of Directors

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

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

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

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

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
4	Board Assurance Framework (BAF)	The Committee agreed for the BAF Risk score to remain at 12. Once the organisational priorities for 2025/26 have been agreed, these will be integrated into the framework.	Board of Directors
5	Freedom to Speak Up Quarterly Report	The Committee received the quarterly report and noted the referral from Audit and Risk Committee to consider more triangulation. The committee discussed the triangulation with quality assurance and other information to support concerns and would make this more explicit in future reports.	Board of Directors
6	Safe Staffing and Quality	The Committee reviewed the report and highlighted the level of training and development in the context of our aspirations for Teaching Hospital status. Further details were also given on engagement with colleges and universities to be the employer of choice to mitigate the subsequent risk to the organisation for the short fall of applications to universities.	Board of Directors
7	Equality Delivery System (EDS)	The Committee approved the EDS for publication and submission to NHSE, noting that the actions and priorities align with the People & Culture Strategy and the Equality, Diversity and Inclusion (EDI) Plan.	Board of Directors

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/27/25iii**

Report: **Chairs Report from Finance and Performance Committee (FPC)**

Author and Presented by: Martin Temple, Chair of Finance & Performance Committee

Action required: To note

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

2.0 Since the last presentation to the Council of Governors, the Finance and Performance Committee met on:

- Wednesday 26th February 2025
- Wednesday 26th March 2025
- Wednesday 30th April 2025

3.0 The Council of Governors is asked to note the Chair's Logs.

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

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

Committee / Group: Finance & Performance Committee	**Date:** 29th January and 26th February 2025	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Risk Register Report	The Committee welcomed the intention that moving forwards, there would be further triangulation throughout all committee reports with the high level risks. Committee reports should provide further detail on relevant high level risks which would then link back to the main Risk Register Report. Risk details should be acknowledged in each report's Executive Summaries to ensure the triangulation has been considered and included. The Committee agreed that there is need to develop from good papers, to papers that can make a difference, which can change the focus, decisions and possibly the resources of the Trust based on the mature risk information provided to the Committees and Board.	Board of Directors
2	Integrated Performance Report (IRP)	Under some pressured circumstances the IPR measurement parameters are potentially misleading with data appearing to show some poor performance. The Committee however agreed that quality can be seen to still be high and the financial position. The Committee noted the improved performance position with the report RAG (Red-Amber-Green) rating quadrants indicating sustained and stable improvement trajectories. Although did also	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		note concerns related to specific areas such as ambulance hand-over delays, with partnership working with the Yorkshire Ambulance Service underway.	
3	Integrated Financial Performance Report	The Committee noted the current Trust financial position and the positive work completed regarding clinical coding, continued grip and control and the belief that the trust was on course to deliver at year end, whilst also advising the Board that the next Financial Year 2025/26 would be a very challenging one financially.	Board of Directors
4	Operational Update	There is continuing demand on services, Care Group and Corporate Services action plans are in train.	Board of Directors
5	Agency Collaborative Tender - Award to Holt Doctors	The Committee commended the regional collaborative work undertaken related to the procurement process and agreed to recommend the paper to the Board for approval.	Board of Directors

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

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

Committee / Group: Finance & Performance Committee	**Date:** 26th March 2025	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Financial, Activity and Performance Planning 2025/2026	Financial, Activity and Performance Planning 2025/26 plan approved	Board of Directors
2	Procurement Policy	The policy was approved	Board of Directors

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

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

Committee / Group: Finance & Performance Committee	**Date:** 30th April 2025	**Chair: Mr Martin Temple**

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

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/27/25iii**

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 March 2025 (Month 12 2024/25):
    - A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management.
    - The Trust was notified in September that it would receive £5,718K of national deficit funding. The overall impact was the requirement to improve the 2024/25 planned deficit from £6,302K to £584K
- Section 2 – Income & Expenditure Account for March 2025 (Month 12 2024/25:
    - Financial results for March 2025.
        - A control total surplus to plan of £1,042K in month and £883K year to date against the plan deficit of £584K. In-year, the Trust agreed within the SY ICS to work to a target control total deficit of £184K, the Trust has achieved a £299K surplus in 2024/25 and met its requirement to breakeven.
        - NHS England measures the Trust's I&E performance against its control total having adjusted for depreciation on donated assets, impairments and accounting for Private Finance Initiatives under IFRS 16 – Leases (total of £1,059K).
- Section 3 – Capital Expenditure for March 2025 (Month 12 2024/25)
    - Results for March 2025 show expenditure of £9,673K in month and £16,940K year to date. The Trust delivered its capital expenditure plan. The under-spend of £249k was forecast and is required to meet the SY ICS' overall capital spending limit.
- Section 4 – Cash Flow 2024/25
    - A cash flow graph showing actual cash movements between April 2023 and March 2025. A month-end cash value as at 31st March 2025 of £15,912K, which is £14,446K favourable to plan, in part due to the deficit funding, additional Public Dividend Capital being received for the infrastructure development of the Urgent and Emergency Care Centre and the timing of payments falling due after 31st March 2025.

1. Key Financial Headlines

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

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

Key Headlines	Month			Year to date			Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Forecast variance £000s
I&E Performance (Actual)	(102)	781	884	(1,949)	(760)	1,189	(1,809)
I&E Performance (Control Total)	(41)	1,001	1,042	(584)	299	883	(2,279)
Capital Expenditure	8,156	9,673	(1,517)	17,189	16,940	249	0
Cash Balance	(2,261)	5,123	7,384	1,466	15,912	14,446	4,718

1.2 The Trust has under-spent against its I&E control total in March 2025 by £1,042K and year to date by £883K. The Trust agreed within the SY ICS to work to a target control total deficit of £184k, the Trust has achieved a £299k surplus in 2024/25 and met its requirement to breakeven. NHS England measures the Trust's I&E performance against its control total having adjusted for depreciation on donated assets, impairments and accounting for Private Finance Initiatives under IFRS 16 - Leases.

1.3 These figures include an under performance on elective recovery activity of £1,459K, it is expected that this will improve prior to the deadline for 2024/25 data (data is currently at flex for month 11 and an estimate for month 12).

1.4 Capital expenditure is ahead of plan in month and delivered its plan for 2024/25. The under-spend of £249K was forecast and notified to the SYICS to meet the requirements for the overall system capital spend. The capital programme has continued to be monitored by the Capital Monitoring Group chaired by the Director of Finance.

1.5 The cash position at the end of March 2025 is £15,912K and is favourable to plan by £14,446K. This is due to the receipt of deficit funding, additional Public Dividend Capital for specific schemes, the most significant being for the infrastructure development of the Urgent and Emergency Care Centre, and the timing of payments falling due after 31 March 2025.

2. Income & Expenditure Account for March 2025 (Month 12 2024/25)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered a surplus to plan in March 2025 of £1,042K and £883K year to date. The Trust received surge funding in month 12 which has supported the improvement in the financial position.

Summary Income and Expenditure Position	Annual plan	Month			Year to date			2024/2025
		Plan	Actual	Variance	Plan	Actual	Variance	Monthly Trend /
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	Variance
Clinical Income	351,008	30,302	50,590	20,289	351,008	375,594	24,585	
Other Operating Income	26,740	3,376	4,288	912	26,740	32,408	5,668	
Pay	(248,447)	(22,378)	(38,329)	(15,951)	(248,447)	(278,091)	(29,644)	
Non Pay	(115,123)	(14,125)	(16,967)	(2,841)	(115,123)	(126,399)	(11,277)	
Non Operating Costs	(4,743)	(373)	(507)	(134)	(4,743)	(4,271)	472	
Reserves	(11,385)	3,096	1,706	(1,391)	(11,385)	0	11,385	
Retained Surplus/ (Deficit)	(1,949)	(102)	781	884	(1,949)	(760)	1,189	
Adjustments	1,365	61	219	158	1,365	1,059	(306)	
Control Total Surplus/ (Deficit)	(584)	(41)	1,001	1,042	(584)	299	883	

2.2 Clinical Income is ahead of plan in-month and year to date due to a year end disclosure relating to pension payments of £15,286K (2023/24: £9,499K). These are paid centrally by NHSE during the year and are disclosed in provider accounts at year end, within income and pay, with the overall impact being net neutral. Excluding this, the year to date position would be an over performance of £9,299K. This is largely due to the true up position on the 2023/24 ERF of £1,250K, consultants pay reform £800K, Industrial Action funding £604K, Community Diagnostic Centre (CDC) income of £1,311K, Advice and Guidance £750K, Surge Funding of £1,900K and settlement of income from commissioners. These figures include an adverse year to date position on ERF in 2024/25 of £1,459K (Appendix 3). The overall ERF target for South Yorkshire ICB and the Trust is 103% of 19/20's activity (priced at current tariff), for variable activity the plan is based on 2023/24 outturn uplifted for 2024/25 tariff.

2.3 Other Operating Income is ahead of plan in month and year to date with increased income from staff recharges (£1,107K), which will be an offset to the pay over-spend, and increased research, education and training income (£3,796K) and clinical and non-clinical services (£1,142K).

2.4 Pay costs are over-spending by £15,951K in month and £29,644K year to date. The impact of the pension payment disclosure referred to in clinical income above of £15,286K explains most of the in-month variance. The year to date is further impacted by bank and agency expenditure which is not currently being maintained within the gross establishment budget, and contributing to this is £2,167K under-delivery against the planned cost improvements.

2.5 Non Pay costs are over-spending by £11,277K year to date. The over-spend is largely related to Drugs and Clinical Supplies £7,536K and Premises £1,655K. There is also a year end disclosure adjustment of £700k in respect of the apprenticeship levy (an equal and opposite amount is also included in Other Operating Income).

2.6 The positive performance in Non-Operating Costs is due to the inflationary uplift on the Carbon Energy Fund (Service Concession) lease of £426K.

2.7 Reserves is a favourable position, these have been used to fund the under delivery of ERF, efficiencies and overspends referred to above including the additional capacity over and above funded bed capacity.

3. Capital Programme

3.1 During March 2025 the Trust incurred capital expenditure of £9,673K, and year to date it is £16,940K

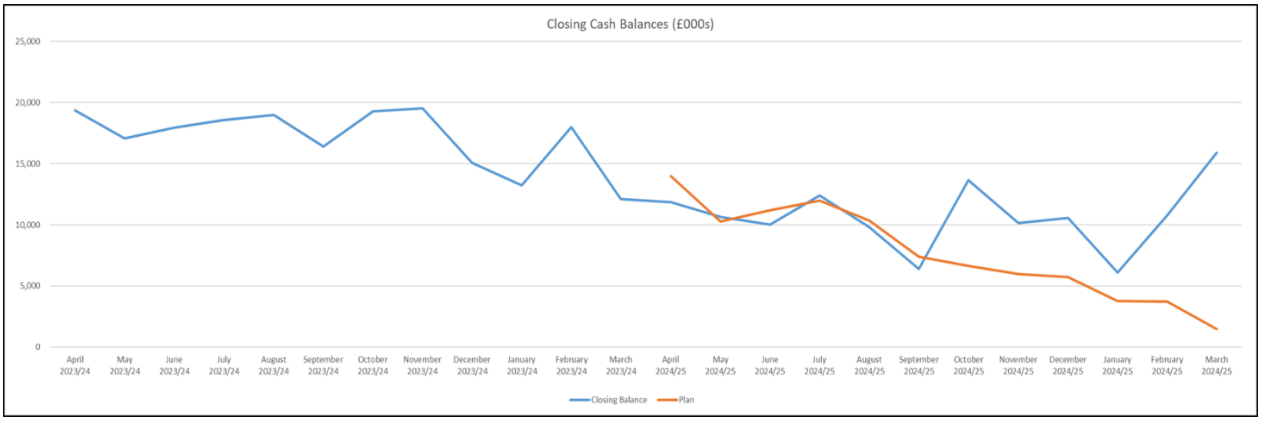
Capital Expenditure	Month			Year to date			Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Forecast Variance £000s
Estates Strategy	5,701	4,028	1,673	8,548	6,340	2,208	0
Estates Maintenance	346	2,744	(2,398)	3,720	4,353	(633)	0
Information Technology	584	1,388	(804)	2,173	3,289	(1,116)	0
Medical & Other Equipment	405	1,513	(1,108)	1,494	2,958	(1,464)	0
Other	1,120	0	1,120	1,254	0	1,254	0
TOTAL	**8,156**	**9,673**	**(1,517)**	**17,189**	**16,940**	249	0

3.2 The forecast capital spend for the year at month 11 was £16,941K. This included an additional £5,904K of capital PDC which was agreed in-year after the plan submission and also an additional capital allocation of £400k from SY ICS.

3.3 Additional PDC capital funding was agreed in Dec 2024 of £7m. This is split over 2024/25 (£5.5m) and 2025/26 (£1.5m). This has been agreed from the Additional Capacity Targeted Investment Fund (ACTIF) to expand our Urgent and Emergency Care Centre (UECC). The funding is to be used to increase our patient capacity for urgent care and minor injuries, medical same day emergency care (SDEC), and to improve our work towards the national four-hour emergency care standard.

4. Cash Management

4.1 The cash position at the end of March is £15,912K and is favourable to plan by £14,446K. This is due to the receipt of deficit funding, additional Public Dividend Capital for specific schemes, the most significant being for the infrastructure development of the Urgent and Emergency Care Centre, and the timing of payments falling due after 31 March 2025. This has allowed the Trust to earn interest on its daily cash balances of £813K year to date.



Steve Hackett
Director of Finance
23 April 2025

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/27/25iv**

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

Author and Presented by: Kamran Malik, Chair of Audit and Risk Committee

Action required: To note

1.0 The Audit and Risk Committee (ARC) continues to meet quarterly, with Chair's Assurance Logs from recent meetings provided to the Board of Directors and the Council of Governors to demonstrate the degree of assurance received on all key matters.

2.0 Since the last presentation to the Council of Governors, the Audit and Risk Committee met on:

- Friday 25th April 2025

3.0 The Council of Governors is asked to note the Chair's Log.

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

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

Committee / Group: Audit & Risk Committee	**Date: 25 April 2025**	**Chair: Kamran Malik**

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

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

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/27/25v**

Report: **Chairs Report from Charitable Funds Committee (CFC)**

Author and Presented by: Heather Craven, Chair of Charitable Funds Committee

Action required: To note

1.0 The Charitable Funds Committee (CFC) continues to meet bi-monthly, with Chair's Assurance Logs from recent meetings provided to the Corporate Trustee and Council of Governors to demonstrate the degree of assurance received on all key matters.

2.0 Since the last presentation to the Council of Governors, the Charitable Funds Committee met on:

- Wednesday 19th March 2025

3.0 The Council of Governors is asked to note the Chair's Log.

Subject:	**Charitable Funds Committee CHAIR'S ASSURANCE LOG** **Quorate: Yes**	Ref:	**CFC**

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

Committee / Group: Charitable Funds Committee	**Date:** 19th March 2025	**Chair: Mrs Heather Craven**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Charitable Funds Finance Report	A strong financial position continues with income from donations exceeding previous years. All funding pots were in balance, there were healthy reserves and good proportioning of direct and indirect costs. The committee agreed the appointment of Kingswood Chartered Accountants to perform the Independent Review of 2024/25 Accounts.	Corporate Trustee
2	Strategy and Fundraising Report	The Committee maintains oversight of the operational plan, strategic objectives and fundraising activities. There had been extremely positive feedback on the Business Breakfast events and the commendable strategic placement of the charity, becoming part of the jigsaw for Place work and creating real tangible connections. The charity team have also been proactive in securing pro-bono work, corporate volunteering, multiple fundraising events and the committee commended the breadth of activity and achievements relative to each need.	Corporate Trustee

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
2	Annual Budget	The Committee approved the Annual Budget for recommendation to Corporate Trustee.	Corporate Trustee
3	Charity Commission Guidance	The Committee received updates in charity guidance from the Charity Commissioner, with the emphasis on simplifying the guidance to make it easier to understand. The updates and recommendations would be integrated into the terms of reference review.	Corporate Trustee
4	Charity Policies	As part of the Investment Strategy review, the Committee review the Reserves Management and Policy on a six monthly basis. There were no changes or recommendations to report. The Committee approved the Corporate Volunteering Policy, and Charity Community Volunteering Policy for ratification by the Corporate Trustee.	Corporate Trustee
5	Service Level Agreement	The Committee received and supported the proposal to recommend to Corporate Trustee.	Corporate Trustee
6	Dementia Appeal	The charity had agreed to support the Trust on Dementia and the appeal has been launched, with £30k raised so far and grant applications submitted for £50k. A key priority will be the conversion of a ward area to create a dementia style café, a games area and a home from home area.	Corporate Trustee

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		The Committee would recommend that the period of the appeal be extended to the end of December 2025, to allow more time to reach the £250k goal.	

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/28/25**

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 March 2025, where available, and outlines performance in relation to established national, local, or benchmarked targets.

Statistical Process Control (SPC) charts are used throughout this report. A brief explanation of the main features of these charts is provided at the back for your reference.

Council of Governors Meeting

Integrated Performance Report - March 2025

Performance Matrix Summary

The Rotherham NHS Foundation Trust

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

How to read the ICONs in this report:

Have we achieved in month?

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

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

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

Performance Matrix Summary - Quality

The Rotherham NHS Foundation Trust

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

Quality

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
SHMI	"As expected"	"As expected" (104.8)	Nov-24	N/A	P		-	G
Readmissions (%)	-	5.5	Feb-25	-	-			S
VTE Risk Assessments (%)	95.0	96.4	Mar-25	☑	?			S
Care Hours per Patient Day	7.2	6.8	Mar-25	☒	?			S
Combined Positivity Score (%)	95.0	91.8	Mar-25	☒	?	L	-	C
Complaints (per 10k Contacts)	8.0	13.9	Mar-25	☒	?		-	S
Patient Safety Incident Investigations	3	0	Mar-25	☑	?		-	S
Patients Falls (Moderate and Above per 1000 bed days)	0.2	0.35	Mar-25	☒	?		-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 1000 bed days - Acute	0.8	1.3	Mar-25	☒	?		-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 100 contacts - Community	0.1	0.1	Mar-25	☑	?		-	S
Medication Incidents - Moderate and Above per 1000 bed days – Acute	0.1	0.1	Mar-25	☑	?	L	-	G
Medication Incidents - Moderate and Above per 100 contacts - Community	0.0	0.0	Mar-25	☑	?		-	S
C. difficile Infections	4	2	Mar-25	☑	?			S

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

SHMI: Summary Hospital-Level Mortality Indicator Mar 2025

Data, Context and Explanation

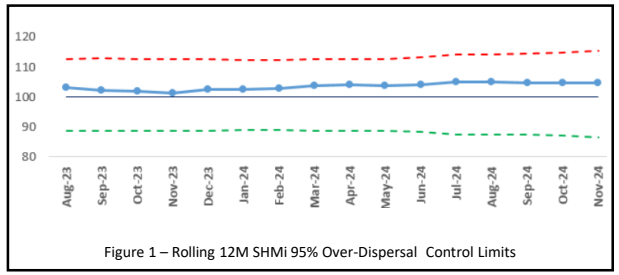


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

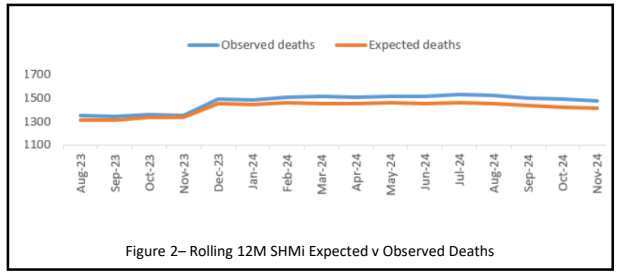


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

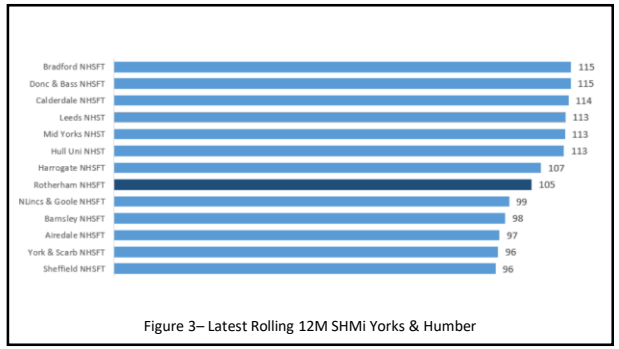


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

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

Covid activity was added back into the SHMI data Dec 2023

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

Metric	Current	Target	Exec Owner	Organisational Lead
Latest Rolling 12 Month SHMI -Nov 24	104.8	-	Jo Beahan	John Taylor
Expected Deaths	1410	-		
Observed Deaths	1475	-		
Trust Banding	Expected	-		

What actions are planned?

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

What is the expected impact?

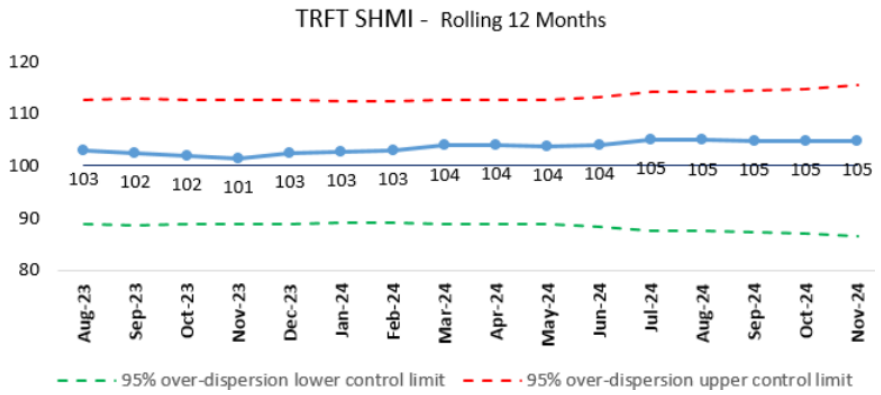
- Investigations or reviews resulting from SHMI investigations will give the Trust Assurance when there are significantly more deaths observed than expected
- Intelligence from SHMI investigations/reviews may lead to changes/improvements in practice

Potential risks to improvement?

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

SHMI: Summary Hospital-Level Mortality Indicator - Update

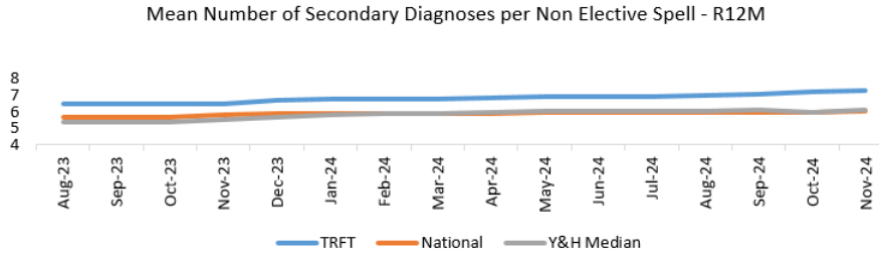
SHMI Update



This chart shows that TRFT has consistency been in the As Expected band. The trend pattern shows common cause variation, within this band.

Interpretation Guidance NHS England June 2024

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



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

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

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

SHMI: Summary Hospital-Level Mortality Indicator

SHMI: Coding & Alerts

SHMI - Diagnostic Group Alerts

TRFT currently has no alerts for its diagnostic groups.

The last alert was for Fluid & Electrolyte Disorders for the SHMI release in Sept 2024.

Diagnosis Group	SHMI Banding	VLAD Alert (Accumulated Risk)
Acute bronchitis	As Expected	No
Acute myocardial infarction	As Expected	No
Cancer of bronchus; lung	As Expected	No
Fluid and electrolyte disorders	As Expected	No
Fracture of neck of femur (hip)	As Expected	No
Gastrointestinal hemorrhage	As Expected	No
Pneumonia (excluding TB/STD)	As Expected	No
Secondary malignancies	As Expected	No
Septicaemia (except in labour), Shock	As Expected	No
Urinary tract infections	As Expected	No

SHMI Changes – Methodology, Process or Specification

No new changes

SHMI Coding Metrics –

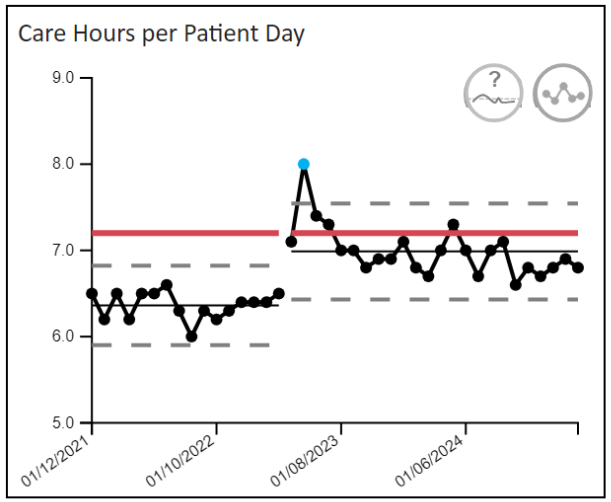
TRFT continue to have a high rate of spells with an Invalid Primary Diagnosis Code and where the code is a Sign or Symptom.

TRFT continue to have a high depth of comorbidity coding for its non elective spells.

TRFT Rank of 13	3rd Highest	2nd Highest	2nd Highest	7th Highest	4th Highest
Yorks & Humber Region Non Spec Provider Trusts	% of Spells: Primary Diagnosis is a Sign & Symptom	% of Spells: Invalid primary diagnosis code	MEAN Secondary Diagnoses per Spell Non	% of Spells with palliative care	% of deaths with palliative care
Harrogate NHSFT	35.9	25.0	4.1	1.6	29
Rotherham NHSFT	16.1	3.2	7.2	2.0	45
Bradford NHSFT	8.6	1.5	4.0	1.3	42
Mid Yorks NHST	8.8	0.5	6.8	2.3	44
Donc & Bass NHSFT	12.7	0.1	5.1	2.2	51
NLincs & Goole NHSFT	17.4	0.1	4.7	1.3	28
Barnsley NHSFT	14.6	0.0	7.7	2.5	49
Sheffield NHSFT	9.9	0.0	5.2	1.8	38
Hull Uni NHST	8.3	0.0	6.2	2.3	37
Leeds NHST	5.6	0.0	6.5	2.2	36
York & Scarb NHSFT	13.5	0.0	6.1	1.2	27
Calderdale NHSFT	6.7	*	7.1	3.2	50
Airedale NHSFT	15.0	*	4.7	1.2	24
England	14.8	2.7	6.0	2.1	44

Subtheme: Care hours per patient day

Data, Context and Explanation



- Care Hours Per Patient Day (CHPPD) is the formal, principal measure of workforce deployment in ward-based settings.
- CHPPD should be used alongside clinical quality and safety outcome measures to understand and reduce unwarranted variation, and support delivery of high quality, efficient patient care.
- CHPPD for March was 6.8 against planned 7.2
- Percentage of fill rate against funded establishment is below;
- Fill rates for RN days was 92%
- Fill rates for HCSW days was 88%
- Fill rates for RN nights was 97%
- Fill rates for HCSW nights was 109%
- Twice daily staffing huddles continue and actions fed into bronze operational meeting.
- The safe staffing escalation SOP is used to ensure all areas are safely staffed.
- All staff redeployments, unavailability's and bank and agency use are picked up in roster meetings and weekly bank/agency meeting.

Metric	Target	Value	Exec Lead	Ops Lead
Care Hours per Patient Day	7.2	6.8	Helen Dobson	Cindy Storer

What actions are planned?

- Continued roll out of the Exemplar Accreditation programme to triangulate CHPPD with patient outcomes.
- Recruitment cycle for September NRN/NRM has started
- Retention work still sees sustained improvements in leaver rates
- B4 winter ward on roster

What is the expected impact?

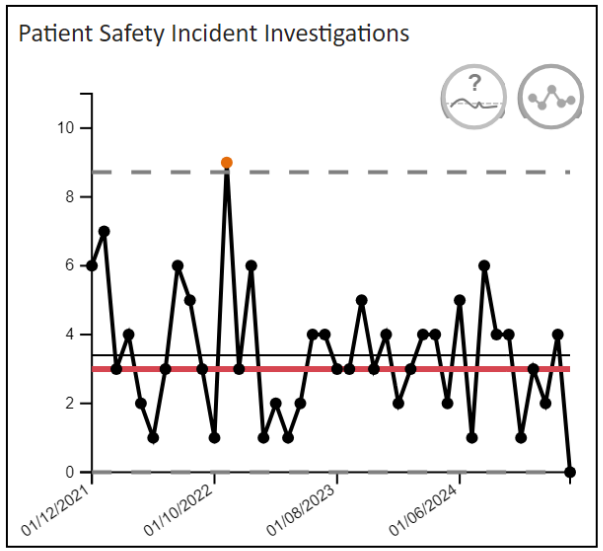
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.

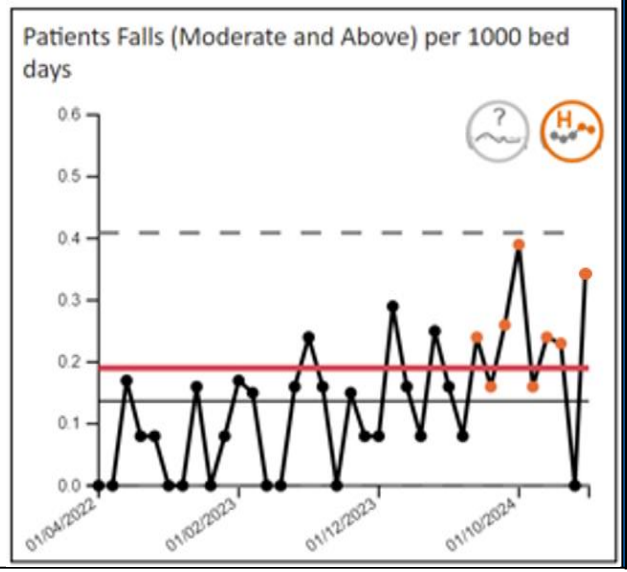
Potential risks to improvement?

- Needing to open additional beds due to operational pressures using existing establishments and temporary NHS staff
- Roster KPI not being met
- High rates of sickness absence.

Subtheme: Care Incidents (1)

Data, Context and Explanation





•Patient Safety Incident Investigations are completed when a patient has been involved in a moderate harm incident and significant learning identified. Number of PSII's has reduced to 0 in month in line with adhering to the Trust and national guidance in criteria.

•The updated Patient Safety Incident Response plan now provides clear guidance on what the national criteria is for PSII and the Trust guidance for the type of incident response required when a patient safety incident occurs.

•The number of patient falls at moderate harm has risen in month. However, this was a total of 5 and none of those had any opportunities for improvement or learning.

•The moderate and above falls rate remains below national average.

Metric	Target	Value	Exec Lead	Ops Lead
Patient Safety Incident Investigations	3	0	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.2	0.35	Helen Dobson	Victoria Hazeldine

What actions are planned?

•A Falls Prevention Lead has now been agreed for the Trust to help reduce the total number of all falls and moderate harm falls through Qi projects and education. This recruitment has taken a slight pause due to external factors.
•There has been a focused deep dive into the moderate harms falls.
•The Patient Safety Incident Response Plan has now been published with a clear direction on when a PSII is warranted.

What is the expected impact?

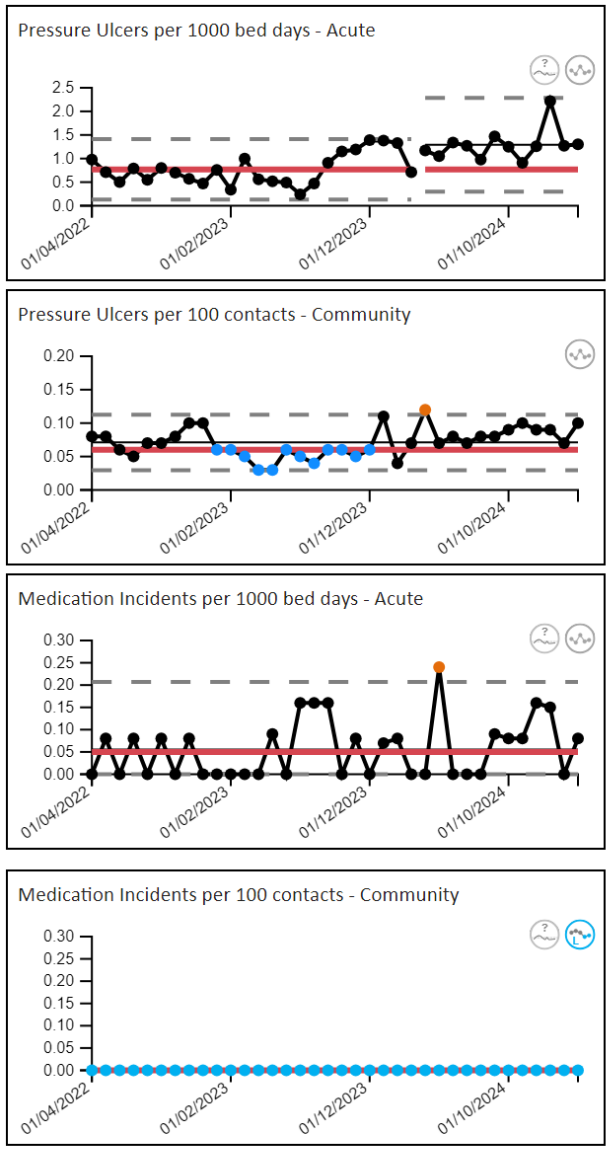
- Stabilisation of PSII's with adequate evidence of shared learning
- There is likely to be an increase in the number of After Action Reviews due to the new categorisation for when a PSII is warranted.
- Reduction in the total number of falls
- Key themes identified from moderate harm falls will drive a Qi initiative

Potential risks to improvement?

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

Subtheme: Care Incidents (2)

Data, Context and Explanation



•Pressure ulcers (PU) remain a concern and are considered, in the main, an avoidable harm associated with healthcare delivery.

•The rate of Pus in Acute has fallen and those in Community have now stabilised.

•The reported Cat 3 and 4, SDTI's and unstageable damage are all reviewed and graded by Tissue Viability, some are downgraded when assessed even though this assessment work has shown an improvement in initial grading by the community staff.

•There were only 2 incidence of Category 3 and above PU's that identified opportunities for improvement.

•Medication incidents in both Community and Acute remain in common cause, although Community the rate persists at 0 whilst in Acute it fluctuates with a mean of 0.05.

Metric	Target	Value	Exec Lead	Ops Lead
Pressure Ulcers per 1000 bed days - Acute	1.76	1.3	Helen Dobson	Victoria Hazeldine
Pressure Ulcers per 100 contacts - Community	0.1	0.1	Helen Dobson	Victoria Hazeldine
Medication Incidents per 1000 bed days - Acute	0.1	0.1	Jo Beahan	Victoria Hazeldine
Medication Incidents per 100 contacts - Comm...	0.0	0.0	Jo Beahan	Victoria Hazeldine

What actions are planned?

- Medication incidents at moderate harm and above remain low, however actions to address those incidents related to critical medication have been identified and will be presented at the next Medication Safety Committee.
- Pressure Ulcer Identification Tool audit has demonstrated improved compliance and started to see improvements in the Acute.
- •Business case currently being completed for a full mattress replacement program.
- .

What is the expected impact?

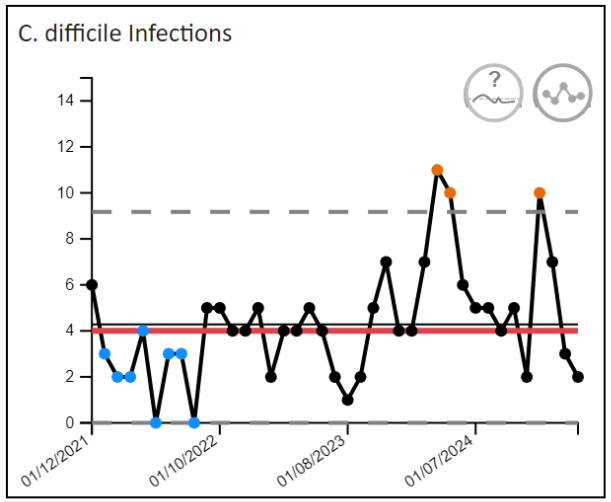
- Reduction in the number of critical medication incidents.
- Removal of the SDTI category.
- There will be an increase in Category 3 PU's as under the new guidance, SDTI will now be Category 3.
- Converting to hybrid mattresses will mean that patients requiring pressure relieving equipment will have it immediately and reduce the incidence of PU's.

Potential risks to improvement?

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

Subtheme: Infection Prevention & Control

Data, Context and Explanation



- •Clostridium difficile (C. diff) is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It can usually be treated with a different type of antibiotic.
- April, May, December and January 24/25 showed higher than expected rates.
- Nationally there is a trend for increasing rates of C. diff with a renewed focus on AMR. The UKHSA safety alert has been shared with clinicians
- Learning from harm is reviewed monthly at Harm Free Care panels and the emerging themes linked to antimicrobial stewardship and prescribing practices.
- Action are in place to address (see planned action box). It is noticeable that, at present, we will continue to see infections higher than target.

Metric	Target	Value	Exec Lead	Ops Lead
C. difficile Infections	4	2	Helen Dobson	Jen Hilton

What actions are planned?

- Microbiology support through ward rounds on AMU three times a week to advise on antimicrobial prescribing. Supported by antimicrobial guide on the EOLAS app
- New process to acquire a code for prescribing ciprofloxacin in response to new guidance around fluoroquinolone antibiotics
- Monthly Harm Free panel continues with shared learning on timely stool sampling and antibiotic prescribing main themes.
- Launch of SY SIGHT campaign to promote good hygiene practices

What is the expected impact?

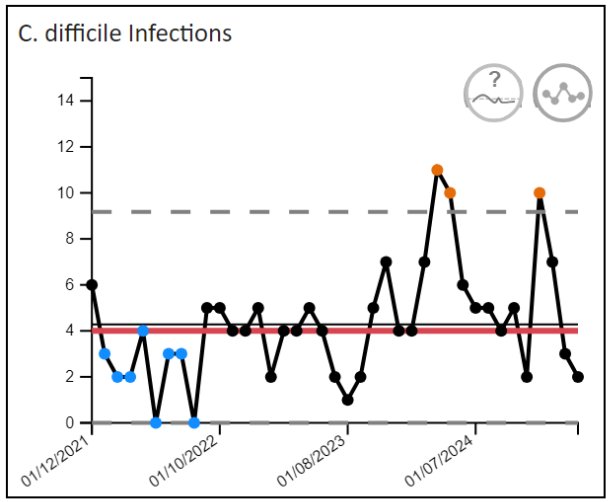
- A stabilisation of C. diff cases associated per 100,000 bed day rate

Potential risks to improvement?

National patterns of increases in rates of CDI
Antibiotic prescribing practices in primary care for ‘admission avoidance’
Limited availability of single rooms

Subtheme: Infection Prevention & Control

Data, Context and Explanation



- Clostridium difficile infection (CDI) is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It can usually be treated with a different type of antibiotic.
- Total number of cases for 2024/5 was 71 against a trajectory of 44
- All cases of CDI are reviewed at the monthly harm free care panel. The emerging themes are linked to timely sampling, antimicrobial stewardship and prescribing practices.
- January saw 7 cases of CDI, February 3 cases and March 2 cases.
- Action are in place to address (see planned action box).

Metric	Target	Value	Exec Lead	Ops Lead
C. difficile Infections	4	2	Helen Dobson	Jen Hilton

What actions are planned?

- Microbiology support through ward rounds on AMU three times a week to advise on antimicrobial prescribing. Supported by antimicrobial guide on the EOLAS app
- New process to acquire a code for prescribing ciprofloxacin in response to new guidance around fluoroquinolone antibiotics
- Monthly Harm Free panel continues with shared learning on timely stool sampling and antibiotic prescribing main themes.
- Launch of SY SIGHT campaign to promote good hygiene practices

What is the expected impact?

- A stabilisation of C. diff cases associated per 100,000 bed day rate

Potential risks to improvement?

National patterns of increases in rates of CDI
Antibiotic prescribing practices in primary care for ‘admission avoidance’
Limited availability of single rooms

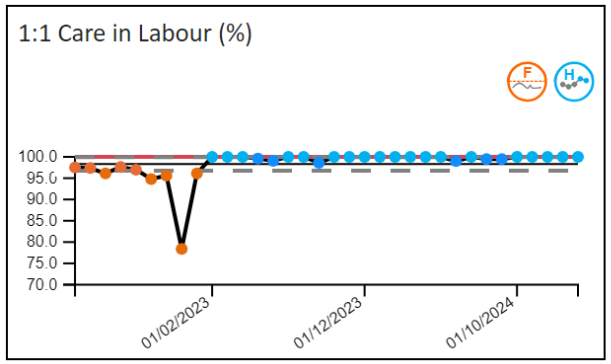
Maternity

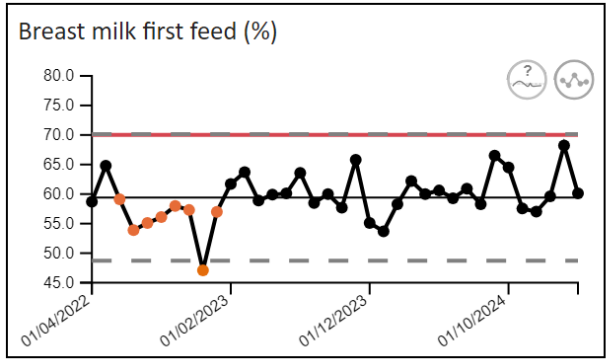
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	100.0	Mar-25	☑	F	H	-	CI
Breast milk first feed (%)	70.0	60.1	Mar-25	☒	?			S
Stillbirth rate (per 1000 births)	3.29	4.1	Mar-25	☒	P	H	-	C

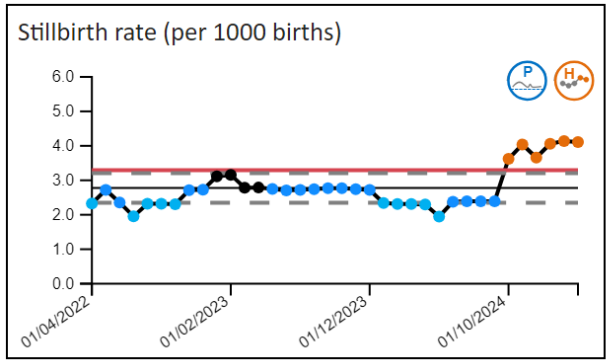
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Maternity

Data, Context and Explanation







- No concerns currently with 1:1 care in labour.
- Breast Milk First Feed continues to be below the Trust target, with an average of 60.1% against a Trust target of 70% in the month of March.
- In March2025 we had no further stillbirths in this month.
- We are aware of an increase in the local stillbirth rate from 2022-2024
- 2022 – 2.68/1000 births
- 2023 – 2.88/1000 births
- 2024 – 3.66/1000 births
- ONS data showed a 25% reduction nationally in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic.

National rate 2021 – 3.52 per 1000 births
- 2022 – 3.33 per 1000 births
- 2023 – 3.9 per 1000 births

(ONS) 2024 data not yet published

Metric	Target	Value	Exec Lead	Ops Lead
1:1 Care in Labour (%)	100.0	100.0	Helen Dobson	Sarah Petty
Breast milk first feed (%)	70.0	60.1	Helen Dobson	Sarah Petty
Stillbirth rate (per 1000 births)	3.3	4.66	Helen Dobson	Sarah Petty

What actions are planned?

- **1:1 care in labour** – continue to monitor for variation.
- **Breast milk first feed** – continue with action plans to move infant feeding status to BFI gold following reaccreditation at TRFT to level 3 accreditation. Work will consider the inequalities and inequities seen in the Rotherham birthing population to attempt to improve rates.
- **Stillbirth rate**: -Continue to work as an MDT to reduce stillbirth rates to meet the national ambition.
- Continue to learn from stillbirths and neonatal deaths and PMRT reviews and listen to families and understand how their experience can change the care moving forwards.
- Sharing actions plans and learning with staff.
- And the wider MDT for learning – LMNS and the Maternity and Neonatal Service Voices Partnership (MNVP).

What is the expected impact?

- Safety of women and babies will be maintained on labour ward
- Rates of first feed breastmilk will increase for all women who are cared for at TRFT.
- Learning from recently released reports and pending national recommendations will inform the work undertaken at TRFT to monitor, learn and improve services for woman at risk of suffering a stillbirth.

Potential risks to improvement?

- If staffing levels were not maintained, 1 to 1 care in labour may be impacted.
- Lack of focus on public health work streams for pregnant women. Women are often disadvantage within the Rotherham's birthing population. TRFT maternity need to maintain focus on the health promotional needs of all women to inform of the benefits of breastfeeding.
- Stillbirth national targets need to be re-set so that trusts have clear trajectories.

Performance Matrix Summary – Finance and Performance

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • Urgent 2 Hour Response	**GOOD: CELEBRATE AND UNDERSTAND** • FDS	**CONCERNING: CELEBRATE BUT TAKE ACTION** • RTT
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND**	**STATIC: INVESTIGATE AND UNDERSTAND** • Waiting List Size • 52+ weeks - CYP • 65+ weeks • OP to PIFU • Overdue Followups • DM01 • 31 Day Treatment Standard • 62 Day Treatment Standard • >12 hours in A&E • LoS >21 Days • Date of Discharge = Discharge Ready Date • Patients on Virtual Ward • First Outpatients (%Plan) • Inpatients (%Plan) • Daycases (%Plan) • LoS >7 Days • Mean LoS (Elective) • Mean LoS (Non-Elective) • A&E Attendances from Care Homes • 12 hour Trolley Waits	**CONCERNING: INVESTIGATE & TAKE ACTION** • 4 Hour Performance • Average time to be Seen • Criteria to Reside is No • Admissions from Care Homes • Clinic Utilisation • Capped Theatres Utilisation • Did Not Attend • Discharged <5pm • 52+ weeks • Ambulance Handovers >30min
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION** • Bed Occupancy	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

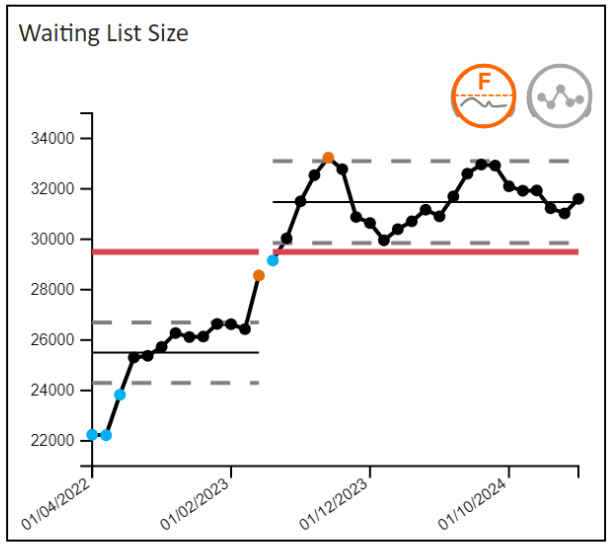
Elective Care and Cancer

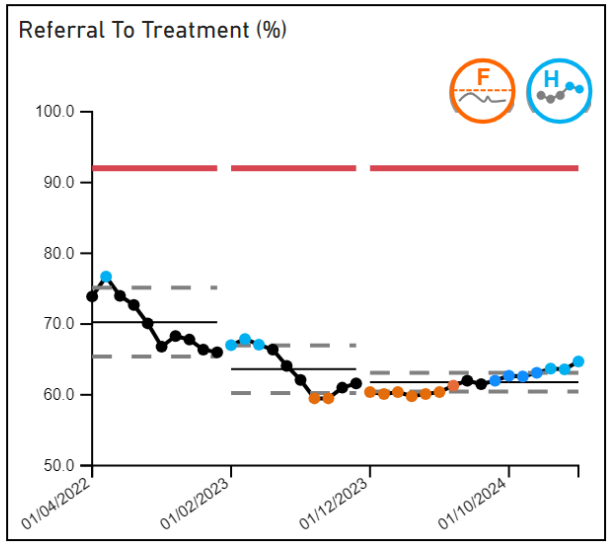
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	29,500	31,601	Mar-25	✗	F			S
Referral To Treatment (%)	92.0	64.7	Mar-25	✗	F	H		CI
Number of 52+ Weeks	380	790	Mar-25	✗	F			C
Number of 52+ Weeks - CYP	0	60	Mar-25	✗	F			C
Number of 65+ Weeks	0	0	Mar-25	✓	?			S
OP Activity moved or Discharged to PIFU (%)	2.5	2.9	Mar-25	✓	?			S
Overdue Follow-ups	-	18,330	Mar-25	-	-	H	-	S
DM01 (%)	1.0	0.6	Mar-25	✓	?			S
Faster Diagnosis Standard (%)	77.0	84.8	Feb-25	✓	?			S
31 Day Treatment Standard (%)	96.0	96.1	Feb-25	✓	?			S
62 Day Treatment Standard (%)	70.0	68.7	Feb-25	✗	?			S

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

Subtheme: Waitlist & RTT

Data, Context and Explanation





- The Trust had committed to reducing the elective waiting list to 29,500 by March 2025. Due to significant operational pressures over winter, which impacted on our ability to increase activity, the waiting list sits at 31,601 in March 2025. Despite these challenges, we have seen an 4% improvement from 32,920 in August 2024 where the waiting list peaked.
- We have seen a 4.9% improvement in the RTT Standard over the year with the Trust achieving 64.7% in March 2025 compared to 59.8% in March 2024.
- The RTT standard was achieved across several specialties, including General Medicine, Geriatric Medicine, Respiratory, Paediatrics, and Paediatric Cardiology, as well as sub-specialties such as Diabetes & Endocrine, Stroke, and Rheumatology.

Metric	Target	Value	Exec Lead	Ops Lead
Waiting List Size	29,500	31,601	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	92.0	64.7	Sally Kilgariff	Andrea Squires

What actions are planned?

- Implementation of Super Clinics in key specialties (Orthopaedics, ENT, OMFS and Gynaecology) in May to increase outpatient and surgical throughput
- All specialties to standardise clinic templates by 30th May 2025 – templates have been reviewed and variation shared with services; Orthopaedics already implemented
- Implement high flow theatre lists in key specialties (Orthopaedics, ENT, OMFS and Gynaecology) in May – Orthopaedic high flow list planned for 24 April
- Establishment of weekly task and finish group for 6 weeks to streamline pre-op slot booking

What is the expected impact?

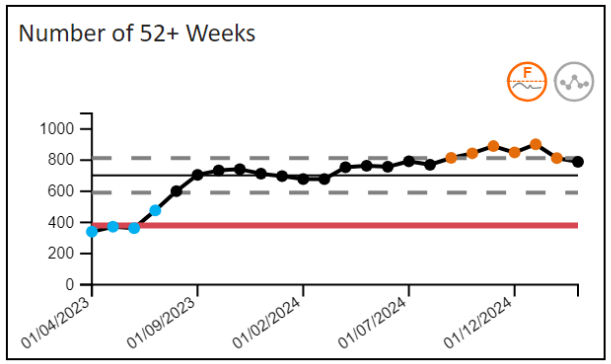
- The super clinics will boost clinic capacity and treatment volumes, thereby directly reducing RTT and waiting lists in May 2025
- Standardisation of clinic templates will improve consistency and efficiency in appointment allocation, supporting quicker patient access and reduced backlogs
- High flow lists will maximise surgical productivity and reduce the volume of long-wait patients, improving RTT
- Pre-operative process improvements will minimise

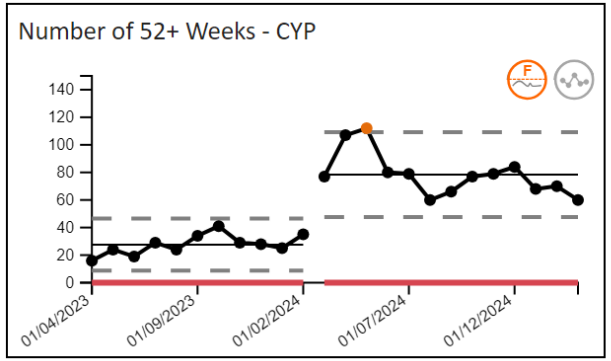
Potential risks to improvement?

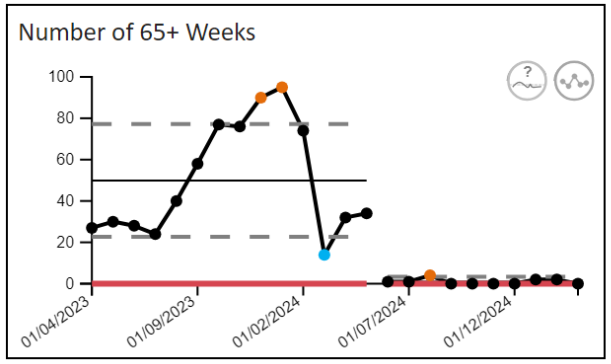
- Operational pressures (e.g. HDU capacity, elective demand) may delay planned actions
- Waiting list additions continue to exceed removals
- Limited financial resources may restrict delivery of additional activity
- Enhanced validation may uncover further long waits

Subtheme: Long Waiters

Data, Context and Explanation







- The Trust had committed to reducing the number of patients waiting over 52 weeks by 50% by March from 755 to 380. Due to significant operational pressures over winter, we saw an increase to 902 in January 2025, however this has now reduced to 790 in March which places the Trust in second quartile nationally.
- Particular growth in patients waiting over 52 weeks has been noted in OMFS, Gynaecology, T&O, General Surgery and ENT. Insourcing and outsourcing options continue to be prioritised for these specialties.
- Similar growth was noted in children and young people waiting over 52 weeks for treatment in orthopaedics, ENT and OMFS; though these continue to reduce.
- For 2024/25, the national planning guidance set an objective for 0 patients to still be waiting over 65 weeks for their treatment by the end of Sept-24. We submitted 2 breaches in Jan-25 and Feb-25; and successfully achieved 0 patients waiting more than 65 weeks in March 2025.

Metric	Target	Value	Exec Lead	Ops Lead
Number of 52+ Weeks	380	790	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks - CYP	0	60	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	0	0	Sally Kilgariff	Andrea Squires

What actions are planned?

- Implementation of Super Clinics for high volume specialties (Orthopaedics, ENT, OMFS and Gynaecology) in May to fast-track patients through treatment pathway
- Implement standardised clinic templates by 30th May 2025 – variation analyses completed; implementation underway
- Delivery of high flow theatre lists in key specialties (Orthopaedics, ENT, OMFS and Gynaecology) in May – Orthopaedic high flow list planned for 24 April
- Strengthen Theatre list validation and booking controls – weekly huddles with services to proactively resolve booking gaps

What is the expected impact?

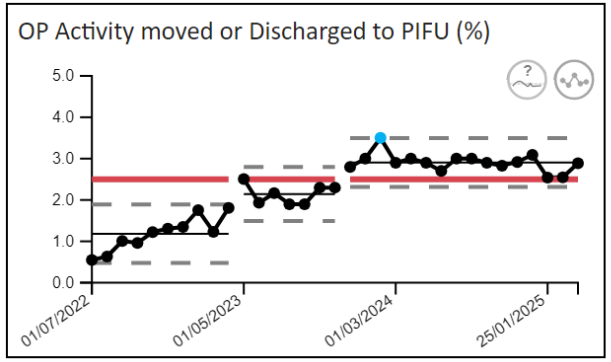
- The super clinics will accelerate assessment and scheduling for long-wait patients in May 2025
- Standardisation of clinic templates increase outpatient capacity and scheduling efficiency, supporting earlier intervention for patients approaching or exceeding 52 weeks
- High flow lists will increase surgical throughput, targeting long-waiting patients and reducing >52-week breaches
- Theatre list booking improvements will ensure maximum use of available theatre time for long-waiting patients

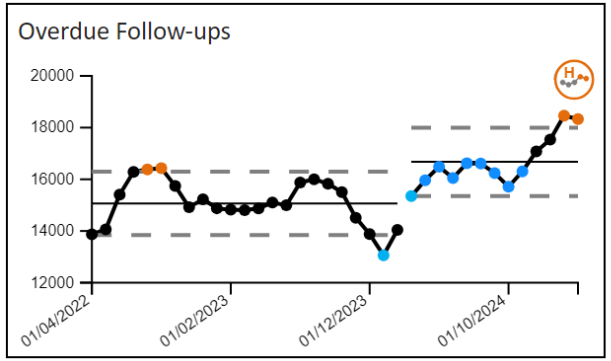
Potential risks to improvement?

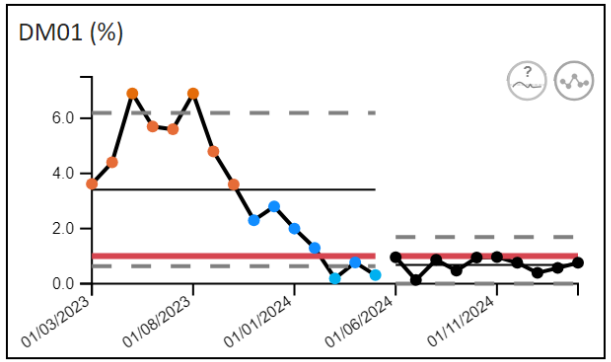
- Operational pressures (e.g. HDU capacity, elective demand) may delay implementation of planned actions.
- Limited staff availability, high sickness rates, and change fatigue may affect uptake of new processes and technologies.
- Financial constraints may limit delivery of additional activity.
- Enhanced validation may identify further long-wait patients.

Subtheme: Diagnostics & Follow-ups

Data, Context and Explanation







- The 2024/25 national planning guidance set an objective to continue to implement outpatient transformation approaches, including patient-initiated follow-up (PIFU).
- The Trust set the objective to ensure 1.5% of patients waiting for an outpatient follow-up appointment is moved or discharged to PIFU, by Mar-25. We have seen significant improvement in this area from Dec-23, achieving 2.9% in March 2025
- The last 12 months have seen a step change in the average number of overdue follow ups, with recent increases seen in Cardiology, Gastroenterology, Respiratory, ENT, OMFS, Orthopaedics, Urology and Gynaecology. Work is ongoing to reduce the number of patients waiting for a follow up appointment.
- The 2024/25 national planning guidance also set an objective to increase the % of patients that receive a diagnostic test within 6 weeks to 95%. The Trust consistently exceeded this standard, also achieving its internal ambition to maintain performance at 99% for 24/25. The Trust has maintained this achievement since Mar-24.

Metric	Target	Value	Exec Lead	Ops Lead
OP Activity moved or Discharged to PIFU (%)	2.5	2.9	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	-	18,330	Sally Kilgariff	Andrea Squires
DM01 (%)	1.0	0.8	Sally Kilgariff	Andrea Squires

What actions are planned?

- Develop PIFU clinical protocols following agreement of the PIFU SoP and cascading to clinical leads
- Establish T&F Group to target and reduce the number of patients waiting for an overdue follow-up appointment, working with clinical colleagues to ensure appropriate clinical management including PIFU where appropriate
- Implementation of virtual fracture clinic – clinical lead in place, simple 3-step process drafted, and patient letter (with helpline) ready
- Review and align clinic templates, targeting slot allocation and reduce unnecessary follow-up appointments

What is the expected impact?

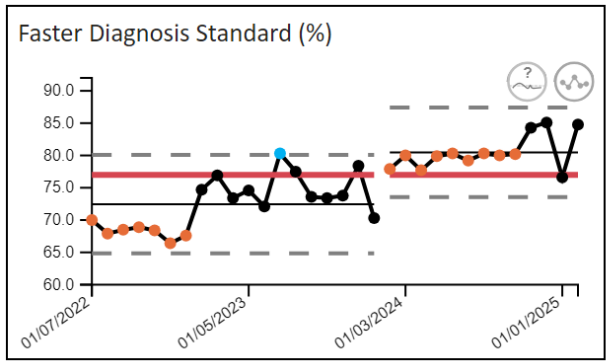
- PIFU clinical protocol will enable consistent and safe application of PIFU across services, facilitating more patients being moved appropriately to PIFU pathways
- Direct intervention will reduce backlog volumes and improve follow-up timelines
- The virtual fracture clinic will reduce unnecessary follow-up appointments and facilitate use of PIFU in MSK pathway

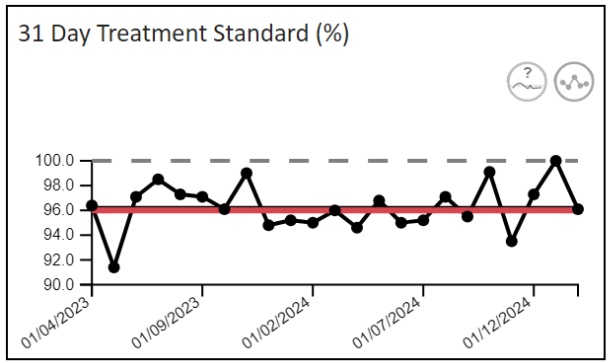
Potential risks to improvement?

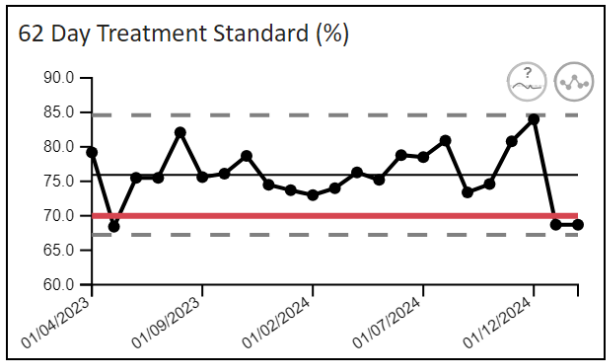
- Inclusion of overdue surveillance patients in Endoscopy DM01 from September 2024 and Audiology patients from July 2025 may impact performance due to additional capacity requirements
- Financial constraints may limit delivery of additional activity
- Transfer of long-wait DM01 patients under mutual aid agreements may affect local performance.
- Limited staffing, high sickness rates, and change fatigue may hinder adoption of new processes and technologies.

Subtheme: Cancer

Data, Context and Explanation







- In 2024/25, the national target was to achieve 77% against the 28-day Faster Diagnosis Standard by March 2025. We met this in 11 of the last 12 months, averaging 79% since February. A local ambition of 80% by March was also set and successfully achieved.
- The 31-day standard continues to show normal variation patterns. The Cancer Improvement Team are focusing support in the Lower GI tumour site to improve this standard.
- The national planning guidance also sets the objective to improve the 62-day performance to 70% by Mar- 25.
- The Trust also set a further ambition to improve performance to 77% by March 2025. We met this in 5 of the last 12 months, averaging 75% across the year.

Metric	Target	Value	Exec Lead	Ops Lead
Faster Diagnosis Standard (%)	77.0	84.8	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	96.0	96.1	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	70.0	68.7	Sally Kilgariff	Andrea Squires

What actions are planned?

- Establish robust surveillance pathways for at-risk patients as part of the Failsafe Liver (HCC) and Prostate (PSA) Surveillance programme
- Launch of Netcall Converse Cx to streamline patient communication and booking of Endoscopy patients
- Develop Patient Letters Using Behavioural Science - refine communication to improve patient engagement and attendance
- Undertake 62-Day Pathway Analysis for Head and Neck – include detailed review of delays

What is the expected impact?

- Robust surveillance pathways will enable timely monitoring and escalation, supporting faster diagnosis and treatment within 62-day standard
- Netcall will improve diagnostic coordination, support earlier appointments for Lower Gi, and enable delivery of FDS
- Patient letters using behavioural science will reduce delays from DNAs and late responses, improving performance across FDS and 31-day treatment metrics
- Pathway analysis will Identify improvement opportunities, with learning applicable to Gynaecology and Lower GI

Potential risks to improvement?

- Limited capacity in diagnostics, clinics, and workforce, particularly in urology, may constrain delivery of targeted interventions
- Operational pressures and emergency demand (e.g. HDU capacity for LGI) may delay planned actions
- Change fatigue and competing priorities may affect engagement with new processes and service changes
- Cancer Alliance funding for the Cancer Service Improvement Team has not been secured for 2025/26, reducing the capacity to support delivery of planned improvements

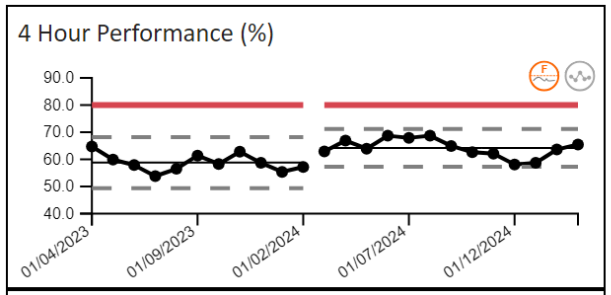
Non-elective and Flow

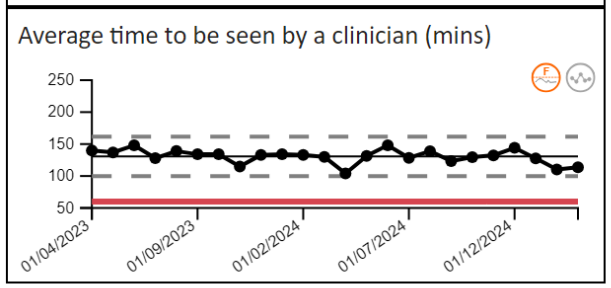
Metric	Trust Target	Latest Data	Period	Achieved (in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	80.0	65.5	Mar-25	☒	F			C
Ambulance Handover Times >30 mins (%)	0.0	16.7	Mar-25	☒	F			C
Average time to be seen by a clinician (mins)	60.0	113.8	Mar-25	☒	F		-	C
Patients spending >12 hours in A&E from time of arrival (%)	2.0	4.4	Mar-25	☒	?			S
12hr Trolley Waits	0	35	Mar-25	☒	?		-	S
Bed Occupancy (%)	92.0	94.3	Mar-25	☒	?	H		C
Length of Stay over 21 Days	64	62	Mar-25	☑	?		-	S
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	81.8	Feb-25	☒	?		-	S
Criteria to Reside is No (%)	10.0	19.1	Mar-25	☒	F		-	C

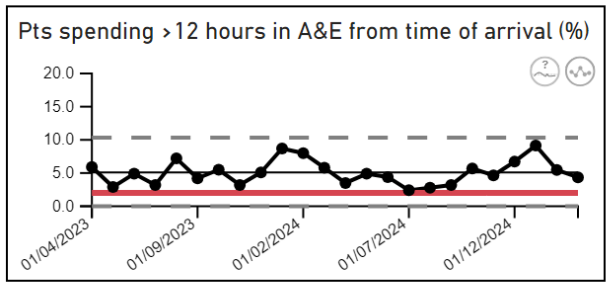
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

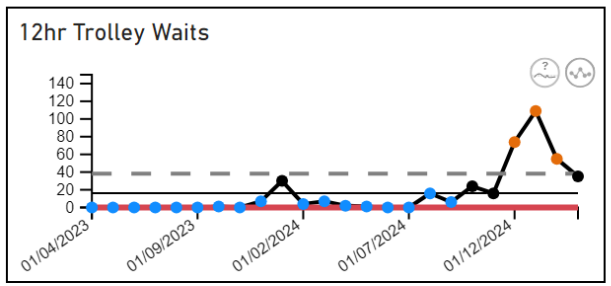
Subtheme: Emergency Care - Waiting Times

Data, Context and Explanation









- National guidance set an objective for all Trusts to achieve the 4 hour performance standard of 78% by March 2025. While performance falls below this standard, there is sustained improvement in this area, which is now performing at a stable average of 67%.
- Average time to see a clinician remains in a natural variation pattern. The consistent increase in demand alongside workforce challenges continues to impact the ability to sustain improvements.
- The number of patients spending more than 12 hours in the department is a key national focus. The number of patients spending more than 12 was increasing but has reduced in recent months.
- The Trust has set a standard to achieve zero trolley waits in line with national guidance. Following a number of challenging winter months, performance is now improving.

Metric	Target	Value	Exec Lead	Ops Lead
4 Hour Performance (%)	80.0	65.5	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	60.0	113.8	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	2.0	4.4	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	0	35	Sally Kilgariff	Lesley Hammond

What actions are planned?

- For April “every minute counts” to support flow through the organisation.
- This will bring the day forward for by leaving empty beds on assessment areas to enable flow through the peak demand times in the Trust.
- The Community ready unit will support early transfer of patients for discharge and wards highlighting patients over night that can be transferred the next morning.
- Utilisation of NHS responders to take patients medications out to patients if there is a delay between sending patients home and medication ready

What is the expected impact?

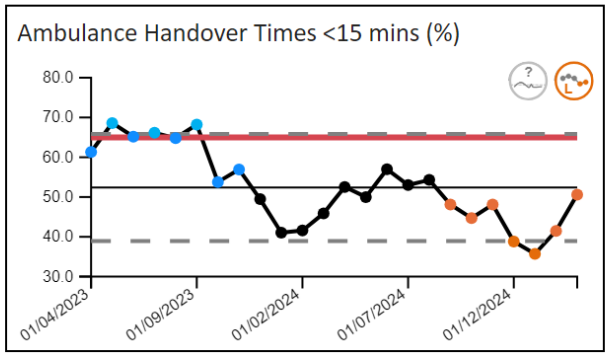
- Reduce delays waiting for admission to wards
- Reducing patients spend over 12 hours in the department
- Reduce the average time spent in the department by admitted patients
- Improvement in 4 hour performance
- Reduction in over crowding
- Empowerment of ward managers to support flow and patients home in a timely fashion

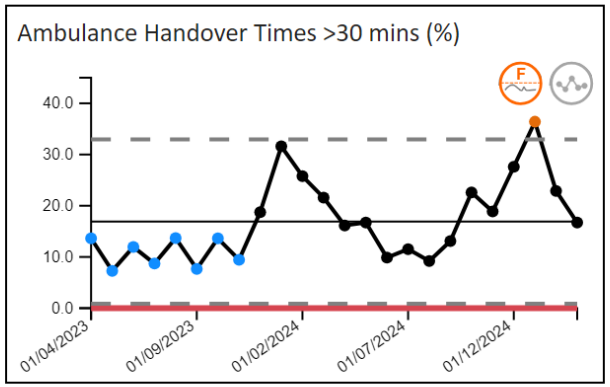
Potential risks to improvement?

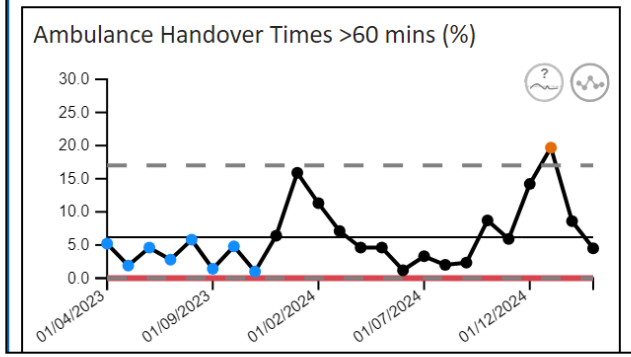
- Increase in demand will impact the Trust ability to achieve the 4 hour performance standards.
- Medical workforce staffing availability
- Sickness across medical and nursing workforce
- Infection control challenges in relation to bed occupancy

Subtheme: Emergency Care - Ambulance

Data, Context and Explanation







- The Operational Planning Guidance set an objective to achieve an average of 30 minutes to handover by March 2025.
- Achievement of this standard is dependent on compliance with two other standards; patients wait less than 15 minutes for handover and patients must not wait over 60 minutes for handover.
- The Trust compliance with Ambulance handover times <15 minutes remains below the standard of 65%. The last couple of months have begun to see performance back in line with 50% of patients being handed over in less than 15 mins.
- For handover times >30mins, average times are coming back in line with previous performance levels of 17%.
- Ambulance handover times >60 did not meet the standard of 0%. Current performance trends indicate that we should expect an average of 5% in any given month, we have been just below our current average in month at 4.5%.

Metric	Target	Value	Exec Lead	Ops Lead
Ambulance Handover Times <15 mins (%)	65.0	50.6	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >30 mins (%)	0.0	16.7	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	0.0	4.5	Sally Kilgariff	Lesley Hammond

What actions are planned?

- YAS working along side Transfer of care team to reduce conveyance to hospital
- Key focus on ambulance handover by Operational managers and Nursing workforce
- Text Messages will alert Operational Managers and Clinical Site Managers to delays with Ambulance Handovers as well as alerts on MS Teams
- Visit STH “Good Practice” of streaming of ambulance patients April /early May
- Ongoing work with YAS around fit to sit patients
- Workshop to look at direct referral to SDEC for the new build with YAS and community teams

What is the expected impact?

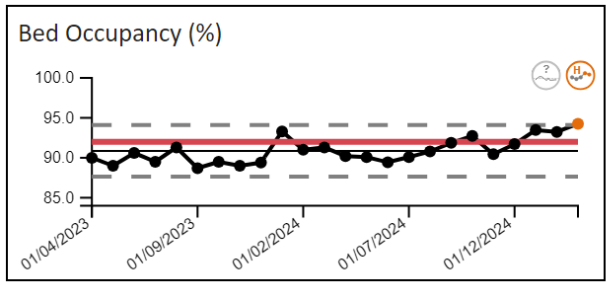
•There will be an improvement in ambulance handover times and TRFT sustained high levels of performance.
•Pilots will support reduction in conveyance to ensure all pathways in and out of hospital are utilised by March 2025
•Patients seen by the right clinician at the right time in the right place first time

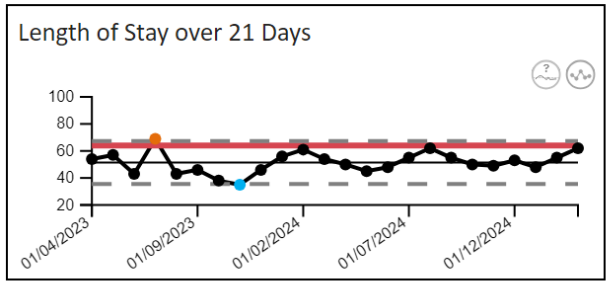
Potential risks to improvement?

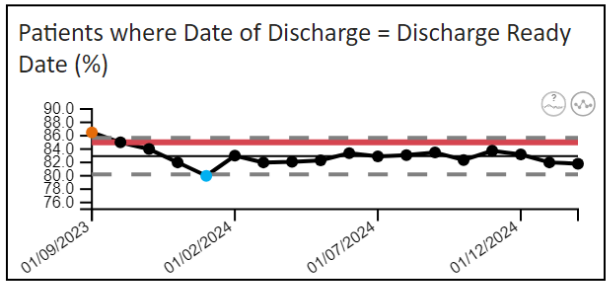
•High demand resulting in possible increase in ambulance attendances or batching of ambulances
•Ongoing demands for UEC services
•Peaks in demands for services
•Flow within the Trust/organisation and Place
• IPC challenges in relation to bed occupancy

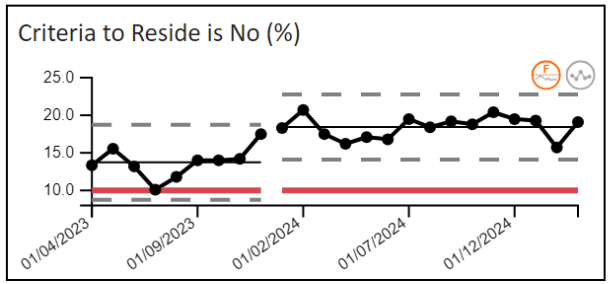
Subtheme: Inpatient Flow

Data, Context and Explanation









- Bed occupancy for March 94.3% this includes both core and escalation capacity in line with national reporting requirements. If the escalation beds were excluded General and Acute bed occupancy would be 95.17%. (B5 101% and SU 111.69%).
- 92% is recognised as optimum bed occupancy. It should be expected that we would see values fluctuate between 87% and 94% based on current patterns and Winter pressures. This month has seen the highest occupancy seen over the last two years, at 94.3%, which is significantly higher than normal.
- Length of stay >21 days remains in line with natural variation and achieving the target for the month
- Date of Discharge = Discharge Ready holds steady below target at around 83%.
- Criteria to Reside continues to fluctuate, showing natural variation between 22% and 14%, consistently not achieving the target of below 10%. Nationally there is variation in recording process, TRFT has been acknowledged via the regional team to be reporting accurately and work continues to focus on place based collaboration to achieve a reduction.

Metric	Target	Value	Exec Lead	Ops Lead
Bed Occupancy (%)	92.0	94.3	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	64	62	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	81.8	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	10.0	19.1	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Plan to de-escalate additional inpatients beds on B6 to maximise SDEC throughput
- Length of Stay meetings – Actions discussed in operational meeting with ward managers
- Focus on criteria to reside and internal delays
- Board round standardisation across medical wards with support from Ward managers and Clinical Nursing lead for patient flow
- Pilot of a new discharge form for IDT

What is the expected impact?

- Increase patients streamed through SDEC in April
- Continued reduction in patients in hospital over 21 days in April
- Reduction in those patients that have been an inpatient over 7 days in April
- Reduction in delays of paper work to IDT from wards – approve pilot end April
- Empowerment of ward base teams to own their patients to improve patient experience

Potential risks to improvement?

•Increase demand through UECC sustained
•Continued pressures across the system in health and social care and discharge delays become more frequent
•De-escalation of inpatient beds not possible due to ongoing pressures

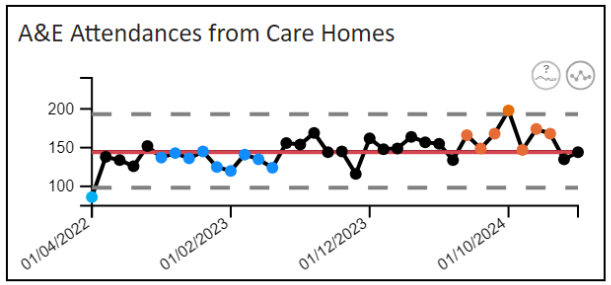
Community

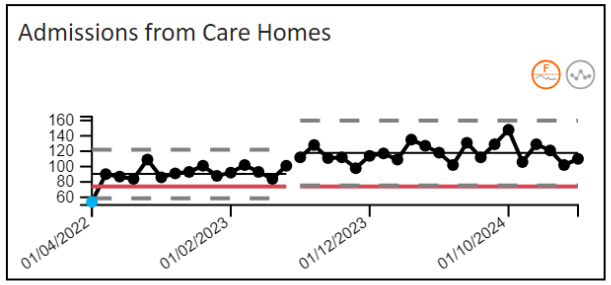
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	144	144	Mar-25	☑			-	S
Admissions from Care Homes	74	110	Mar-25	☒			-	C
Number of Patients on Virtual Ward	80	55	Mar-25	☒			-	S
Urgent 2 Hour Community Response (%)	70.0	74.0	Jan-25	☑			-	VG

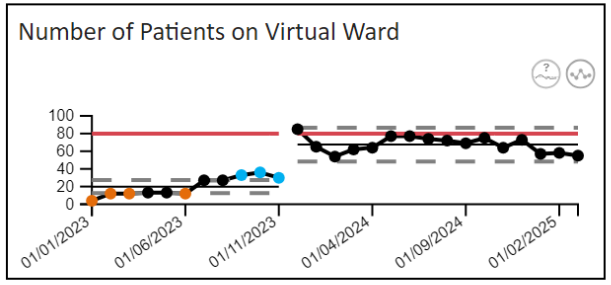
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

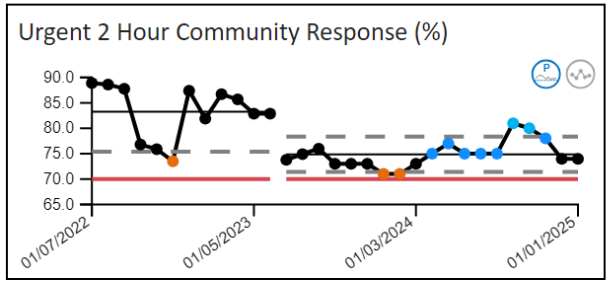
Subtheme: Community

Data, Context and Explanation









- The Community Teams, including the Trusted Assessors, continue to in reach into the Acute setting to facilitate early supported discharges for care homes residents.
- Community Teams continue to work with YAS. YAS colleagues to join the TOCH early January
- All care homes attendances and admissions are analysis each month. The average number of inpatients from care homes throughout March was 20.
- The number of patients on Virtual Wards has decreased in month. The average occupancy in March was 57 against a Trust standard of 80. Occupancy reached a peak of 69 on the 31 March. Capacity was impacted in month by acuity, sickness and vacancies
- The National standard for the 2 hour urgent community response is 70% of appropriate referrals. The trust is consistently meeting this target, and recent performance indicated this is now at a level where is can sustainably met the standard.

Metric	Target	Value	Exec Lead	Ops Lead
A&E Attendances from Care Homes	144	144	Sally Kilgariff	Lesley Hammond
Admissions from Care Homes	74	110	Sally Kilgariff	Lesley Hammond
Number of Patients on Virtual Ward	80	55	Sally Kilgariff	Lesley Hammond
Urgent 2 Hour Community Response (%)	70.0	74.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Continue to embed the role of Trusted Assessors and monitor impact.
- Undertake a review of capacity and demand – Attain v. SWIFT Model
- Improve sickness and absence rates – Engagement Events in planning stage
- Improve step down admissions to virtual ward
- Test remote technology with a small number of heart failure patients
- Ongoing review of specialist planned nursing activity to identify any UCR activity, including a review of the Directory of Service and Data quality.

What is the expected impact?

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

Potential risks to improvement?

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

Productivity Priorities

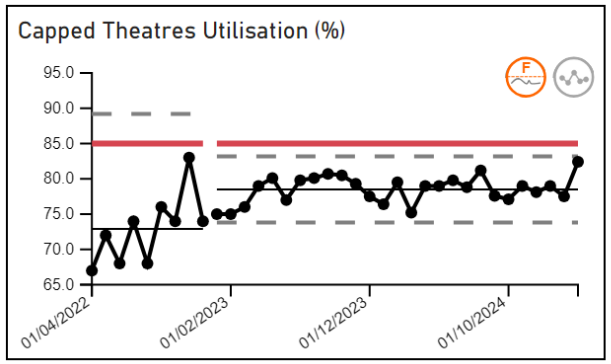
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%)	85.0	77.8	Mar-25	✗	F		-	C
Capped Theatres Utilisation (%)	85.0	82.4	Mar-25	✗	F			C
Did Not Attend (%)	7.0	7.0	Mar-25	✓	?			S
First Outpatients (% of Plan)	100.0	106.0	Mar-25	✓	?			S
Inpatients (% of Plan)	100.0	95.0	Mar-25	✗	?		-	S
Daycases (% of Plan)	100.0	97.0	Mar-25	✗	?		-	S
Length of Stay over 7 days	-	195	Mar-25	-	-		-	S
Mean Length of Stay (Non-elective)	-	5.6	Mar-25	-	-			S
Mean Length of Stay (Elective excluding Daycases)	-	2.5	Mar-25	-	-			S
Discharged before 5pm (%)	70.0	66.2	Mar-25	✗	F			C

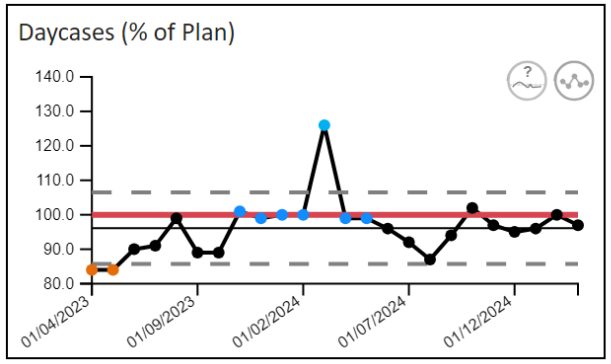
Plan is 19/20 + 3% i.e. *103% of 19/20*, therefore 100% achievement against Plan is 103% of 19/20

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

Subtheme: Theatres

Data, Context and Explanation





- National planning guidance has set a trajectory of 85% capped theatre utilisation (operating time of planned theatre sessions).
- Trust Capped Theatre Utilisation is improving, with current utilisation at 81.7% against the 85% standard. Orthopaedics and Gen Surgery theatre utilisation has improved with increases cases from Jan.
- Working with FF20 national team to improve Theatre utilisation and capacity,
- Model hospital data shows TRFT in the top quartile for utilisation.
- Day case activity had been achieving plan for a number of months. Work continues across a variety of targeted specialties.
- Anaesthetic and theatre staffing sickness has continued through March with the loss of 20.5 sessions lost in month. This has also impacted trauma capacity, with resulting elective cancellations

Metric	Target	Value	Exec Lead	Ops Lead
Capped Theatres Utilisation (%)	85.0	82.4	Sally Kilgariff	Darren Howlett
Daycases (% of Plan)	100.0	97.0	Sally Kilgariff	Darren Howlett

What actions are planned?

- Change in emergency theatre staff shift patterns
- Increased anaesthetic SAS additional session payments for a 6 month period for uncovered theatre sessions
- Improved utilisation of MEOC for simple cases
- Continue to increase cases per list in Ophthalmology
- Theatre Manager appointed and commenced in post
- Stricter policy on scheduling, lists being removed from specialties if non compliant

What is the expected impact?

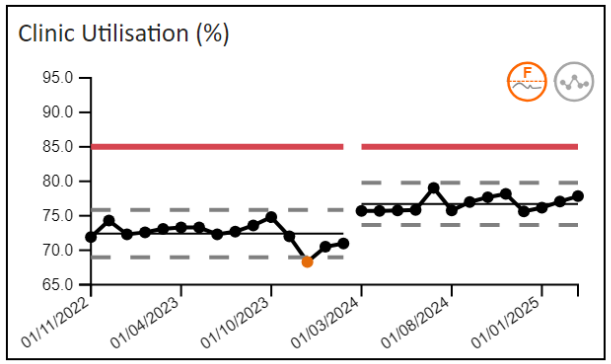
- Reduced gaps in emergency theatre will lead to less cancellations of extended trauma
- Reduced elective and extended trauma theatre session cancellations
- Improved overall utilisation and avoidance of 65 week breaches
- Increased day case rate in Ophthalmology
- Avoidance of 65 week breaches, challenges in scheduling
- More cohesive on the day theatre co-ordination and management of sickness

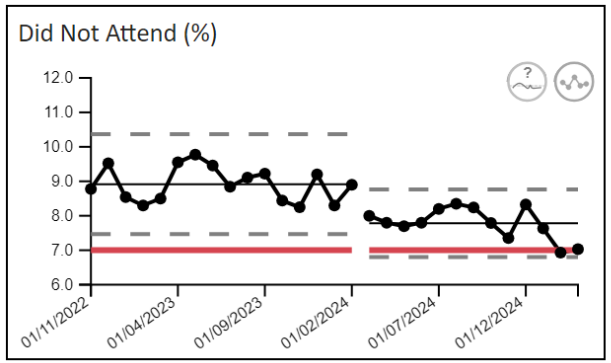
Potential risks to improvement?

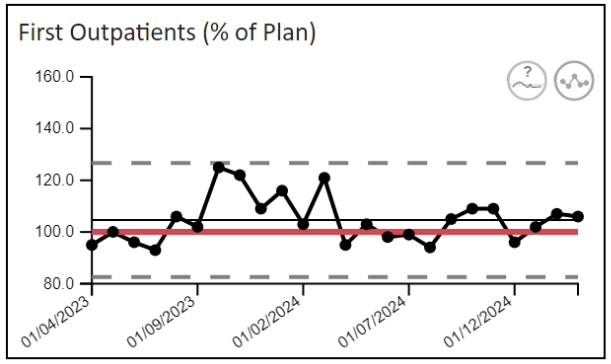
- Anaesthetic rotas may continue to impact on the ability to run theatre activity which significantly impacts on T&O in particular
- Capacity to deliver pre-op assessment may impact on patients available and fit for surgery
- High levels of anaesthetic and theatre staff absence impacting on lists being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

Subtheme: Outpatients

Data, Context and Explanation







- Clinic Utilisation is key to productivity and underutilised clinics is a key focus for the Trust this year. A 4% improvement step change has been noted since Mar 24, with further work to do to achieve the standard of 85%.
- Our current report includes all clinic types, inclusive of ring-fenced emergency clinics. For those Elective and 2ww wait clinics, that should be fully utilised, the utilisation is 93.77%. This will be reported more clearly into 25/26.
- Trust DNA rates have shown sustained reductions. The target has been met over the last 2 months. Work is focused on meeting the needs of our local population when attending for outpatient appointments to improve attendance via digital reminders and targeted patient engagement.
- Outpatient productivity provides the organisation with the opportunity to increase activity levels and improve outcomes for patients. The last two months have seen performance exceed plan as previously forecast, with the target to sustain this into 25-26.
- The Further Faster programme (GIRFT) supports each speciality in addressing their own specific productivity challenges in relation to outpatients in line with the GIRFT handbooks.

Metric	Target	Value	Exec Lead	Ops Lead
Clinic Utilisation (%)	85.0	77.8	Sally Kilgariff	Kevin Wilkinson
Did Not Attend (%)	7.0	7.0	Sally Kilgariff	Kevin Wilkinson
First Outpatients (% of Plan)	100.0	106.0	Sally Kilgariff	Kevin Wilkinson

What actions are planned?

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

What is the expected impact?

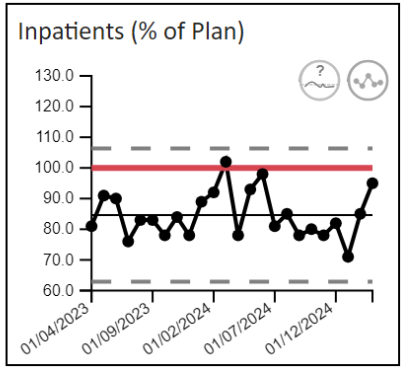
- Continued improvement of clinic utilisation into 2025/26.
- Sustained reduction in patients that DNA to 7% into 2025/26
- Sustained delivery at 100% into 2025/26.

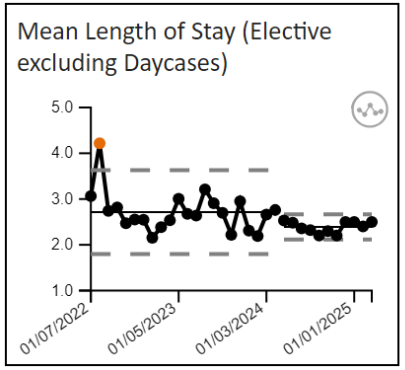
Potential risks to improvement?

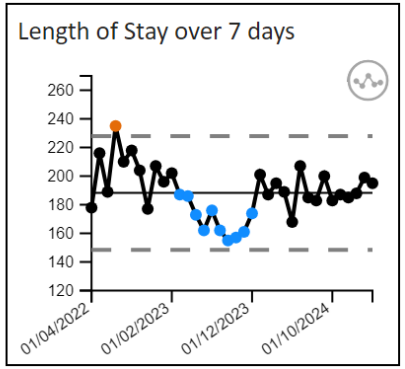
- Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
- Patient availability may impact on the ability to improve clinic utilisation, particularly short notice backfilled appointments.
- GP collective action and impact on referrals to specialities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

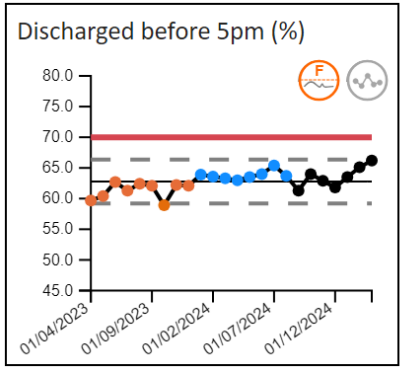
Subtheme: Inpatients

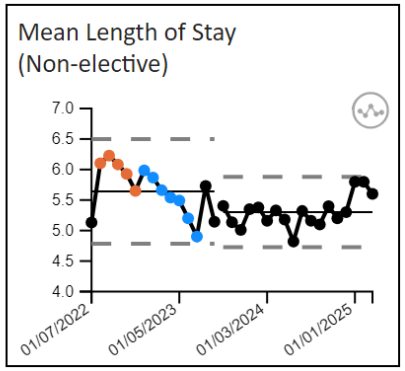
Data, Context and Explanation











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

Metric	Target	Value	Exec Lead	Ops Lead
Inpatients (% of Plan)	100.0	95.0	Sally Kilgariff	Jodie Roberts
Length of Stay over 7 days	-	195	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	-	5.6	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	-	2.5	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	70.0	66.2	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increase daily numbers through the Community Ready Unit by 5 further patients.
- Ongoing LLOS reviews focusing on patients not known to IDT and patients under 7days LOS
- Focus on Internal delays to reduce patients with no criteria to reside- pathway 0
- Focus on LOS in surgical specialities
- Focus from PLACE partners to reduce number o f complex patients with NCTR- pathways 1-3
- MDT/partner reviews of community bed bases to create capacity out of hospital.
- Daily board rounds led by senior nurses

What is the expected impact?

- Increase number of patients discharged before 5pm to 70%
- Reduction of 7 day LOS patients by 20 patients
- Continued reduction in average LOS for elective inpatients
- Increased number of discharges before 5pm supported by CRU

Potential risks to improvement?

- Increased complexity of patients and availability of home care and bed based placements
- Increased number of beds open to deal with demand with limited medical support to support discharge planning
- Limited capacity in social care
- Ability for the CRU to manage significant increase in numbers and transport to support earlier discharge (peaks and troughs in demand)

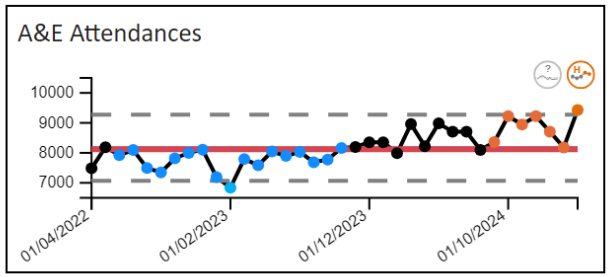
Activity

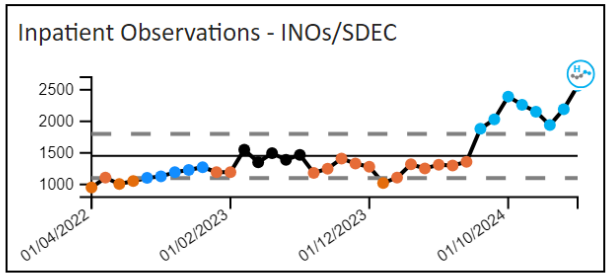
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances [Block]	8,124	9,429	Mar-25	☒	?	H	-	S
Inpatient Observations – INOs/SDEC [Block]	-	2,564	Mar-25	-	-	H	-	G
Non-Elective Inpatients [Block]	-	2,561	Mar-25	-	-	H	-	C
Outpatients Follow Up - Attendances [Block]	14,699	14,836	Mar-25	☒	?		-	S
Daycases [ERF]	1,998	1,928	Mar-25	☒	?		-	S
Inpatients - Electives [ERF]	350	326	Mar-25	☒	?		-	S
Outpatients New - Attendances [ERF]	6,049	6,433	Mar-25	☑	?		-	S
Outpatient Procedures - New and Follow Up [ERF]	4,767	6,328	Mar-25	☑	?	H	-	S
Referrals [Outpatient Demand]	-	8,377	Mar-25	-	-		-	S
2ww Referrals [Outpatient Demand]	-	1,242	Mar-25	-	-		-	S

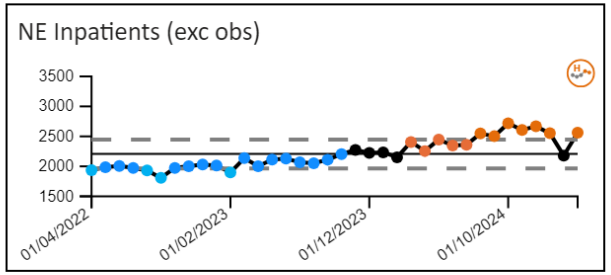
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

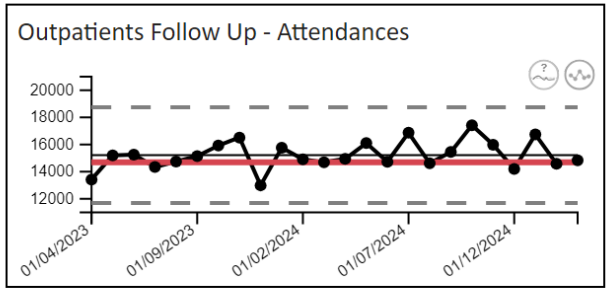
Subtheme: Block

Data, Context and Explanation









- Key activity lines on block contract are based on 23/24 M10 forecast outturn (block funding will not directly reflect activity)
- Block contracts do not allow additional income generation where activity lines are over performing
- A&E attendances are above plan both in-month and year-to-date.
- Non-Elective admission reductions are linked to introduction of SDEC from August 24
- Outpatient Follow-ups have increased slightly in-month but look to be sustained at lower levels when compared to previous months. An improvement in performance is linked to a) resolution to the outpatient procedure recording issues, b) introduction of SDEC returners, increased use of Patient Initiated Follow-up (PIFU)
- Despite the improving follow-up position, the Trust continues to experience significant follow-up backlogs therefore over performance in some areas is expected to continue/increase whilst we look to clear these.

Metric	Target	Value	Exec Lead	Ops Lead
A&E Attendances	8,124	9,429	Sally Kilgariff	Jodie Roberts
Inpatient Observations - INOs/SDEC	-	2,564	Sally Kilgariff	Jodie Roberts
NE Inpatients (exc obs)	-	2,561	Sally Kilgariff	Jodie Roberts
Outpatients Follow Up - Attendances	14,699	14,836	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Review of un-coded A&E attendances – work underway to review documentation and recording in MT
- Continue to monitor follow-up performance and benchmark new to follow-up ratios at specialty level and improve level of transfer to PIFU pathways
- Identify any areas of correlation between non-elective pressures and reduction in elective procedures (impacting ERF)

What is the expected impact?

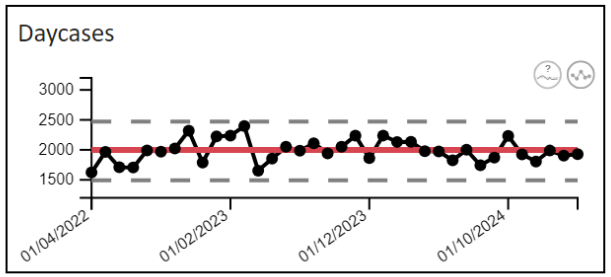
- Confirm SDEC/NEL activity is accurately being reflect in the data submission/contract monitoring. Fully understand the impact of EDS4.
- Ensure accurate record keeping for A&E attendances (should the contract mechanism change in the future this could potentially impact any re-basing)
- Identify areas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

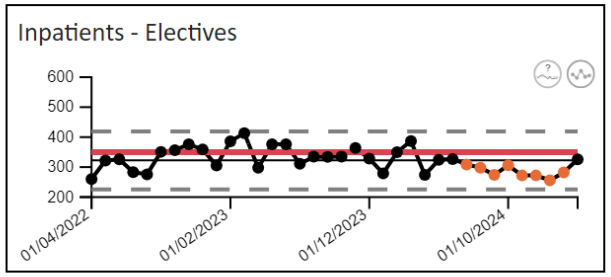
Potential risks to improvement?

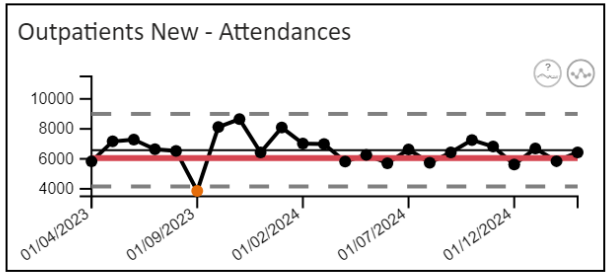
- Despite being on block, all key lines require scrutiny to ensure the Trust a) understands how this is impacting on financial performance b) we maintain an accurate position to safeguard changes to future contracting models
- Continuing increase in non elective demand, which is unfunded due to block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

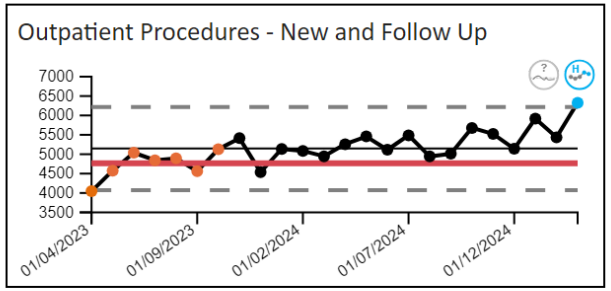
Subtheme: ERF

Data, Context and Explanation









- ERF contracted activity targets are based on 19/20 actuals + 3% (24/25 plans include the 3% increase)
- ERF lines operate on a cost and volume basis as per National Planning Guidance
- The updated tariff price uplifts for the pay award were transacted on both plan and actuals in October.
- Daycase activity is 70 below plan in-month . Ophthalmology, General Surgery, T&O, OMFS are the biggest contributors to the year-to-date under performance. Actions are being taken to address the position.
- In-month Elective is 25 below activity plan. General Surgery, T&O, Urology are the biggest contributors to the year-to-date under performance but improvements are in performance have been sustained over the last 2 months and actions continue to be taken to further improve the position.
- In-month Outpatient New Attendances are 384 above planned levels. ERF schemes have contributed to the improved position in Q4
- In-month Outpatient Procedures are 1,561 above activity plan. This is a result of the corrective action taken to address technical system issues.

Metric	Target	Value	Exec Lead	Ops Lead
Daycases	1,998	1,928	Sally Kilgariff	Jodie Roberts
Inpatients - Electives	350	326	Sally Kilgariff	Jodie Roberts
Outpatients New - Attendances	6,049	6,433	Sally Kilgariff	Jodie Roberts
Outpatient Procedures - New and Follow Up	4,767	6,328	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Residual activity recording issues continue to be addressed and corrected in time for month 12 freeze
- 25/26 activity schemes have been agreed in principle
- Alignment of capacity and demand linked to contracted activity is underway

What is the expected impact?

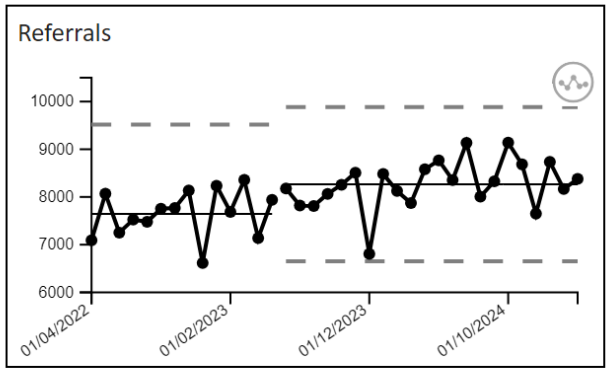
- Correction of activity recording issues for month 12 freeze will ensure activity is correctly aligned and the appropriate income is received.
- Early agreement of activity schemes for25/26 will allow early implementation to support maintenance of performance levels achieved in 24/25
- Aligning capacity/demand and targets will demonstrate areas requiring further support in 25/26

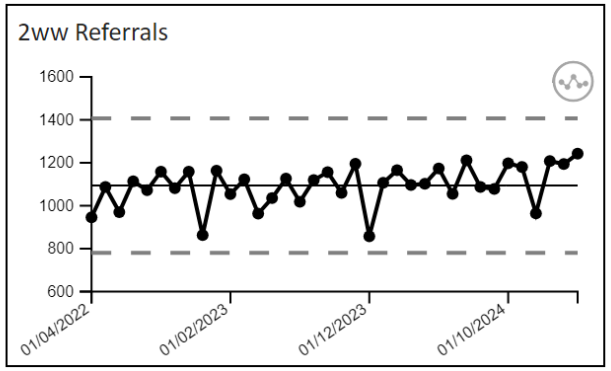
Potential risks to improvement?

- Internal workforce (consultant and wider) to support additional sessions
- Efficient utilisation of core capacity (e.g. if core lists are stood-down or consistently underutilised, any additional sessions/insourcing will be replacing that loss of activity as opposed to delivering additional capacity)
- Timely rectification of IT system data mapping issues
- Activity fixes are sustained in the position

Subtheme: OP Demand

Data





- Changes in referral patterns are key drivers affecting our ability to deliver waiting time and waiting list metrics
- Even small changes in specific specialties can generate significant increases in waits
- Referral patterns and trends are available in the Contract Monitoring Power BI data
- Significant changes generate discussion with Commissioners to identify what is driving the variation

Metric	Target	Value	Exec Lead	Ops Lead
Referrals	-	8,377	Sally Kilgariff	Jodie Roberts
2ww Referrals	-	1,242	Sally Kilgariff	Jodie Roberts

What actions are planned?

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

What is the expected impact?

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

Potential risks to improvement?

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

Finance

April 24 to Mar 25

Key Headlines	Month			YTD			Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Forecast variance £000s
I&E Performance (Actual)	(102)	781	883	(1,949)	(760)	1,189	(1,809)
I&E Performance (Control Total)	(41)	1,001	1,042	(584)	299	883	(2,279)
Efficiency Programme (CIP)	1,449	4,430	2,981	12,741	10,764	(1,977)	(3,164)
Capital Expenditure	8,156	9,673	(1,517)	17,189	16,940	249	0
Cash Balance	(2,261)	5,123	7,384	1,466	15,912	14,446	4,718

Performance Matrix Summary – People and Culture

NHS The Rotherham NHS Foundation Trust

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

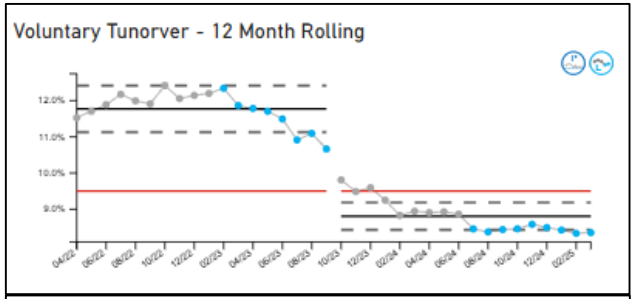
People and Culture

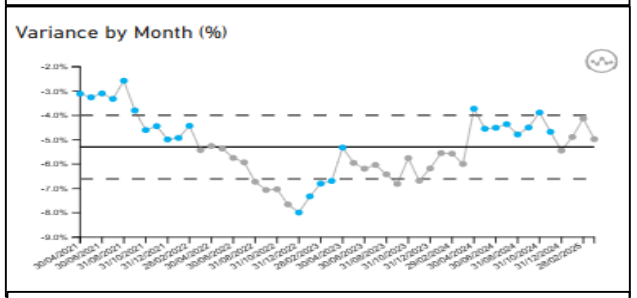
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	8.4	Mar-25	☑	P	L		VG
Vacancy Rate (total %)	-	5.0	Mar-25	-	-		-	G
Sickness Rates (12 month rolling %)	4.8	6.1	Mar-25	☒	F	H	-	VC
Sickness Rates (%)	4.8	6.2	Mar-25	☒	F			VC
Appraisal Rates (12 month rolling %)	90.0	79.7	Mar-25	☒	F		-	C
Appraisals Season Rates (%)	90.0	79.7	Mar-25	☒	F	H	-	C
MAST – Core (%)	85.0	89.9	Mar-25	☑	P		-	G
MAST – Job Specific (%)	85.0	86.7	Mar-25	☑	P		-	G

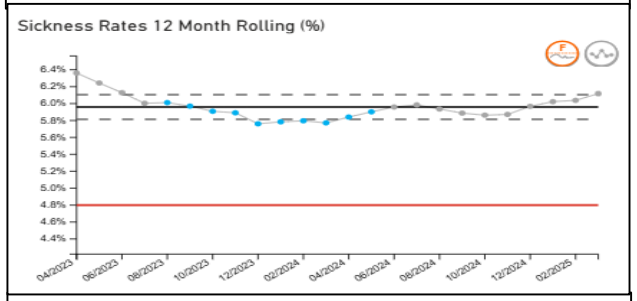
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

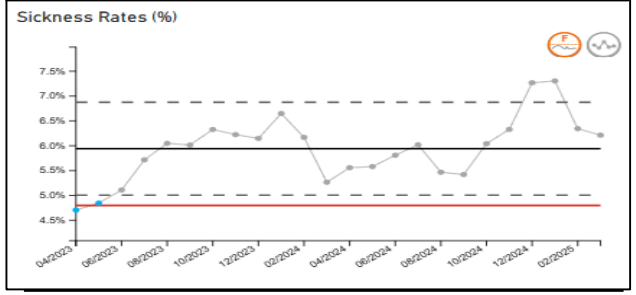
Subtheme: People

Data, Context and Explanation









- Retention performance continues to be strong and in within our target range for 2024/25 of 8-9.5%. Care Groups are all within a healthy range with more detailed breakdowns provided as part of operational management information for action where appropriate.
- Vacancy rate is in a strong position with strong recruitment campaigns for newly qualified nurses and midwives attracting success.
- Sickness absence rate performance -the rolling 12 month measure shows a 5% performance (6.1 % vs 5.8%) deterioration from 2023/24 end of year position and as such is a cause for concern with deep dive presented.
- The rate of sickness absence is been driven primarily by long term sickness absence. Links between deprivation, population health and the health and wellbeing of our people are also relevant here.

Metric	Target	Value	Exec Lead	Ops Lead
Turnover (12 month rolling %)	9.5	8.4	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	-	5.0	Daniel Hartley	Paul Ferrie
Sickness Rates (12 month rolling %)	4.8	6.1	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	4.8	6.2	Daniel Hartley	Paul Ferrie

What actions are planned?

- Comprehensive work on Health Wellbeing and Attendance including a full review of the Trust's approaches to this informed by; evidence based tools; best practice and audit work as per People and Culture Strategy
- Currently out to tender for Occupational Health Service with an emphasis in specification for more support to operational managers
- Launch of new Return to work form and Supporting attendance policy and increased senior leader and manager accountability

What is the expected impact?

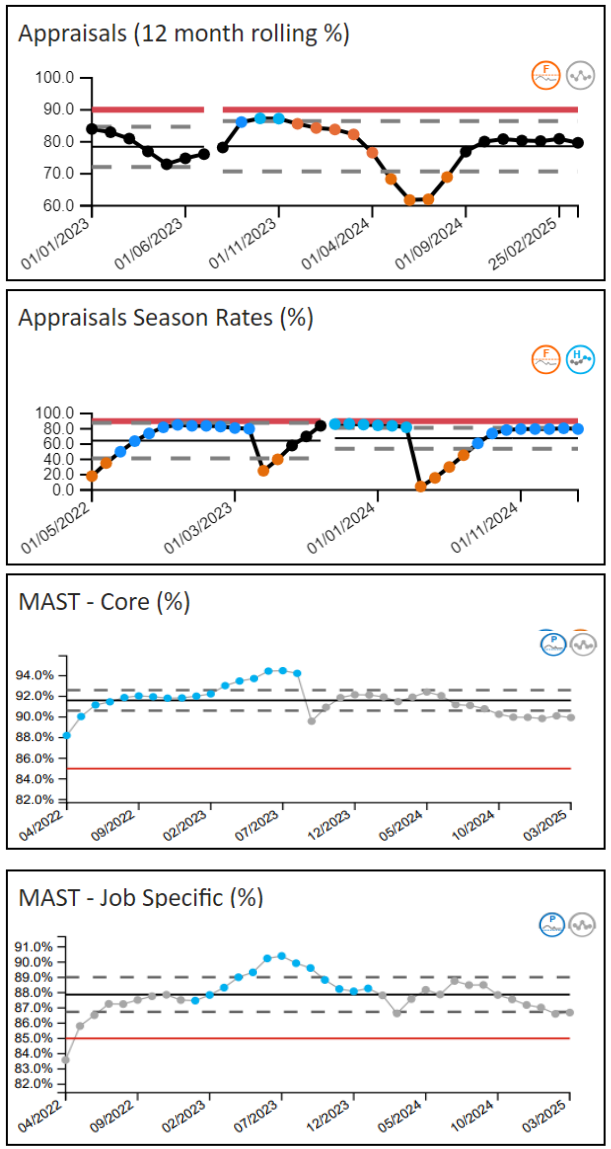
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

Potential risks to improvement?

- Continued impact of ill-health of staff on attendance
- Lack of manager compliance with return to work and policy application
- Areas of poor levels of engagement and low morale make insufficient progress

Subtheme: MAST & Appraisals

Data, Context and Explanation



- End of year rolling appraisal completion showing 79.7% which is below Trust target of 90%. 90% of the 3156 respondents to the NHS staff survey stated they have had an appraisal, suggesting not every appraisal is recorded effectively.
- This is a focus for senior leaders and part of internal performance mechanisms.
- MAST performance is on track with more detailed breakdowns provided as part of operational management information for action where appropriate.

Metric	Target	Value	Exec Lead	Ops Lead
Appraisals (12 month rolling %)	90.0	79.7	Daniel Hartley	Paul Ferrie
Appraisals Season Rates (%)	90.0	79.7	Daniel Hartley	Paul Ferrie
MAST - Core (%)	85.0	89.9	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	85.0	86.7	Daniel Hartley	Paul Ferrie

What actions are planned?

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

What is the expected impact?

- Improvement in appraisal completion rates both in month and rolling 12 months
- Improvement in MAST Core and Job Specific completion rates
- Improvement in the MAST burden freeing up time to care and improving productivity

Potential risks to improvement?

- Operational pressures resulting in reduced time for proactive people management and time for Appraisals and MAST completion

APPENDIX

Assurance

Variation/Performance

	PASS	HIT OR MISS	FAIL
H	**VERY GOOD: CELEBRATE AND LEARN** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**GOOD: CELEBRATE AND UNDERSTAND** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**CONCERNING: CELEBRATE BUT TAKE ACTION** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.
L	This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	• This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	• This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.
	GOOD: CELEBRATE AND UNDERSTAND • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**STATIC: INVESTIGATE AND UNDERSTAND** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.
H	**CONCERNING: INVESTIGATE AND UNDERSTAND** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**VERY CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change
L	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change

APPENDIX: SPC Summary Icons Key

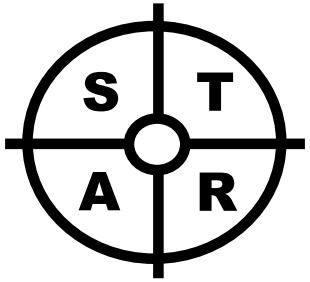
Assurance Icons

Icon	Technical Description	What does this mean?	What should we do?
	This process will consistently HIT AND MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target will not be consistently achieved.	**Consider** whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process** if you want to meet the target.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can be consistently achieved.	**Celebrate** the achievement. **Understand** whether this is by design and **consider** if the target is still appropriate.

Variation Icons

Icon	Technical Description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable.** If the process limits are far apart you may want to change something to reduce the variation in performance
	Special cause variation of a **CONCERNING** nature where the measure is significantly HIGHER.	**Something is going on!** Your aim is to have LOW numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is going on. Is it a one-off event that can be explained or do you need to change something?
	Special cause variation of a **CONCERNING** nature where the measure is significantly LOWER.	**Something is going on!** Your aim is to have HIGH numbers but you have some low numbers – something one-off, or a continued trend or shift of low numbers.	**Investigate** to find out what is going on. Is it a one-off event that can be explained or do you need to change something?
	Special cause variation of a **IMPROVING** nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is to have HIGH numbers and you have some – either something one-off, or a continued trend or shift of high numbers.	Find out what is going on. **Celebrate** the improvement and **share learning** with other areas.
	Special cause variation of a **IMPROVING** nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is to have LOW numbers and you have some – either something one-off, or a continued trend or shift of low numbers.	Find out what is going on. **Celebrate** the improvement and **share learning** with other areas.

Data Quality STAR Key



Domain	Definition
Sign Off and Validation	Is there a named responsible person apart from the person who produced the report who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency?
Timely and Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data? Are all elements of information need present in the designated data source and no elements of need information are missing?
Audit and Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur?
Robust Systems and Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
SHMI	Ratio between the actual number of patients who die following hospitalisation and the number expected to die based on population average.	Benchmark	As Expected	
Readmissions (%)	Proportion of readmissions within 30 days from the same Treatment Function specialty back to same Treatment Function specialty.	-	-	
VTE Risk Assessments (%)	Proportion of patients eligible for VTE Screening who have had a VTE screen completed electronically as per DH and NICE guidance.	National	95.0	
Care Hours per Patient Day	The Number of Care Hours per patient day.	National	7.3	
Combined Positivity Score (%)	The Positivity Rate of all the Friends and Family tests done combined - includes IP/DC/OP/UECC/Community/Maternity/Paeds/Long Covid	National	95.0	
Complaints	The number of formal complaints received.	Local	-	
Patient Safety Incident Investigations	The number of Patient Safety Incident Investigations that take place.	Local	0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Medication Incidents	The number of recorded medication incidents	Local	-	
Pressure Ulcers (Cat 3/4/STDI and Unstageable) per 1000 bed days	The number of Pressure Ulcers (Cat 3/4/STDI and Unstageable) per 1000 bed days	Local	-	
Patient Falls	The number of Patients Falls (Moderate and Above) per 1000 bed days	Local	0	
C. difficile Infections	The number of recorded C. difficile infections	Local	0	
1:1 Care in Labour (%)	Proportion of women in established labour who receive one-to-one care from an assigned midwife.	Local	75.0	
Breast milk first feed (%)	The percentage of babies born that receive maternal or donor breast milk as their first feed	National	70.0	
Stillbirth rate (per 1000 births)	The number of still births per 1000 live births	Local	4.66	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Waiting List Size	Number of patients waiting to receive a consultative, assessment, diagnosis, care or treatment activity	Local	-	
Number of 52+ Weeks	Number of patients on the incompletes waiting list for more than 65 weeks	Local	200	
Number of 65+ Weeks	Number of patients on the incompletes waiting list for more than 65 weeks	Local	37	
Referral To Treatment (%)	Proportion of patients that receive treatment in less than 18 weeks from referral	National	92.0	
OP Activity moved or Discharged to PIFU (%)	Proportion of patients moved to a Patient Initiated Follow-up Pathway following an outpatient appointment	National	3.0	
Overdue Follow-ups	Number of patients who are overdue their follow-up appointment, based on the requested time-period for the appointment made by the clinician	Local	-	
DM01 (%)	Proportion of diagnostics completed within 6 weeks of referral for 15 Key Tests	National	1.0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Faster Diagnosis Standard (%)	Proportion of patients diagnosed with cancer or informed cancer is excluded within 28 days from receipt of urgent GP referral for suspected cancer, breast symptomatic referral or urgent screening referral	National	75.0	
31 Day Treatment Standard (%)	Proportion of Patients receiving first definitive treatment for cancer within 31 days following an urgent referral for suspected cancer	National	96.0	
62 Day Treatment Standard (%)	Proportion of Patients receiving first definitive treatment for cancer within 62 days following an urgent referral for suspected cancer	National	85.0	
4 Hour Performance (%)	Proportion of Patients that have been seen and treated and left dept within 4hrs (admitted or discharged) based on Dept date.	Local	70.0	
Ambulance Handover Times <15 mins (%)	Proportion of Ambulance Handovers where the time recorded was as waiting less than 15 mins for handover.	-	-	
Ambulance Handover Times >60 mins (%)	Proportion of Ambulance Handovers where the time recorded was as waiting over 60 mins for handover.	National	0.0	
Average time to be seen by a clinician (mins)	The average time a patient waits from Arrival to being seen by a clinician in ED.	Local	60	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Patients spending >12 hours in A&E from time of arrival (%)	Proportion of Patients who are in ED for longer than 12hrs from Arrival to Departure/Admission	Local	2.0	
12hr Trolley Waits	Number of patients waiting more than 12 hours after a decision to admit	National	0	
Bed Occupancy (%)	Proportion of Adult G&A beds occupied as at midnight snapshots daily as per KH03 guidance.	Local	91.6	
Criteria to Reside is No (%)	Proportion of inpatients where Criteria to Reside is no	Local	9.9	
Length of Stay over 21 Days	Snapshot of number of Inpatients with a current LOS of 21 days or more as at month end.	Local	70	
Patients where Date of Discharge = Discharge Ready Date (%)	Proportion of patients where date of discharge is same as the recorded Discharge Ready Date	Local	85.0	
A&E Attendances from Care Homes	Number of care home residents attending A&E (based on postcode)	Local	144	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Admissions from Care Homes	Number of care home residents admitted (based on postcode)	Local	74	
Number of Patients on Virtual Ward	Number of patients on a virtual ward at the end of the month in line with the National Trajectories submission	Local	80	
Urgent 2 Hour Community Response (%)	Proportion of standard Urgent 2 Hour Community Response (UCR) referrals seen within 2hrs.	Local	70.0	
Clinic Utilisation (%)	Proportion of Outpatient clinic slots that are utilised	Local	85.0	
Capped Theatres Utilisation (%)	Proportion of time spent operating in theatres, within the planned session time only.	National	85.0	
Model Hospital Daycase Rate (%)	The total number of Day Cases done on patients over 17 where the admission method is elective and the episode is "pre-planned with day surgery intent"	Local	85.0	
Did Not Attend (%)	Proportion of Outpatient clinic slots where the outcome was Did Not Attend	Local	7.0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
First Outpatients (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	100.0	
Inpatients (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	100.0	
Daycases (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	100.0	
Length of Stay over 7 days	Snapshot of number of Inpatients with a current LOS of 7 days or more as at month end.	Local	-	
Mean Length of Stay (Non-elective)	Average LOS for all discharged patients where the admission method is non-elective, 0 LOS are excluded and Observations are excluded.	Local	-	
Mean Length of Stay (Elective excluding Daycases)	Average LOS for all discharged patients where the admission method is elective, 0 LOS are excluded and Daycases are excluded.	Local	-	
Discharged before 5pm (%)	Proportion of patients discharged before 5pm - includes transfers to discharge lounge.	Local	70.0	

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/29/25**

Report: **Operational Objectives 2024/25 for review**

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

Action required: **For noting**

The purpose of this paper is to present to the Council of Governors a review of progress against the 2024/25 Operational Objectives and associated programmes during the period October 2024 to March 2025.

The highlight reports at Appendix 1 inform the Council of Governors of the key achievements and any delays to delivery during the most recent reporting period to board assurance committees as at the end of Q4 2024/25.

By the end of the financial year there have been no significant escalations to the Executive Management Team that would warrant a formal request to assurance committees to make fundamental changes to the overall aim of any particular priority.

However, it is evident that although the work streams developed to deliver the key change actions as outlined in the original mandates have made significant improvements in the main areas of focus, the perpetual increase in demand particularly for elective and non-elective services has hindered achievement of both local and national performance standards in some cases.

A summary of the quarter four position for the four Organisational Priorities can be found below:-

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

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

People and Culture - Focus on improving the experience of our people and developing our culture

This priority achieved top quartile engagement measure in the 2024-25 staff survey as planned. Staff turnover performance has remained stable and within the desired target range that is between 8% and 9.5%. Sickness absence has, unfortunately, not achieved the 4.8% target by year end.

Operational Delivery - Focus on our operational delivery and improving access to care

By the end of March 2025 two out of four metrics were showing statistically significant improvement.

RTT has delivered a 4.9% improvement over the last 12 months from 59.8% in March 2024 to 64.7 March 2025. Progress has been made against achieving the constitutional standard with the following specialties achieving over 92% in March; General Medicine, Geriatric Medicine, Respiratory, Paediatrics, and Paediatric Cardiology, as well as sub-specialties of Diabetes & Endocrine, Stroke, and Rheumatology. T&O, Gynae and OMFS remain a concern with ongoing plans in place to support recovery.

The 4 hour standard has not achieved trajectory at the end of 2024-25, however, performance has improved on previous years despite significant increases in attendances. The number of attendances in UEC have been increasing month on month over the past year, peaking at 9,429 in March 2025 against a baseline set at the end of March 2024 of 8219.

Supporting metrics allied to patient flow have correspondingly deteriorated, particularly in terms of patients with no criteria to reside (19.5% in March 2025 against target of less than 10%) as well as time from decision to admit to admission (235.3 minutes in March 25 against a target reduction on last year's baseline of 144.2 minutes)

Time to initial assessment has however improved significantly starting out at 22 minutes as at the end of March 2024, down to 7.3 minutes by the end of March 2025.

Financial Sustainability - Focus on becoming a financially sustainable and productive organisation

This priority has achieved the objective to deliver the financial plan overall, however, the trust remains behind plan on efficiency delivery.

1.0 Introduction

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

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

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

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

1.4 This paper presents a high level update on progress made during the second half of the financial year ending March 2025 and reports by exception any areas of concern.

2.0 Conclusion

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

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

Priority Title	Achievements Q4 - Summary
Quality of Care	**Quality Priorities**:- • **Pain Management** – Improvements in pain assessments on admission achieved. Pain Champions in place across the trust. Updates to Meditech achieved and EOLAS App launched. No further actions were planned during January to March due to awaiting results of the CQC inpatient survey. • **Frailty Assessments** – Virtual ward and Clinical Frailty scores data is now being captured. New registrar has commenced which

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

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

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

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

2.3.1 Quality of Care

Quality Priority - Frailty

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

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

2.3.2 People & Culture

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

2.3.3 Operational Delivery

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

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

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

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

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

2.3.4 Financial Sustainability

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

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

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

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

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

2.4.1 Quality Committee

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

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

2.4.2 People and Culture Committee

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

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

2.4.3 Finance and Performance Committee

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

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

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

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

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

these areas, to reduce the expenditure run rate and recover the income position. An Improvement Group, Chaired by the Chief Executive, is also in place to support progress and increase momentum.

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

3.0 The Council of Governors is asked to note the content of this report.

Bob Kirton
Managing Director
May 2025

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

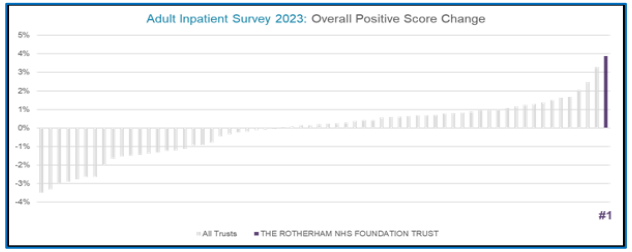
QUALITY OF CARE
FOCUS ON PROVIDING HIGH QUALITY CARE AND IMPROVING THE EXPERIENCE OF OUR PATIENTS

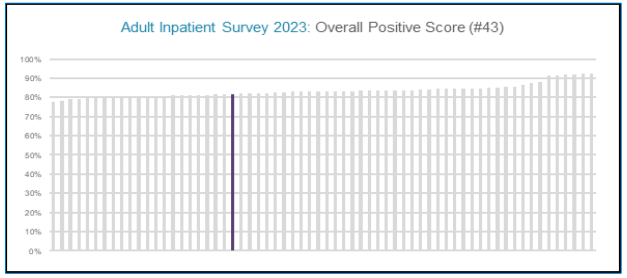
PEOPLE & CULTURE
FOCUS ON IMPROVING THE EXPERIENCES OF OUR PEOPLE AND DEVELOPING OUR CULTURE

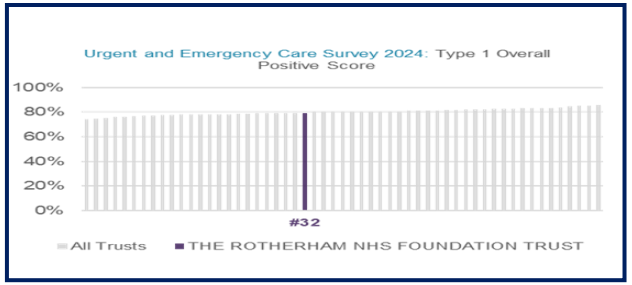
OPERATIONAL DELIVERY
FOCUS ON OUR OPERATIONAL DELIVERY AND IMPROVING ACCESS TO CARE

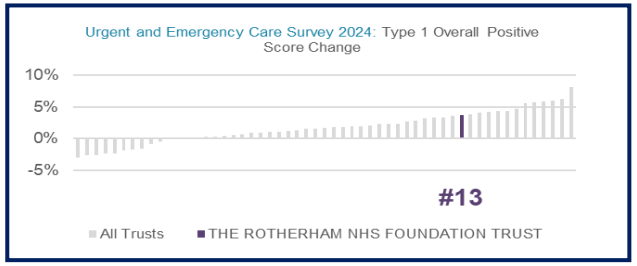
FINANCIAL SUSTAINABILITY
FOCUS ON BECOMING A FINANCIALLY SUSTAINABLE AND PRODUCTIVE ORGANISATION

Quality of Care	**Focus on providing high quality care & improving the experience of patients**	**Executive Lead(s)**	**Medical Director** **Chief Nurse**
Objectives	Deliver care that is consistent with CQC "Good" by the end of 2024/25; ensure improved performance in at least one quartile in the national inpatient and UEC patient experience surveys		
Summary Position	The over arching measure of success for this priority is the national CQC inpatient survey. For the 2023 inpatient survey the trust has scored 43/64 using Picker and is the most improved trust overall compared to 2022 results. Urgent and emergency care surveys show a positive result.		









Delivered this period – Q4 2024-25

Quality Priorities

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

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

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

Quality Improvement Plan 2025-26 – Q1

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

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

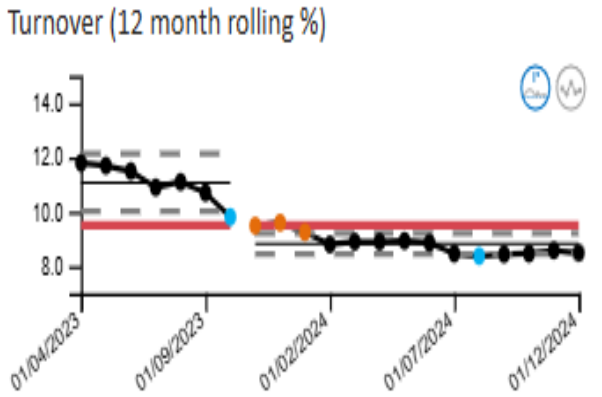
2025-26 Quality Priorities were agreed in principle at the Quality Committee and Executive team meetings held in March and will be subject to approval at Trust Board in May.

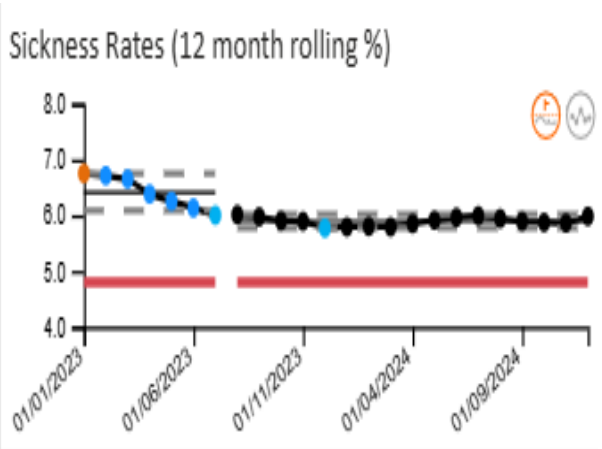
1. Reducing delays in cancer diagnosis and treatment
2. Antimicrobial stewardship
3. Diabetes

Risks/issues/escalations to delivery of the objectives

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

People and Culture	Focus on improving the experience of our people and developing our culture	Executive Lead(s)	Director of People
Objectives	Achieve a top quartile engagement measure in the 2024-25 staff survey, improve attendance by reducing sickness by 1%, retain our people by achieving a healthy turnover rate of between 8% – 9.5%		
Summary Position	Staff turnover performance is currently stable and within the desired target range that is between 8% and 9.5%. Sickness absence rates are not reducing sufficiently to achieve 4.8% target at year end		





Delivered this period

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

Planned next period

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

Risks/issues/escalations to delivery of the objectives

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

Operational Delivery

Objectives

Focus on our operational delivery and improving access to care

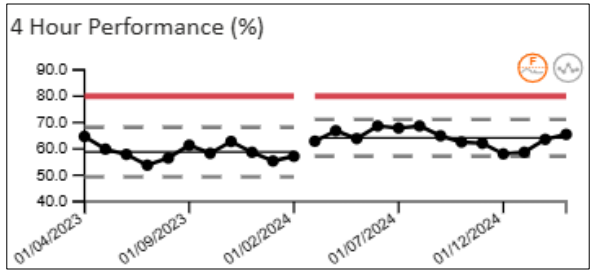
Deliver 4 hour performance of 80% before March 2025; go beyond the national ambition on long waiters and RTT performance; consistently deliver the Faster Diagnostic Standard by Q4

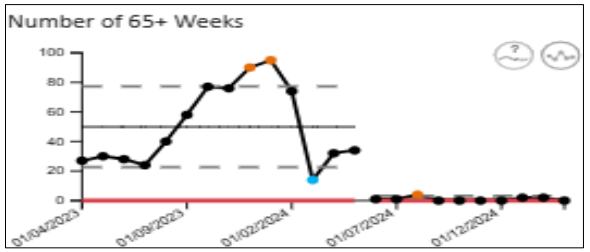
Executive Lead(s)

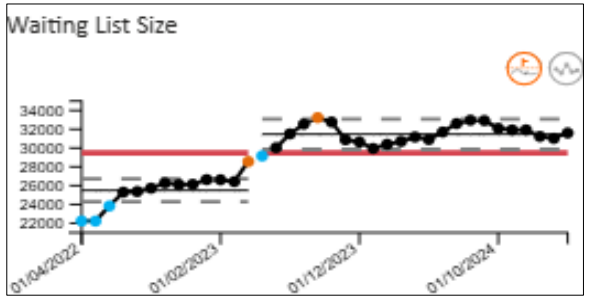
Chief Operating Officer
Director of Operations

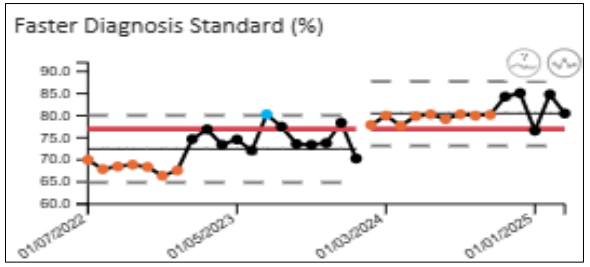
Summary Position

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









Delivered this period

Deliver 4 hour performance of 80% before March 2025

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

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

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

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

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

2025-26 - Q1 planned activity

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

Non-Elective Care

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

Elective Care – Theatres, Outpatients, Cancer and Endoscopy

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

Risks/issues/escalations to delivery of the objectives

- Risk – Staff shortages leading to last minute cancellations – Mitigation – 6-4-2 and utilisation meetings in place to help resolve issues sooner
- Risk - increase in demand is affecting Non-elective and Elective pathways
- Issues - Challenged high volume LGI and Urology pathways with FDS <80% - Mitigation - LGI and Urology improvement plans in place. Dedicated Cancer Improvement Team resource for these pathways.
- Issues - Delays in the implementation of the Rotherham Breast Pain Pathway - Mitigation - Care Group progressing plans for ACP led delivery model.
- Issues – Capacity to complete IT developments in UEC that will progress paperless processes such as e-referrals, paperless ECGs, equipment tracking – Mitigation – delays were caused by unplanned absence of leading team members however work has resumed on their return to work
- Issues – Medicine bed reconfiguration implementation impacting on flow out of UEC/SDEC – Mitigation – ongoing consultation with clinicians and delivery of UEC capital plans

Financial Sustainability	Focus on becoming a financially sustainable and productive organisation	Executive Lead(s)	Managing Director Director of Finance
Objectives	Deliver the financial plan for 2024-25 and deliver Year One of the plan to return the trust to a break even positon for the 2026-27 financial year; ensure significant improvement of at least one quartile across the full range of system productivity measures		
Summary Position	We are behind plan on efficiency delivery. Financial plan delivered overall.		

Efficiency/CIP

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

Financial Plan

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

Elective Recovery

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

Delivered this period

Efficiency/CIP

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

Financial Plan

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

Elective Recovery

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

Planned next period

Efficiency/CIP

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

Financial Plan

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

Elective Recovery

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

Risks/issues/escalations to delivery of the objectives

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

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

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/30/25**

Report: **National, Integrated Care Board and Rotherham Place Update**

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

Action required: **For noting**

The purpose of this report is to provide the Council of Governors with an update on national developments, developments across the South Yorkshire Integrated Care Board (SYB ICB) and Rotherham Place.

Key points to note from the report are:

- The latest SYB ICB CEO report
- New CEO for the council
- Final draft of the Health and Well Being Board Strategy

1.0 Introduction

1.1 This report provides an update on national developments and developments across the
South Yorkshire Integrated Care Board (SYICB) and Rotherham Place.

2.0 National Update

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

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

3.0 South Yorkshire Integrated Care Board (SYICB)

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

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

4.0 Rotherham Place

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

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

4.3 The Rotherham Together Partnership held a showcase event at the Maltby Learning Trust on the 29th April. The session focused on: Children's Capital of Culture, family

hubs, and building stronger communities. The Trust Managing Director was asked to close the event and promote the work of TRFT.

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

Bob Kirton
Managing Director
May 2025

Draft Health and Wellbeing Strategy for Rotherham 2025-2030

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

Vision

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

Foreword from the Chair

TBA

Overview

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

Our aims are to:

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

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

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

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

Introduction

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

Reflections on the 2020 Health and Wellbeing Board Strategy

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

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

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

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

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

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

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

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

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

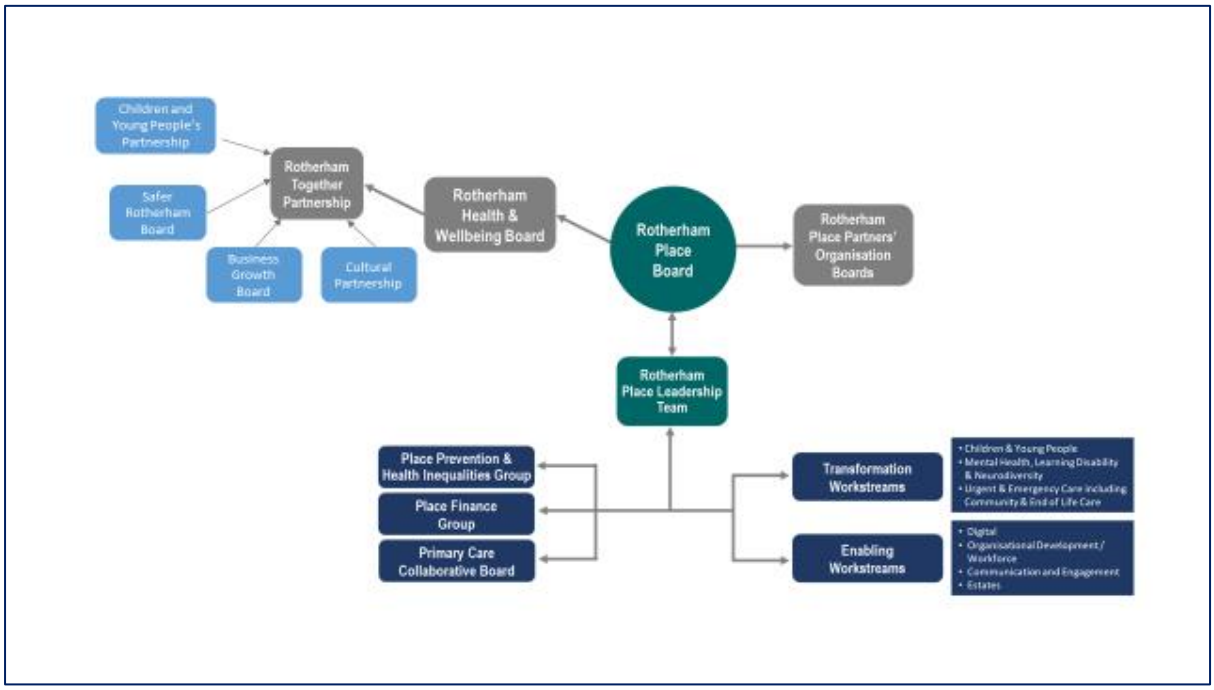


Fig 1. The Rotherham Health and Wellbeing Board in partnership

Developing the 2025-2030 Health and Wellbeing Strategy

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

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

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

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

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

The needs of our population

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

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

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

Population

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

Health Inequality

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

Mental Health

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

Access to care

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

Health behaviours

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

What people are telling us

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

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

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

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

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

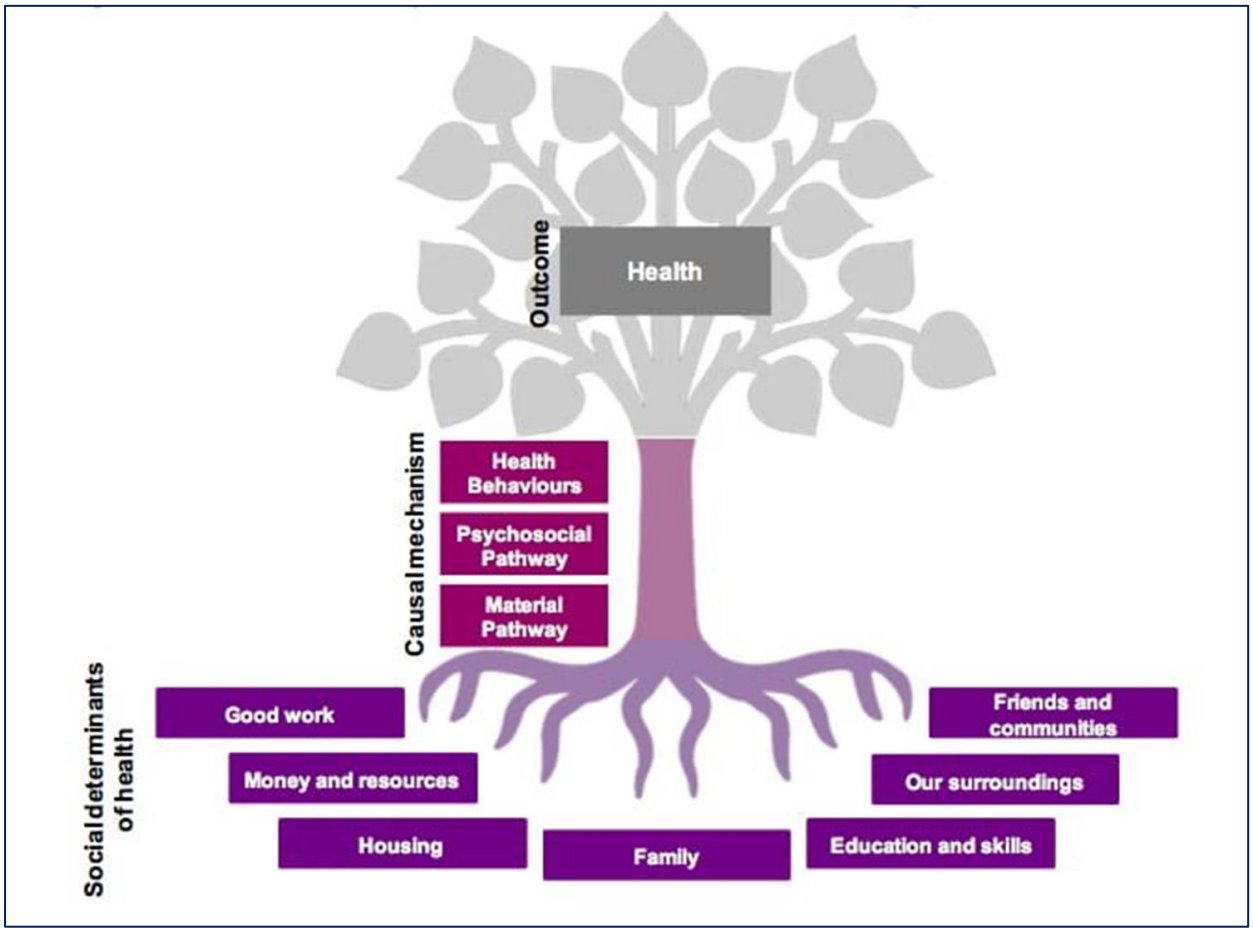


Fig 2. Wider determinants and the causes of the causes of health

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

Box 1: The Marmot Principles

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

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

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

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

What we will do

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

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

Rotherham Health and Wellbeing Strategy 2025-30

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

We will achieve this by:

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

And by working in the following ways:

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

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

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

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

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

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

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

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

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

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

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

How we will do it

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

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

The criteria for inclusion to the priority shortlist are:

a) Is it an issue which would benefit from cross-partner intervention?
b) Would tackling this issue have a significant impact on our population as a whole, or on one of our key vulnerable groups?
c) Is it possible to make substantial, measureable progress within the given timeframe?

The chosen priorities will be built into a live action plan and a Board level champion will be identified for each priority. Through implementation of a regular cycle, progress will be reported and discussed at Board meetings, including updates from supporting groups and other work associated in the delivery of the plan. Progress on our aims, priorities and action plan will be reported through the HWB website.

How we will see the impact

We will track our success in improving health and wellbeing in Rotherham through monitoring existing outcomes frameworks. The **Rotherham JSNA** will continue to provide insight into the detail of the health of our population. In addition, we will be monitoring the high-level outcomes of the **South Yorkshire ICB Outcomes Framework**.

As part of the public consultation about the strategy, a range of questions have been developed to ask residents which, alongside various engagement events, will be

used to gauge changing needs and priorities in the community. These will be regularly presented to Health and Wellbeing Board for discussion and challenge.

Live Action Plan

<This section is not part of the strategy *per se*, but will be linked on the website as a live document>

Placeholder section for when the priority/ horizon scanning workshop is held in April, but structure will be:

1. One page each on our three priorities with a brief paragraph as to why chosen, SMART outcomes and expected impact.

2. The full action plan split by aim (similar to current action plan)

Glossary

Core20PLUS5: a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Health Inequalities: avoidable, unfair and systematic differences in health between different groups of people. There are many kinds of health inequality, and many ways in which the term is used. This means that when we talk about a specific 'health inequality', it is useful to be clear on which measure is unequally distributed, and between which people.

HWB: Health and Wellbeing Board. This is the statutory body with responsibility to set the strategic direction for local population health and wellbeing.

ICB: Integrated Care Boards are NHS organisations responsible for planning health services for their local population. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which says how the NHS will contribute to the integrated care strategy.

ICS: Integrated Care Systems are local partnerships that bring health and care organisations together to develop shared plans and joined-up services.

JSNA: The Joint Strategic Needs Assessment looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services. It takes a wide view of health and is concerned with wider social factors that have an impact on people's health and wellbeing, such as housing, deprivation and employment, it can be used to identify health inequalities, and it identifies gaps in health and care services, documenting unmet needs.

Stakeholders: Everyone with an interest in supporting and improving the health and wellbeing of the people of Rotherham.

Wider Determinants of Health: The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. Systematic variation in these factors constitutes drives health inequalities.

Appendices

<to link>

JSNA slide deck
Consultation slide deck
Links to associated groups
Links to Rotherham inclusion framework, Core 20+5, and other documents
Successes of the 2020-25 strategy slide deck

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/**

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 5th March 2025.

2.0 Membership Engagement

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

Rotherham Wide	8694
Rest of England	1366
Staff	3582
Total	**13,642**

2.2 The Committee discussed recruiting and retaining young members and exploring strategies to improve their reach, noting that Governors were making headway in engaging young people and families through local schools.

3.0 Meet Your Governors

3.1 The group received recent feedback given to Governors, the framework used and the Trust responses.

4.0 Governor Engagement Calendar

4.1 The group have oversight of the engagement calendar which is also shared with the wider Council through Governor Newsletters. The group discussed the Chief Nurse Walk arounds and the benefits of this and other activities within the Trust to stay engaged and informed.

5.0 Election Information

5.1 The group took note of the report in relation to the upcoming elections and the involvement of the elections provider CIVICA. The election had been promoted through various channels including the Rotherham Advertiser and Internal Communications.

Geoffrey Berry
Lead Governor
Chair of Governors Membership Engagement Group

COUNCIL OF GOVERNORS MEETING: 14 May 2025

Agenda item: **COG/32/25**

Report: **AMENDMENTS TO THE CONSTITUTION: APPOINTMENT OF PARTNER GOVERNORS**

Author and Presented by: **Peter Walsh, Interim Director of Corporate Affairs**

Action required: **For approval**

1.0 In accordance with the Code of Governance and Health and Social Care Act 2012, amendments to the Constitution are approved by the Council of Governors.

2.0 Constitution – Partner governors

2.1 In order to support the Trust to work in partnership across South Yorkshire, the constitution enables a number of organisations to appoint Partner Governors. As the Trust works more closely with colleagues in Barnsley Hospital NHS Foundation Trust and Doncaster and Bassetlaw NHS Foundation Trust, we propose that both organisations nominate a Partner Governor to join the Council. Both trusts are also planning to invite a Partner Governor from Rotherham to attend their Council.

2.2 We also propose that we invite Rotherham College to nominate a Partner Governor, recognising our increasing work with the college. We propose that they replace Barnsley and Rotherham Chamber of Commerce, as they have not nominated a Partner Governor.

2.3 If these proposals are accepted, this will mean that there will be seven Partner Governors:

a) Rotherham Partnership
b) Voluntary Action Rotherham (VAR)
c) Sheffield University
d) Sheffield Hallam University
e) Rotherham College
f) Rotherham Ethnic Minority Alliance (REMA)
g) Barnsley Hospital NHS Foundation Trust
h) Doncaster and Bassetlaw NHS Foundation Trust

Public governors will remain the majority of the Council (16 out of 29 members).

3.0 Recommendations

3.1 The Council of Governors is asked to:

- Approve the proposed amendments to Annex 3 of the constitution

Calendar of Business for Council of Governors 2025

REPORT - ORDER		2025			
		Feb	May	Sep	Nov
		12	14	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.	/	/	/	/
Partnership Working	Man. Dir.		/	/	/
Five Year Strategy Update (every 6 months)	CEO		/		/
Quality Accounts	CN			/	
Annual Report (through Annual Members Meeting)	DoCA			/	
Annual Accounts (through Annual Members Meeting)	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) – due June 2025	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
		12	14	03	19
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)