Council of Governors

The Rotherham NHS Foundation Trust

Schedule	Wednesday 20 November 2024, 5:00 PM — 6:30 PM GMT
Venue	Board Room, Level D
Organiser	Claire Rimmer

Agenda

5:00 PM	PROCEDURAL ITEMS	
	COG/54/24.	Chairman's Welcome and announcements - Verbal For Noting - Presented by Dr Mike Richmond
	COG/55/24.	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/56/24.	Declarations of Interest - Verbal For Noting - Presented by Dr Mike Richmond
	COG/57/24.	Minutes of the previous meeting held on 10th September 2024 For Approval - Presented by Dr Mike Richmond
	COG/58/24.	Matters arising from the previous minutes (not covered elsewhere on the agenda) - Verbal For Discussion - Presented by Dr Mike Richmond

	COG/59/24.	Action Log - Nil by return For Decision - Presented by Dr Mike Richmond
	COG/60/24.	Chair's Report - Verbal For Noting - Presented by Dr Mike Richmond
5:15 PM	REPORT FROM NON EXECUTIVE CHAIRS OF BOARD COMMITTEES For Noting	
	COG/61/24.	Report from the Non-Executive Director Chairs of the Board Assurance Committees: i. Quality Committee - Julia Burrows ii. People & Culture Committee - Dr Rumit Shah iii. Finance and Performance Committee inc. Finance Report - Martin Temple iv. Audit and Risk Committee - Kamran Malik v. Charitable Funds Committee - Heather Craven For Noting
	COG/62/24.	Integrated Performance Report For Noting - Presented by Dr Richard Jenkins
	COG/63/24.	Five Year Strategy Update - Ben Gray For Assurance - Presented by Dr Richard Jenkins
6:10 PM	GOVERNOR REGULATORY AND STATUTORY REQUIREMENTS	
	COG/64/24.	External Auditors report following closure of annual audit - Daniel Watson
6:15 PM	COMMITTEE GOVERNANCE	

COG/65/24. Issues to be escalated to Board of Directors - Verbal
For Approval

COG/66/24. Calendar of Business for Council of Governors 2025
For Information - Presented by Dr Mike Richmond

COG/67/24. Any Other Business
For Discussion

COG/68/24. Next meeting to be held on 12th February 2025

CLOSE OF MEETING

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

The Rotherham NHS Foundation Trust

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

Chair: Dr M Richmond, Chair

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNCIL OF GOVERNORS MEETING: 20 November 2024

Agenda item: **COG/ 61/24i**

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

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

Action required: To note

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

2.0 Care Group Updates

2.1 Since the last report to the Council of Governors, the QC have received presentations from the Senior Management Teams from Care Group 2 - Surgery (September) and Care Group 1 – Medicine and UECC (October).

2.2 The Committee received the presentation from Care Group 2 which included updates on the in-patient survey 2023 results, highlighting the most improved scores as well as the opportunities for improvements. The Care Group linked Infection Control work with Quality Improvement (QI) initiatives and celebrated the bronze exemplar accreditation achieved in certain areas.

2.3 A key theme of the Care Group 1 presentation were the intense operational pressures and the committee alerted the Board of the current position relating to the risk posed by sustained increased pressure of demand, currently c17% up from the previous year on services. On a more positive note, the Care Group reflected on a key concern raised at their last attendance regarding Violence and Aggression, and detailed the uplift in support that the staff have felt from the Trust and the positive direction of travel.

3.0 Organisational Priorities

3.1 The committee is tasked with monitoring delivery against this year's Organisational Priority 1: Focus on High Quality Care and Improving the Experience of Patients. Key areas of delivery are Quality Priorities, Patient Experience Improvement Plan and Exemplar Accreditation Programme.

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

3.3 The three Quality Priorities continue to develop both in the planning phases and delivery, setting the foundations to ensure effective and accurate measurement of outcomes, and strong collaboration and engagement to continue the work beyond the year of focus.

Acute Pain Management:
It was reported that good progress was being made with this priority with positive results from the CQC inpatient survey. Pain champions had also been launched which are linked to all areas which will help to disseminate information.

Diabetes Management:
The committee received updates in relation to the Working Groups set up with designated Leads and reporting schedules, and with good progress identified that will flow into reporting metrics shortly. It was reported that the overview for the priority has expanded as the work has matured with broader detail and metrics developing from specialist areas. The staff engagement to move things forward had been positive and a recognisable uplift from previous years.

Frailty Assessments:
This priority is a significant piece of work through the Acute Care Transformation programme. The Frailty Self-Assessment had been completed. The power BI dashboard developed to capture and analyse the Comprehensive Geriatric Assessments had been drafted with a view to switching to live status in quarter three once a data quality issue is resolved.

3.4 The Patient Experience Improvement Plan was presented in September to the committee with the strands interlinked with QI projects and new initiatives. Part of the improvement plan is the new Patient Liaison Service (PALS) that has been launched, which provides a central point of contact for patients and visitors and the feedback has been positive from service users, as well as staff.

3.5 In October, it was reported that the Exemplar Accreditation Programme is ahead of schedule with a further 9 adult inpatient wards completing the accreditation, with 2 of those achieving Bronze award. This has exceeded the original ambition of 6 and subsequently completes the Exemplar Accreditation Programme for Adult inpatient wards for 2023-24.

4.0 Safe Staffing and Quality

4.1 The committee commended the excellent work on nursing recruitment and retention, with 97 Whole Time Equivalent (WTE) Registered Nurses joining the Trust in September, taking a proactive approach to staffing levels, putting the Trust slightly over nursing establishment.

4.2 Concerns were acknowledged on high sickness rates and the committee alerted the People and Culture Committee (P&CC) of their concerns to ensure cross-committee working and triangulation of reporting. The P&CC actively monitor the position, actions and delivery of a reduction in sickness absence rates.

4.3 Following October's report, the Committee alerted the Board of the current additional demand for capacity, which as well as being a risk to patients, is a risk to Trust staff.

5.0 Board Assurance Framework and Risk Register

5.1 The Committee continues to receive monthly update reports regarding the risks rated at 15 or above, which have been monitored and checked at the monthly Risk Management Committee and also the Issues Register, which is managed by the Audit and Risk Committee. The committee takes an active role in scrutinising risks aligned to the committee to prompt deep dives into the mitigating actions and performance, relative to the risk.

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

6.0 Committee Development Workshop

6.1 In December, the committee will be holding a development workshop, facilitated by the People Team. The aim of the workshop is address areas of development highlighted in the committee effectiveness survey earlier in the year, and outline a more strategic approach to committee structure, reporting, planning, and development of the Quality Strategy and Quality Priorities for the next year.

Julia Burrows
Non-Executive Director and Chair of Quality Committee

COUNCIL OF GOVERNORS MEETING: 20 November 2024

Agenda item:	**COG/61/24.ii**
Report:	**People and Culture Committee**
Presented by:	**Dr Rumit Shah, Non-Executive Director and Chair of the People & Culture Committee**
Author:	**Dr Rumit Shah, Non-Executive Director and Chair of the People & Culture Committee**
Action required:	**To note**

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

2.0 Care Group Updates

2.1 Since the last report to the Council of Governors, the P&CC has received a presentation from the Senior Management Team from Care Group 3 – Family Health, Pharmacy, Patient Access, and Outpatients & Support Services (September) and Care Group 4 - Community, Therapies, Dietetics & Imaging (October).

2.2 Care Group 3 updated the committee on the Health and Wellbeing Attendance and the work ongoing to support colleagues and improve performance, their work on inclusive development and leadership, and reflected on the staff survey results and 'We Said We Did' plans. On sickness absence rates, it was reported that there are strong processes in place with support from HR as needed. The Care Group are supporting colleagues whilst providing challenge and escalating as appropriate, and detailed the proactive steps such as psychologist support, preventative measures and over recruitment.

2.3 The committee received a presentation from Care Group 4 which highlighted areas of concern, such as violence and aggression and the steps to support staff. It also drew attention to areas of progress, such as decreasing sickness absence rates and the focus on longer terms absence cases and Return To Work (RTW) meetings. The committee agreed that there was a good level of assurance and that the Care Group were proactive in terms of risks and moving forward.

3.0 Organisational Priorities

3.1 The committee is tasked with monitoring delivery against the Organisational Priorities 2024-25 Priority 2: Focus on improving the experience of our people and developing our culture. Key areas of delivery are People and Culture Strategy, Integrated EDI Plan, We said We Did Plans, and Attendance and Sickness absence.

3.2 The overarching measure of success for this priority to achieve a top quartile engagement measure in the 2024-25 staff survey, improve attendance by reducing

sickness by 1%, and retain our people by achieving a healthy turnover rate of between 8% – 9.5%.

3.3 The committee received a 6 monthly update on the People and Culture Strategy and committee provided challenge on the areas of development to address sickness absence and MaST compliance. It was reported that there are different sources of support for managers and bespoke learning for specific areas however this is an area scheduled for more work to make improvements as per the strategy. . The 'To The Future' work by the People Team is developing greater clarity of roles and support to people managers and this will return later in the year.

3.4 In October, the committee approved the Integrated EDI plan, which spans over 3 years and links closely with the People and Culture strategy. The committee agreed that the plan was well presented, clear and accessible.

3.5 The committee received the Health, Wellbeing and Attendance programme which links into the objectives regarding sickness absence rates. It was reported that there is specific work on core needs such as staff rest areas and other practical issues to support staff. There is also work in train around Occupational Health service and reviewing the current provisions, and work on partnerships to help staff access sport and facilities, as well as work with the Long Covid team to get specific treatment for staff on longer term sickness.

4.0 Board Assurance Framework (BAF) and Risk Register

4.1 The Committee continues to receive reports regarding the risks rated at 15 or above, and alerted the Board of Directories on the number of risks that are dependent on decisions outside the Trust's control, such as from NHSE and ICB. It was advised that going forward, this is an area which will require cross Assurance Committee oversight as the risks relate to funding, delivery, people and quality.

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

5.0 NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

5.1 The committee received the progress report on WRES and WDES in October. In terms of WRES, it was highlighted that BME representation continues to increase (now 15.7% of the workforce), including at more senior levels although this is overwhelmingly in medical and dental areas. . There is a continued focus on improving local recruitment and work with local schools to ensure that Rotherham's communities see the Trust as an employer of choice.

5.2 On the WDES, the committee were updated that the Trust continues to make small incremental improvements in most metrics. Bullying and harassment continuesto remain a key priority for the Trust, operationalised through the Violence and Aggression working group and the Sexual Safety campaign led by the Chief Nurse and Director of People. The Trust's upcoming EDI plan will contain actions across the range of areas to improve the experience of all staff with a particular focus on inclusion and representation.

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

COUNCIL OF GOVERNORS MEETING: 20 November 2024

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

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

2.0 Care Group Updates

2.1 Since the last report to the Council of Governors, the FPC have received a presentation from the Senior Management Teams from Corporate Services (September) and Care Group 1 (October).

2.2 The presentation from Corporate Services included Month 5 position for each Executive area and a drill down into Estates including risks and key concerns, as well as improvements made.

2.3 The committee received the presentation from Care Group 1 and alerted the Board of Directors to the current position relating to the risk posed by sustained increased pressure of demand, currently 8.6% above plan year to date. The Committee agreed that following discussions from the Care Group, the current model for service provision does not fit the current demand and a review of how to deliver the increased demand which effects the entire Trust is required.

3.0 Integrated Financial Performance Report

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

3.2 At the October meeting, the numerous challenges faced were outlined, alongside the mitigating factors to improve the likelihood of delivering balance against the plan. The remainder of the year would not be easy but there is still opportunity to improve from the deterioration. The targets set are doable, however, increased costs or ERF delivery would result in a different position at year end. The committee agreed that they were assurance on the plans in place, but could not be assured of delivery.

4.0 Organisational Priorities 2024-24

4.1 The committee is tasked with monitoring delivery against this year's Organisational Priorities:

- Operational Delivery – Focus on our Operational Delivery and Improving Access to Care. performance; consistently deliver the Faster Diagnostic Standard by Q4
- Financial Sustainability - Focus on becoming a financially sustainable and productive organisation

4.2 On Operational Delivery, it was reported that three out of four metrics are now showing statistically significant improvement; 65 week waiters had achieved trajectory, Faster Diagnostic Standard had achieved locally set target (80%) and is achieving national standard of 77%, Referral To Treatment (RTT) was achieving in 4 specialities with improvements and recovery trajectories in others; T&O, ENT and OMFS remain a concern. Although the 4 hour standard was not achieving trajectory it was showing a sustainable step change in improvement.

4.2 Regarding Financial Sustainability, the committee were updated that the Trust is behind on 2 of the 3 delivery targets. The current position, and particularly the slow start to forecasting efficiencies, represents a significant risk to delivery of the CIP target and ultimately the financial plan. The key actions will be to improve CIP delivery and to also increase grip and control. The Chief Executive has scheduled weekly finance meetings with the Managing Directors and Directors of Finance across both Rotherham and Barnsley to improve the positions going forwards.

5.0 Operational Priorities

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

5.2 An update on Elective Care was received in September and the report highlighted the progress and challenges, focusing on improving patient outcomes and reduction waiting times in line with national targets. The governance process on elective care had been strengthened, the Trust Access Policy had been updated, and a new weekly Trust wide access meeting had been introduced along with revised care group PTL meetings. An enhanced validation process had been implemented and strategic meetings and structures were in place to track patients on the waiting lists. It was reported that the Trust was on track to deliver RTT and was doing very well in a number of areas, and even in the areas where it is not doing so well, the Trust still benchmarks well against other trusts.

5.3 The committee were assured by the update on Cancer provided in October; it was reported that there had been improvements in governance, patient management, service delivery and progress against achieving the 3 key national standards for cancer. There was an overall good picture with the Trust achieving a number of nationally set targets, such as the 31 day General Treatment Standard and the 62 day Cancer Standard.

6.0 Board Assurance Framework and Risk Register

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

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

7.1 The Committee acknowledged the more rigorous process with the ICB leading and reporting to NHSE. It was reported that the Trust remained overall non-compliant, however, good progress had been made and it was highlighted that none of the other Trusts taking part in the process are compliant. The Trust is at a compliance rate of 61% with the target of 76% on the next review. The committee were updated that work is ongoing with Yorkshire Ambulance Service (YAS) and also of the induction of check and challenge meetings with Non-Executive Directors and Executive colleagues.

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

COUNCIL OF GOVERNORS MEETING: 20 November 2024

Agenda item: COG/61/24/iv

Report: Report from Audit and Risk Committee (ARC)

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

Author(s): as above

Action required: To note

1.0 The Audit and Risk Committee met in October 2024, with the Chair's Assurance Log provided to the Board of Directors to demonstrate the degree of assurance received on all key matters.

2.0 Risk Management Report

2.1 The Committee received the latest risk register report including the emerging risks and issues log.

2.2 The Committee recognised the increased focus and work being done in completing actions and mitigating risks but then the risk ratings not moving. The Committee also advised the Board on the new increased focus in the report of the "so what", which they agreed was a positive next step and direction forward.

3.0 Board Assurance Framework (BAF)

3.1 The committee received the BAF in its entirety and noted the relationship between risk appetite and the target risks which was a good example of the developing maturity and understanding of our risks.

4.0 Standards of Business Conduct

4.1 Following the presentation of the report in October, the committee alerted the Board of the continuing poor compliance of staff with the annual declaration of conflicts of interest. The committee reflected on the previously agreed position of medical staff completing their declaration of interest at their appraisals, which is still to be actioned and will be picked up by the Medical Director moving forwards.

5.0 Internal Audit

5.1 The Committee received the Internal Audit Progress Report. Limited Assurance was reported for the CIP 360 audit with relation to the weaknesses in design and/or inconsistent application of the framework. It also noted the requirement for a multi-year focus on the CIP going forward as well as the need for greater links across the region of South Yorkshire, hand in hand with the direction of travel to achieve back to balance.

5.2 A Limited Assurance opinion was also given for Medicines Management with a need to improve the governance and the committee alerted the Board of the importance of having Quality Committee oversight of this and it being a route to the Board of Directors.

5.3 Significant Assurance opinions were given on Pay expenditure, assessing the controls in place within the Trust, Safeguarding and the clear staffing, leadership and governance structure, and finally Ward to Board Risk Management evidencing a demonstrable improvement in risk management processes since their previous audit.

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

COUNCIL OF GOVERNORS MEETING: 20 November 2024

Agenda item: **COG/61/23v**

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

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

Action required: **To note**

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

2.0 Charity Strategy

2.1 The committee received the bi-monthly progress reports against the agreed objectives for 2024/25. Over the past two years, the charity has experienced unprecedented growth, both in terms of fundraising activities and the increasing demand for its support within the Trust. This surge has been fuelled by the charities increased visibility both internally and externally and the charity's expanding portfolio of impactful projects, events and campaigns.

2.2 It was reported that the due to the growth and activity in events and engagement, resource has been limited to implement the 'Legacy' strategy and work will start on this early next year.

2.3 Regarding the In-Memory Strategy, the committee were updated that whilst this has not been fully developed, it is being integrated in the ongoing activities, such as, the Christmas In-Memory Tree.

2.4 The current Charity Strategy will come to an end next year and the committee have been playing an active role in development the next 3 year strategy, which will be designed to grow the charity's impact, financial sustainability, and engagement with the Trust and the broader community.

3.0 Finance Report

3.1 The charity continues to be in a good financial position and the Committee commended the charity team, reflecting on the cumulative donation income in previous years. Direct Income from gifts and donations received to month 7 in 2024/25 is £141K, compared to the 12 month period 2023/24 of £255K and 2022/23 of £104K. grant income of £38K was also received in 2023/24

3.2 The Annual Accounts and Annual Report were presented at November's committee, and subject to minor amendments and final approval, will be submitted for approval by the Corporate Trustee and then submitted to the Charity Commission before the end of January 2025.

4.0 Charity Appeals and Fundraising

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

4.2 The Committee celebrated the successful Tiny Toes appeal and the achievement of £157,000 raised, exceeding the target of £150,000; this has been the largest and most successful appeal of the charity to date and the committee commended the hard work of the charity team. Following on from the success, the next appeal has been launched around Dementia Care, to support and develop dementia friendly environments in the Trust.

4.3 It was reported that there has been significant work and development of partnerships and relationships, resulting in sponsorship agreements, raffle donations, gifts in kind, engagement with local communities, as well as, increased corporate volunteering and continuation of Dunelm's Delivering Joy Campaign.

5.0 Risk Information

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

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

COUNCIL OF GOVERNORS MEETING: 20 November 2024

COG/62/24

Agenda item: **Integrated Performance Report**

Presented by: **Sally Kilgariff, Chief Operating Officer**
Author: **Michael Wright, Managing Director**

Action required: **To note**

1.0 Introduction

1.1 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 September 2024, where available, and outlines performance in relation to established national, local, or benchmarked targets.

1.2 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.

1.3 It is recommended that the Council of Governors note the Trust's performance against the metrics presented in the Integrated Performance Report and receive assurance on the basis of this report.

Michael Wright
Managing Director
November 2024

Integrated Performance Report Commentary

OVERVIEW

The Integrated Performance Report now includes significant data and trend analysis. Where available, national benchmarking is provided, which in the main illustrates a number of positives that can be taken in relation to delivery and progress and also a number of areas where actions are in progress to improve the position.

This executive summary identifies areas where action is required and is taking place. There are also a number of areas referenced where the Trust is performing well.

QUALITY SUMMARY

• **Care Hours Per Patient Day (CHpPD):** This continues to be in common cause, with an average for the current period of 7.1 against a target of 7.3.

• **Mortality**: The Trust's SHMI has consistently remained in the desired "As Expected" band, out of the three SHMI categories (As Expected, Higher, or Lower), since July 2021.

• **C. difficile infections**: After a period of exceptionally high infections (April-May 2024), these have returned to common cause with the latest value meeting the monthly threshold. These rates are reviewed monthly at Harm Free Care panels, with emerging themes pointing to antimicrobial stewardship and prescribing practices.

• **Friends and Family Test**: The Trust consistently achieves the target of 95% for this measure, with an average score over the past 18 months of 97%.

OPERATIONAL PERFORMANCE

- **Elective waits**: The Trust is in the first quartile for 65 week waits with no patients at the end of September. The national target to clear long waits has been

achieved. 52-week waits are second quartile, although progress in reducing 52-week waits has been limited.

- **Cancer**: all three metrics (Faster Diagnosis, 31- and 62-Day Standard) were once gain achieved in month. FDS showing significant sustained improvement.
- **DM01**: performance against this metric remains very positive and has now been achieving against target since March 2024.
- **4 Hour Performance**: gains have been made against this metric and showing significant sustained improvement, from an average of 58% to 67%
- **2 Hour Urgency Community Response**: this metric continues to achieve target and is expected to continue to do so, additionally the past four points are on an upward trajectory which may indicate the start of a trend demonstrating significant improvement.
- **Did Not Attend (DNA**): the proportion of appointments where patient DNAs continues to miss target, although a sustained reduction is now being seen.
- **Referrals**: there has been a sustained increase in the number of referrals leading to increased pressure on services.

PEOPLE AND CULTURE SUMMARY

- **Sickness absence rate:** performance is now broadly static following improvement during 2023/24 and as a result is a cause for concern. The rate of sickness absence is been driven primarily by long term sickness absence. Links between deprivation, population health and the health and wellbeing of our people are also relevant here. Other Trusts in SY have seen a deterioration in performance here and actions are being taken through the HWB and attendance programme to tackle this.

- **Appraisal rate completion:** continues to be below the target however signs of improvement noted as appraisal season comes to its conclusion.

- **Vacancy rate:** performance is a function of the relationship between retention, recruitment and establishment size, and is in a good position.

Council of Governors Meeting

Integrated Performance Report - September 2024

Performance Matrix Summary

NHS The Rotherham NHS Foundation Trust

Assurance

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

Performance Matrix Summary - Quality

The Rotherham NHS Foundation Trust

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

How to read the ICONs in this report:

Have we achieved in month?

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

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

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

Quality

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
SHMI	"As expected"	"As expected" (103.7)	May-24	N/A	P		-	S
Readmissions (%)	-	5.9	Aug-24	-	-	L		G
VTE Risk Assessments (%)	95.0	94.4	Sep-24	☒				S
Care Hours per Patient Day	7.3	7.1	Sep-24	☒				S
Combined Positivity Score (%)	95.0	95.6	Sep-24	☑			-	S
Complaints (per 10k Contacts)	8.0	14.7	Sep-24	☒			-	S
Patient Safety Incident Investigations	3	6	Aug-24	☒			-	S
Patients Falls (Moderate and Above per 1000 bed days)	0.19	0.17	Sep-24	☑			-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 1000 bed days - Acute	0.77	1.48	Sep-24	☒			-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 100 contacts - Community	0.06	0.11	Sep-24	☒		H	-	C
Medication Incidents - Moderate and Above per 1000 bed days – Acute	0.05	0.09	Sep-24	☒			-	S
Medication Incidents - Moderate and Above per 100 contacts - Community	0.00	0.00	Sep-24	☑			-	S
C. difficile Infections	<4	4	Aug-24	☑				S

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

SHMI: Summary Hospital-Level Mortality Indicator

Data, Context and Explanation

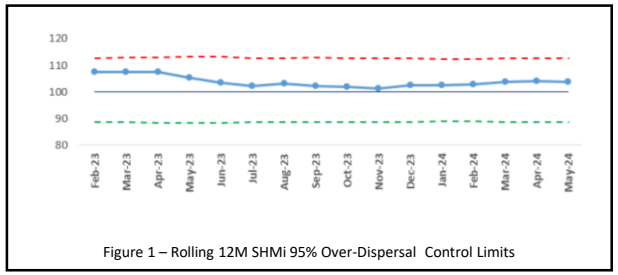


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

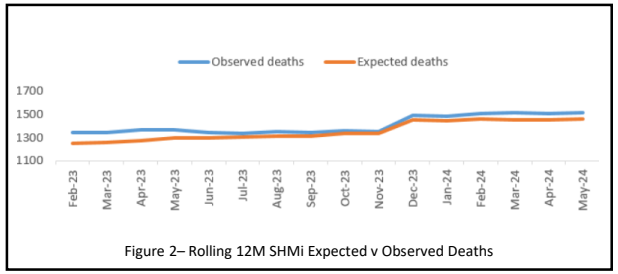


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

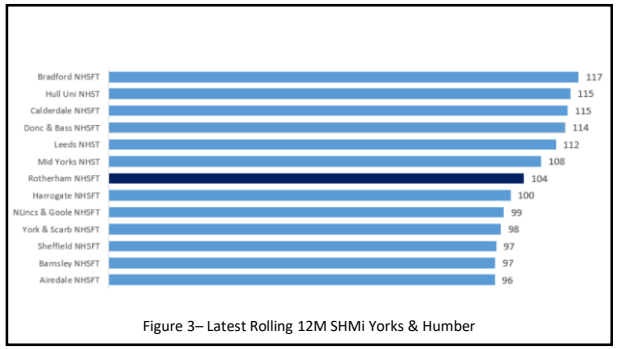


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

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

Covid activity was added back into the SHMI data Dec 2023

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

Metric	Current	Target	Exec Owner	Organisational Lead
Latest Rolling 12 Month SHMI -May 24	103.7	-	Jo Beahan	John Taylor
Expected Deaths	1460	-		
Observed Deaths	1515	-		
Trust Banding	Expected	-		

What actions are planned?

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

What is the expected impact?

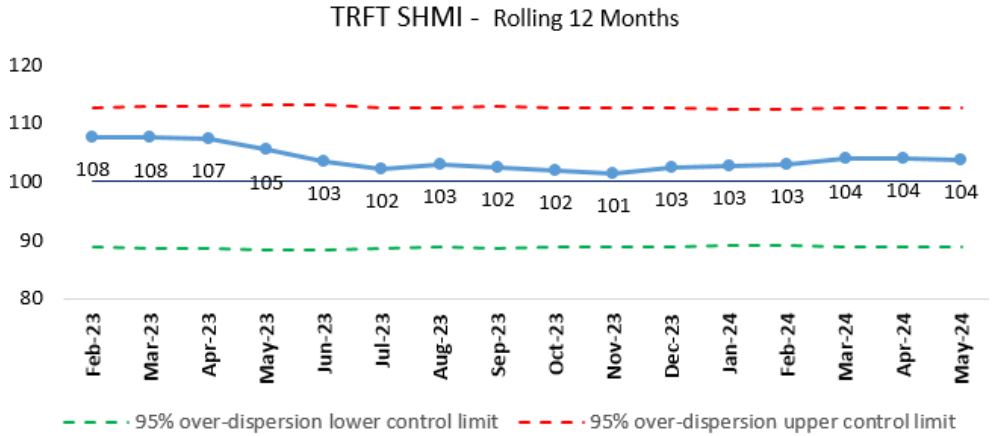
- Investigations or reviews resulting from SHMI investigations will give the Trust Assurance when there are significantly more deaths observed than expected
- Intelligence from SHMi investigations/reviews may lead to changes/improvements in practice

Potential risks to improvement?

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

SHMI: Summary Hospital-Level Mortality Indicator - Update

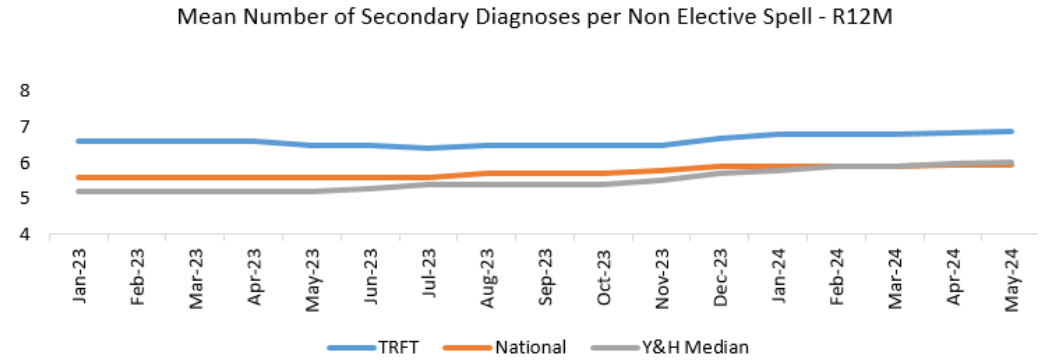
SHMI Update



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

Interpretation Guidance NHS England June 2024

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



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

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

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

SHMI: Coding & Alerts

SHMI - Diagnostic Group Alerts

Acute Myocardial Infarction – VLAD (Variable Life-Adjusted Display) Alert March 2024

This alert was triggered by a higher number of deaths than expected in March 2024. Usually at TRFT there are between 0-5 deaths per month in this group. In March 2024 there were 7.

This alert was discussed at the September Trust Mortality Group meeting. A decision was made to request that Cardiology complete a brief review of the deaths and to request SJRs for 5 of the 7 deaths.

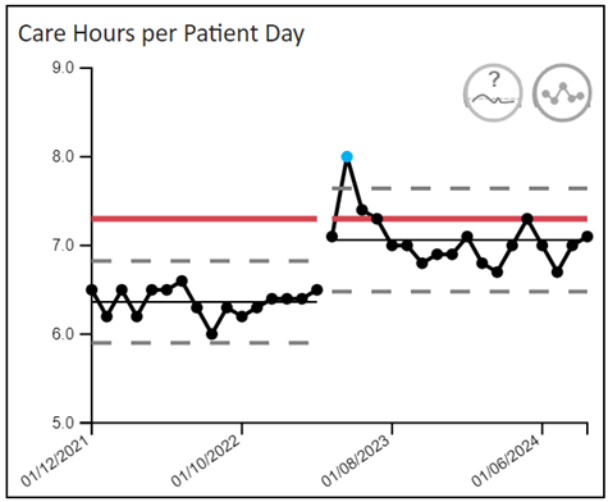
Cardiology have fed back they have looked at the cases and haven't judged any of the deaths to have been preventable. One SJR has been returned, although issues were identified with the care, the death was judged to have 'Definitely Not Preventable'. The remaining SJRs will be viewed upon completion.

SHMI Changes – Methodology, Process or Specification

No new changes

Subtheme: Care hours per patient day

Data, Context and Explanation



- Care Hours Per Patient Day (CHPPD) is the formal, principal measure of workforce deployment in ward-based settings.
- CHPPD forms an integral part of a ward/unit/trust review and oversight of quality and performance indicators to inform quality of care, patient outcomes, people productivity and financial sustainably.
- CHPPD should be used alongside clinical quality and safety outcome measures to understand and reduce unwarranted variation, and support delivery of high quality, efficient patient care.
- Focus on percentage of fill rate against funded establishment.
- Fill rates are within 5% of planned for HCSW day and RN nights. Fill rates are under 5% planned for RN days but there are more support staff around to support safety. Fill rates are over 5% of planned for HCSW nights.

Metric	Value	Target	Exec Lead	Ops Lead
Care Hours per Patient Day	7.1	7.3	Helen Dobson	Cindy Storer

What actions are planned?

- Continued roll out of the Exemplar Accreditation programme. This programme is underpinned by Quality dashboards
- Recruitment of 90 Newly Registered Nurses in September/ October 2024
- Fill rates against planned establishments scrutinised and noted to be lower for RN in the day where more support staff are available.

What is the expected impact?

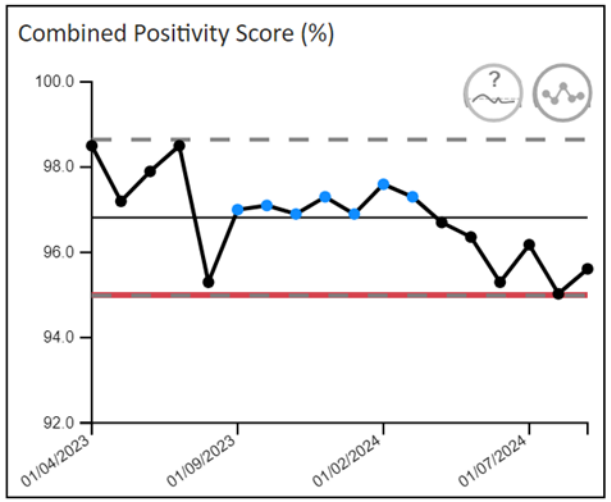
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.

Potential risks to improvement?

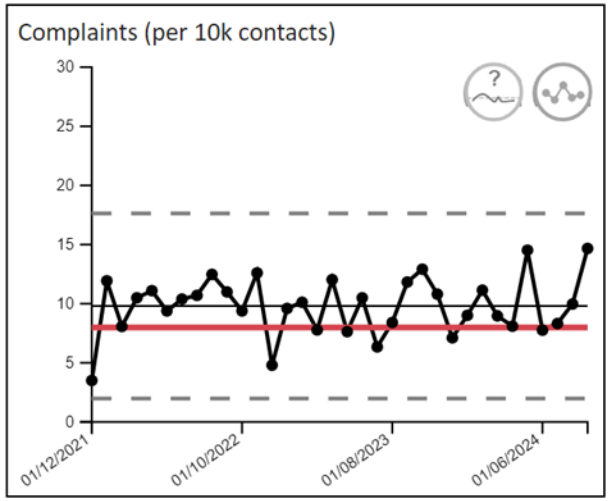
- Needing to open additional beds using existing establishments and temporary NHS staff
- Roster KPI not being met
- Turnover of Nurses, Midwives and HCSW

Subtheme: Patient Experience

Data, Context and Explanation



- The Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
- The FFT asks people if they would recommend the services they have used. Our Combined Positivity Score is consistently meeting our target of 95% of Patient saying they would recommend our services.



- Patients can complain about any aspect of NHS care, treatment or service and this is written into the NHS Constitution.
- The number of complaints continues to be monitored. There has been a consistent rate of written complaints per month over the last three years., despite the rising numbers of patients being seen.

Metric	Value	Target	Exec Lead	Ops Lead
Combined Positivity Score (%)	95.6	95.0	Helen Dobson	Cindy Storer
Complaints (per 10k contacts)	14.7	8.0	Helen Dobson	Cindy Storer

What actions are planned?

- Front line resolution through the new PALS resulting in positive compliments
- Training through new Monopoly board continues
- Purple Butterfly resources boxed launched to support personalised care at the end of life
- Carers promise launched to support those with caring responsibilities

What is the expected impact?

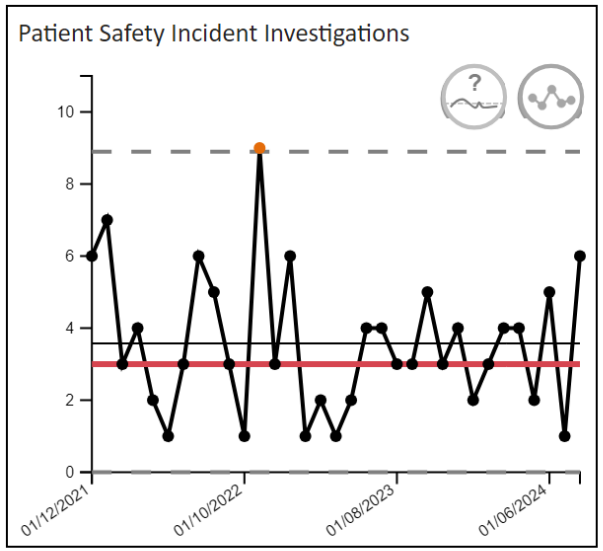
- FFT Continued Positivity score above 95
- The PALS service aims to promote local resolutions to concerns earlier in the process leading to a reduction in formal complaints per 10k contacts

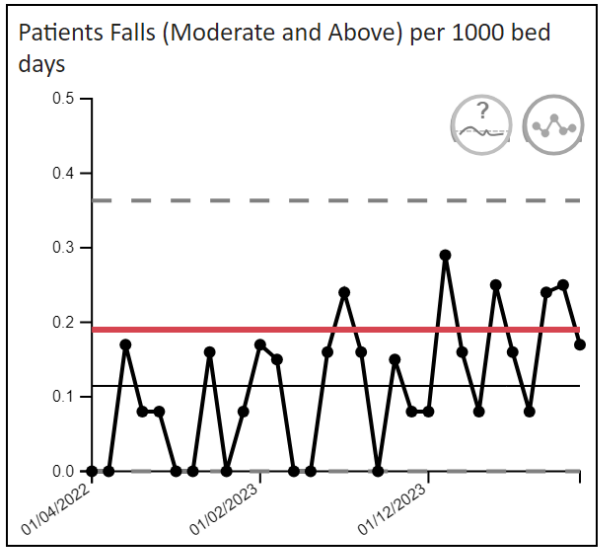
Potential risks to improvement?

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

Subtheme: Care Incidents (1)

Data, Context and Explanation





- Patient Safety Incident Investigations are completed when a patient has been involved in a moderate harm incident and significant learning identified. Number of PSI remain consistent per month.
- The number of patient falls at moderate harm is remaining consistent at present, at times achieving the 0.19 per 1000 bed days target, including this month although this will not be the case every month.

Metric	Value	Target	Exec Lead	Ops Lead
Patient Safety Incident Investigations	6	3	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.17	0.19	Helen Dobson	Victoria Hazeldine

What actions are planned?

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

What is the expected impact?

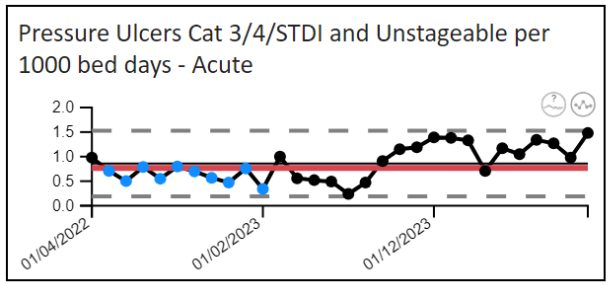
- Stabilisation of PSII's with adequate evidence of shared learning
- Reduction in the total number of falls
- Clear guidance on the use of PSII's against alternative investigation methodology

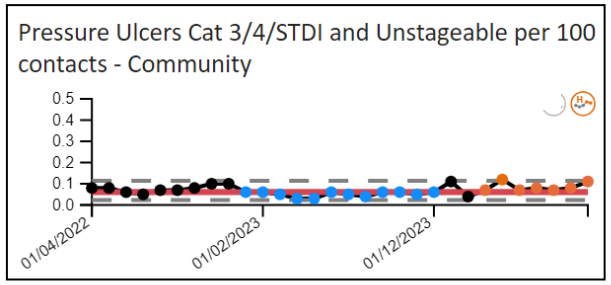
Potential risks to improvement?

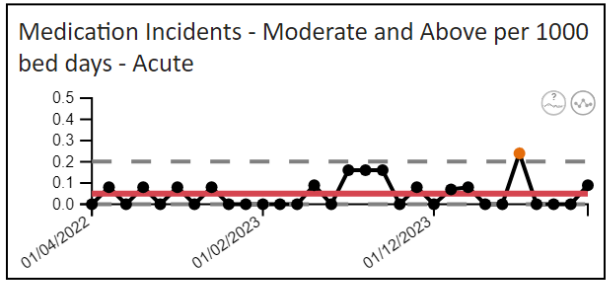
- Increase in the number of patients admitted to acute Trust with complex health problems and additional bed capacity, resulting in reduced nursing and medical ratios
- The lack of a falls lead practitioner to complete work across acute and community to ensure the Trust is compliant with NAIF and Qi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

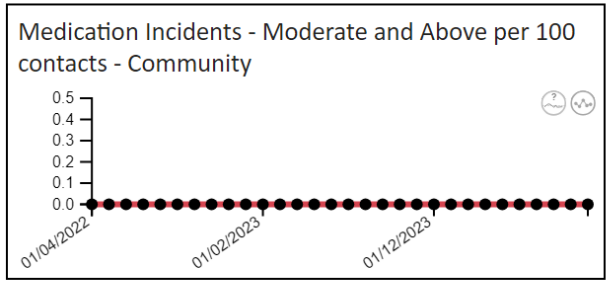
Subtheme: Care Incidents (2)

Data, Context and Explanation









- Medication incidents that are reported through the Datix system can occur for a number of reasons. Over the last 18 months, the Trust has consistently seen just shy 100 incidents reported per month. The aim for 2024/25 is to reduce that down to average of 90 per month (10% reduction)
- Pressure ulcers (PU) remain a concern and are considered, the main, an avoidable harm associated with healthcare delivery. Treating pressure damage costs the NHS more than £3.8 million every day and causes both physiological & psychological harm. The rate of PU in Acute remains in common cause, however in Community the PU rate has shown a deterioration with an increased rate of PU.

Metric	Value	Target	Exec Lead	Ops Lead
Pressure Ulcers Cat 3/4/STDI and Unstagea...	1.48	0.77	Helen Dobson	Victoria Hazeldine
Pressure Ulcers Cat 3/4/STDI and Unstagea...	0.11	0.06	Helen Dobson	Victoria Hazeldine
Medication Incidents - Moderate and Abov...	0.09	0.05	Jo Beahan	Victoria Hazeldine
Medication Incidents - Moderate and Abov...	0.00	0.00	Jo Beahan	Victoria Hazeldine

What actions are planned?

- The metric for medication incidents has now been set for moderate harms and above. This has taken into account the past 2 years data to provide a reasonable target score.
- Pressure ulcers data has been split into Acute (1000 bed days) and Community (1000 contacts). The target has been set using 2 years worth of data to define a reasonable mean

What is the expected impact?

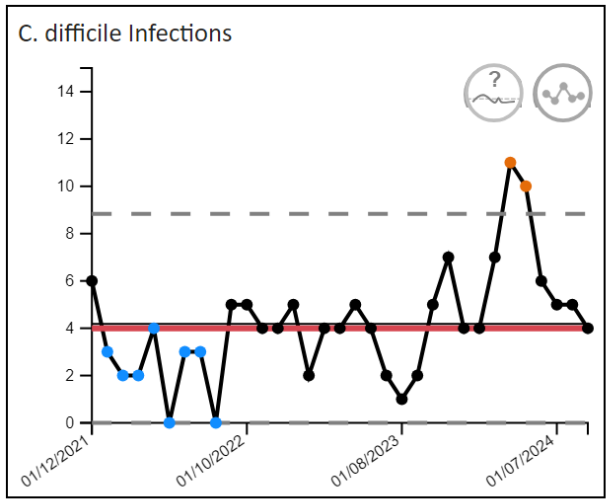
- Reduction in the number of moderate and above medication incidents.
- Reduction in the number of CAT 3/4/SDTI and unstageable pressure ulcers
- Clearer understanding of where the highest area of risk in between community and acute

Potential risks to improvement?

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

Subtheme: Infection Prevention & Control

Data, Context and Explanation



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

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

What actions are planned?

- Harm Free panel continues with continued themes on antibiotic prescribing identified.
- National Standards of Healthcare Cleanliness (2021) have been re-launched.
- New microbiologist appointed and start date anticipated November – the second person will start in February to cover 1 wte.
- Antimicrobial stewardship through prescribing for co-amoxiclav

What is the expected impact?

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

Potential risks to improvement?

- Intermittent microbiology support to lead strategically across the Trust, support proactive ward rounds and input into Trust Harm Free Care Panel. Now appointed to but wont start until November 2024

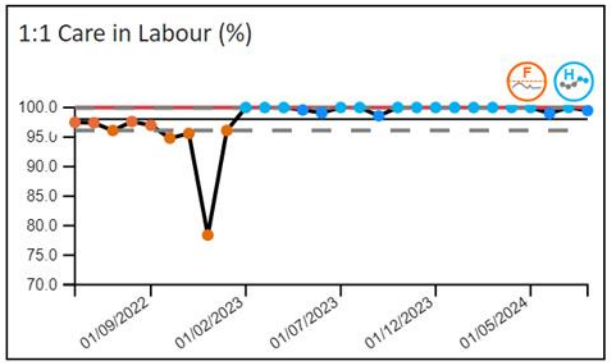
Maternity

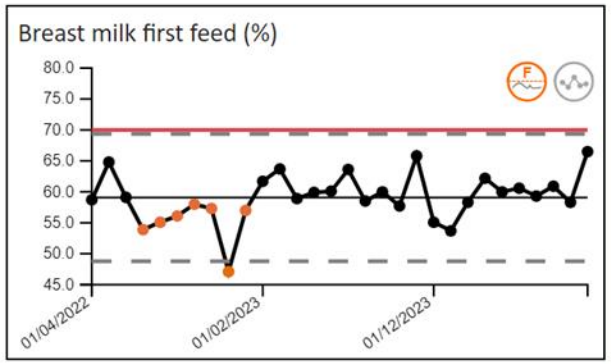
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	99.5	Aug-24	✗	F	H	-	C
Breast milk first feed (%)	70.0	66.5	Sep-24	✗	F			C
Stillbirth rate (per 1000 births)	4.66	2.4	Sep-24	✓	P	L	-	VG

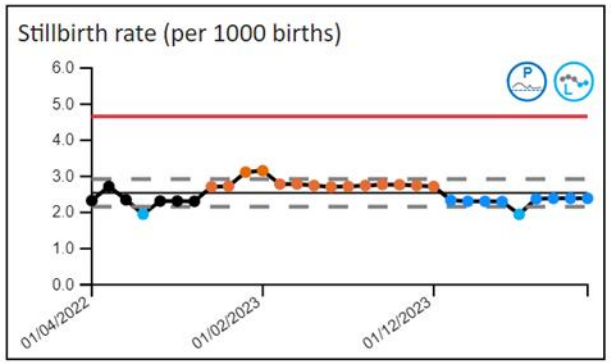
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Maternity

Data, Context and Explanation







- 1:1 care in labour remains at a high performance level, This data is monitored through the Maternity Birth Rate plus Acuity tool to provide assurance for Maternity incentive scheme. Performance on the tool is 100% for August.
- Breast Milk First Feed % continues to be below the Trust target, with an average of 60.9 % against a Trust target of 66%.
- Work is ongoing to educate and support families regarding the benefits of breast milk. TRFT Maternity services are working with partners to support this supporting the Unicef Baby Friendly (BFI) infant feeding standards.
- Still Birth Rates remain consistently lower than the NHS England ambition, of a rate of 2.4 per 1000 births at TRFT. Excluding medical termination of pregnancy (MTOP) and fetal abnormality the rate is 2.39 per 1000 births.

Metric	Value	Target	Exec Lead	Ops Lead
1:1 Care in Labour (%)	99.5	100.0	Helen Dobson	Sarah Petty
Breast milk first feed (%)	66.5	70.0	Helen Dobson	Sarah Petty
Stillbirth rate (per 1000 births)	2.4	4.66	Helen Dobson	Sarah Petty

What actions are planned?

- 1:1 care in labour is a standard for CNST, birth rate plus data is monitored through maternity and neonatal safety paper to monitor compliance. This is to ensure that all women in labour on labour ward receive 1:1 care.
- Breast milk first feed: Unicef Baby Friendly action plan to achieve standards for BFI, working in collaboration with RMBC and 0-19. Actions have included High standards of parent information and education on breast feeding, working with partners in Family hubs to improve infant feeding support.
- Stillbirth rate: Continuous improvement with the Saving Babies Lives care bundle version 3 implementation – TRFT currently at 93% compliance.

What is the expected impact?

- Performance to be maintained following safe staffing /escalation policy for TRFT.
- Achieving BFI accreditation ensures that TRFT meet the required standards to support infant feeding standards across the service. The Three year delivery plan recommends that this is achieved by March 27
- The LMNS assurance visit in September 2024 highlighted compliance at 97% for TRFT.

Potential risks to improvement?

- Maintain birth rate plus establishment setting requirements and backfilling maternity leave and gaps above headroom supports safe staffing on every shift
- Infrastructure and support to gain BFI including training. To maintain partnership working with RMBC.
- The recent withdrawal of public health funding for smoking in pregnancy service could impact service delivery and impact on the delivery of the Saving babies lives care bundle

Performance Matrix Summary – Finance and Performance

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

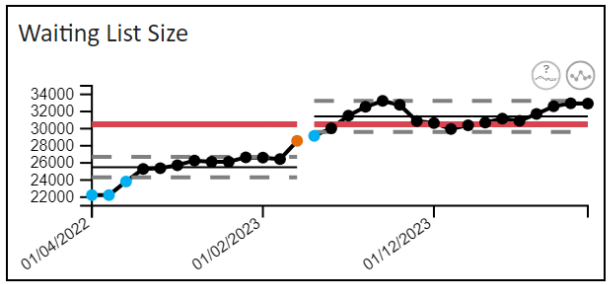
Elective Care and Cancer

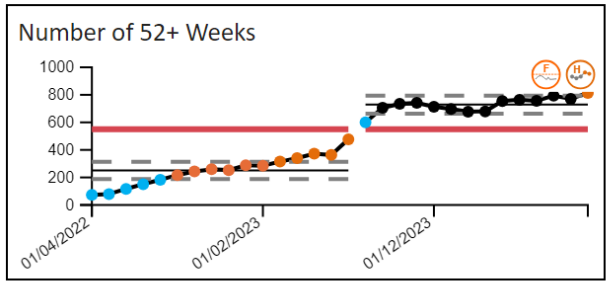
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	30,500	32,920	Sep-24	✗	?			S
Number of 52+ Weeks	550	814	Sep-24	✗	F	H		VC
Number of 65+ Weeks	0	0	Sep-24	✓	F	L		CI
Referral To Treatment (%)	92.0	62.0	Sep-24	✗	F			C
OP Activity moved or Discharged to PIFU (%)	2.5	2.9	Sep-24	✓	?	H		G
Overdue Follow-ups	-	16,240	Sep-24	-	-	H	-	C
DM01 (%)	1.0	0.5	Sep-24	✓	?	L		G
Faster Diagnosis Standard (%)	77.0	80.4	Aug-24	✓	?	H		G
31 Day Treatment Standard (%)	96.0	96.8	Aug-24	✓	?			S
62 Day Treatment Standard (%)	70.0	80.5	Aug-24	✓	?			S

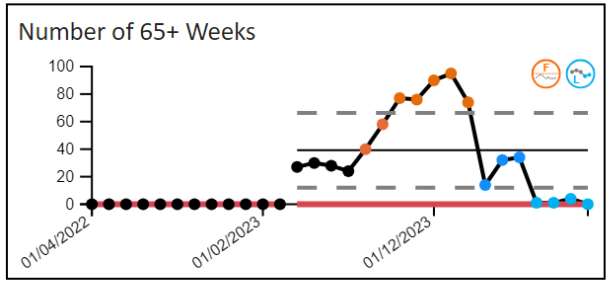
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

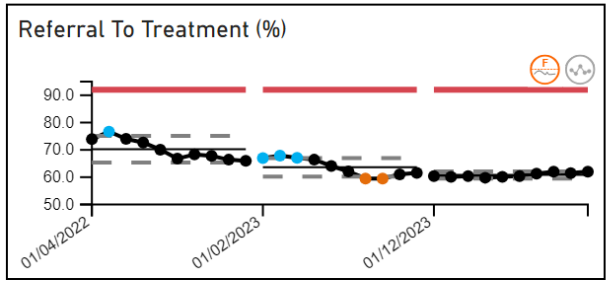
Subtheme: Long Waiters

Data, Context and Explanation









- The number of patients on our RRT waiting list continues to be within normal variation, although has been above plan for the last three months. This growth is naturally impacting on the ability to reduce the number of patients waiting over 52 weeks.
- The Trust has committed to reducing the number of patients waiting over 52 weeks by 50% by March 2025. Whilst there has been a further reduction in month, from 771 in August to 733 this month, this is normal variation, indicative that next month could fall within a similar range.
- For 2024/25, the national planning guidance set an objective for 0 patients to still be waiting over 65 weeks for their treatment by the end of Sept-24. The Trust committed to deliver this target by July-24.
- We continue to see significant improvements in our run rate and achieved 0 breaches in Sept-24. We will now focus on sustaining this position moving forwards.
- A transformation programme focusing on increased theatre and outpatient productivity, linked to GIRFT Further Faster is in place. This work aims to see us reach our Trust ambition to achieve RTT performance of 92% in a minimum of 5 specialties. Respiratory has now achieved compliance with the RTT standard.

Metric	Value	Target	Exec Lead	Ops Lead
Waiting List Size	32,920	30,500	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks	814	550	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	0	0	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	62.0	92.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Continuation of additional clinics in Gastroenterology throughout October 2024 to support patients to receive their first outpatient appointment, improving the RTT position.
•Continuation of additional clinics in Cardiology throughout October 2024 to support patients to receive their first outpatient appointment, improving the RTT position.
•Outsourcing of 256 orthopaedic patients in October 2024 to ensure they receive their treatment in a timely manner, improving the RTT position.

What is the expected impact?

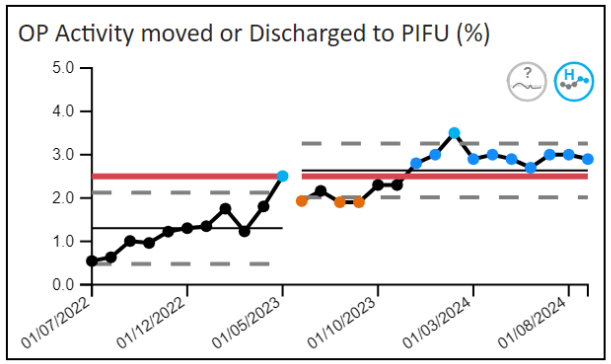
•Improved RTT position in Gastroenterology by January 2025, supporting the Trust to achieve RTT status by March 2025.
Improved RTT position in Cardiology by January 2025, supporting the Trust to achieve RTT status by March 2025.
•Sustained achievement of zero patients waiting longer than 65 weeks for surgery in T&O from September 2024 onwards and a reduction in the number of patients waiting longer than 52 weeks by March 2025.

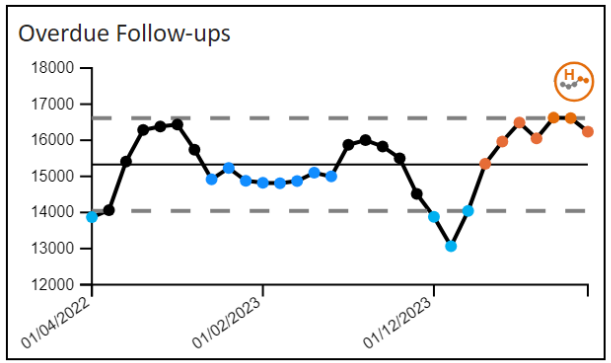
Potential risks to improvement?

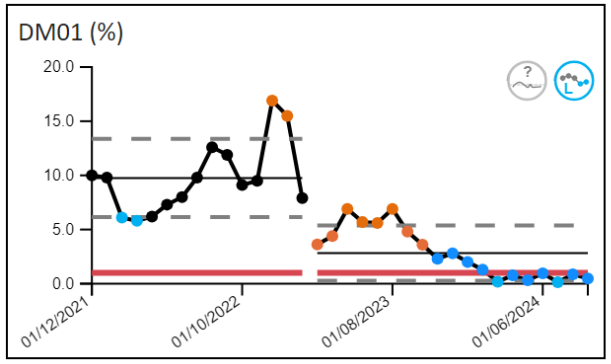
- Clinician agreement and availability to undertake additional sessions as required to support the outpatient and elective activity.
- Potential impact of any future industrial action affecting availability of doctors or nurses.
- Availability of financial resource to support additional activity.
- Risk of identification of long waits through enhanced validation of waiting list.

Subtheme: Diagnostics & Follow-ups

Data, Context and Explanation







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

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

•The last quarter, has seen the number overdue follow ups fall outside of the upper limits, this means the number exceed the anticipated 'normal' run rate, with notable increases seen in Ophthalmology, Respiratory, Dermatology, ENT and Rheumatology.

•The 2024/25 national planning guidance also set an objective to increase the % of patients that receive a diagnostic test within 6 weeks to 95%.

•As the Trust is consistently achieving this standard, we have set an internal stretch ambition to maintain performance at 99% for 24/25. The Trust has maintained this achievement since Mar-24.

Metric	Value	Target	Exec Lead	Ops Lead
OP Activity moved or Discharged to PIFU (%)	2.9	2.5	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	16,240	-	Sally Kilgariff	Andrea Squires
DM01 (%)	0.5	1.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Additional outpatient clinics in place throughout October 2024 to ensure Respiratory patients receive their follow-up appointment in a timely manner.
•Continuation of additional Ophthalmology weekend clinics in October 2024, which will ensure patients waiting for an overdue follow-up appointment are prioritised affectively.
•Delivery of mutual aid via Montagu CDC to increase Endoscopy provision continues to ensure the Trust maintains compliance with DM01 standards following the change to reporting requirements at the end of September 2024.
•Demand & Capacity Planning continues to be progressed for 2025/26.

What is the expected impact?

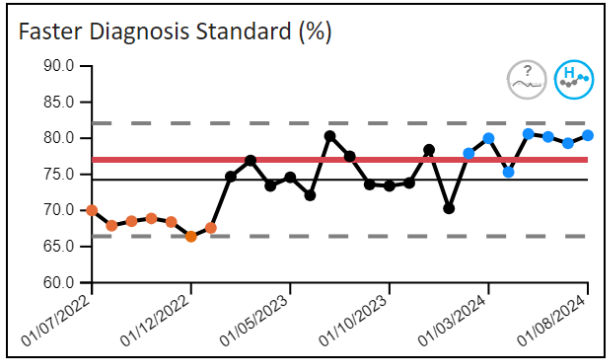
•Patients overdue a follow-up appointment will have confirmed that they still want/need a follow-up appointment by the end of September 2024 and plans will be in place to increase capacity where required by October 2024.
•Endoscopy will continue to achieve the DM01 standard following changes to guidance regarding surveillance patients in October 2024.
•Services will identify gaps in service provision and develop 'closing the gap' plans to support 2025/26 planning cycle.

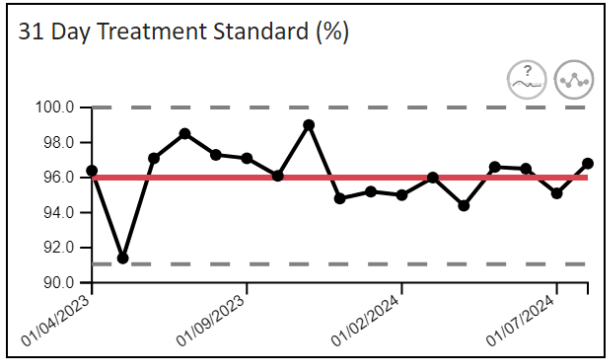
Potential risks to improvement?

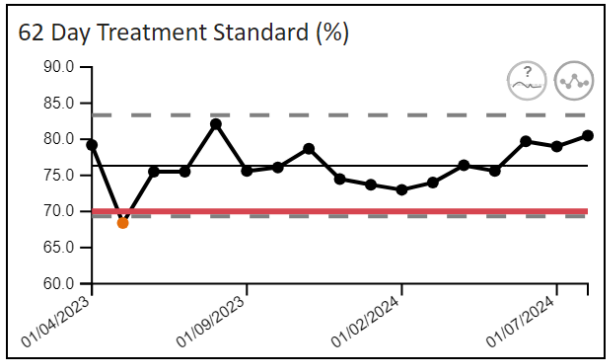
- Addition of overdue surveillance patients in endoscopy to DM01 from September 2024 may impact on DM01 performance.
- Reliance on additional activity to support endoscopy capacity continues which if unavailable may impact the ability to achieve the DM01 standard from September 2024 onwards.
- Availability of financial resource to support additional activity.
- Impact of the transfer of long waits in DM01 as part of any mutual aid agreements across the system.

Subtheme: Cancer

Data, Context and Explanation







•In 2024/25, the national planning guidance set an objective to improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025. 5 out of the last 6 months have achieved the national target, with an average of 76% since Feb 23 and we continue to work towards consistently achieving this standard and have set a further ambition to improve performance to 80% by March 2025.

•The 31-day standard continues to show normal variation patterns. There are actions to improve this.

•The national planning guidance also sets the objective to improve the 62-day Referral-to-Treatment performance to 70% by Mar-25. As the Trust is consistently achieving this standard, we have set a further ambition to improve performance to 77% by March 2025. The trust continues to meet this target, and current variation/process indicates that it is extremely unlikely that performance will fall below target levels, however it is not impossible

Metric	Value	Target	Exec Lead	Ops Lead
Faster Diagnosis Standard (%)	80.4	77.0	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	96.8	96.0	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	80.5	70.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Plan our second Patient Focus Group on 03/12/24 to gain a greater understanding of our patients needs and improve quality of cancer care.
•Finalise the pancreatic GIRFT return and audit clinical leadership.
•Development of our first stand-alone Cancer Access Policy by November 2024.
•Finalise the UGI (28 day) and Gynaecology (62 day) Improvement Plans by October 2024.

What is the expected impact?

•Improve the Faster Diagnosis Standard in Lower GI further from 65.1% to above 70% by March 2025.
•Improve the Faster Diagnosis Standard in Upper GI further from 65.8% to above 70% by March 2025.
•Reduce the number of patients waiting longer than 62 days for treatment following diagnosis of cancer in gynaecology.
•Improve the National Patient Experience Survey responses further for 2024.

Potential risks to improvement?

•Reliance on additional activity to support endoscopy capacity continues which if unavailable may impact the ability to achieve the FDS and 62 Day standard in Lower GI.
•Workforce challenges in both Lower GI and Urology continue to impact cancer pathway progression and improvement work with consultant vacancies and sickness absence.

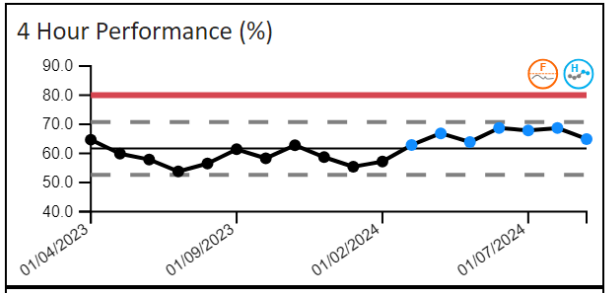
Non-elective and Flow

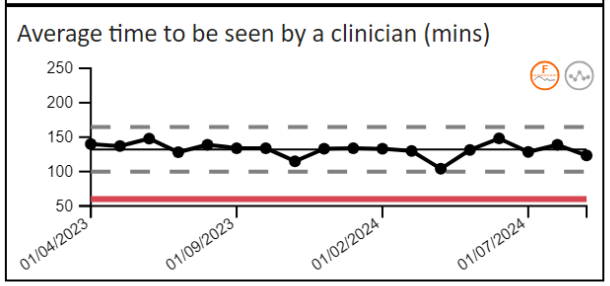
Metric	Trust Target	Latest Data	Period	Achieved in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	80.0	65.0	Sep-24	☒	F	H		CI
Ambulance Handover Times >30 mins (%)	0.0	13.1	Sep-24	☒	F			C
Average time to be seen by a clinician (mins)	60.0	123.3	Sep-24	☒	F		-	C
Patients spending >12 hours in A&E from time of arrival (%)	2.0	3.2	Sep-24	☒	?			S
12hr Trolley Waits	0	6	Sep-24	☒	?		-	S
Bed Occupancy (%)	92.0	91.9	Sep-24	☑	?			S
Length of Stay over 21 Days	64	55	Sep-24	☑	?		-	S
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	82.9	Jul-24	☒	?		-	S
Criteria to Reside is No (%)	10.0	19.2	Sep-24	☒	F		-	C

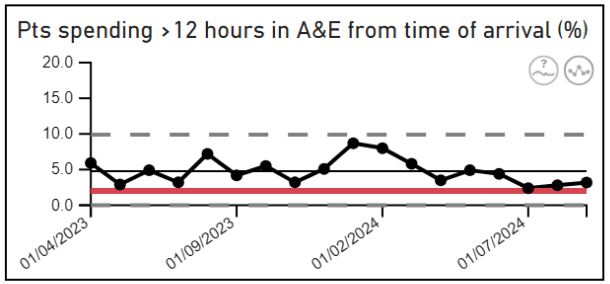
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

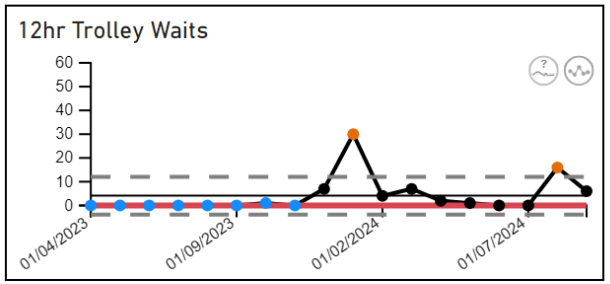
Subtheme: Emergency Care - Waiting Times

Data, Context and Explanation









- In 2024/25, the national planning guidance set an objective for all Trusts to achieve the 4 hour performance standard of 78% by March 2025. While performance falls below this standard, there is sustained improvement in this area, which is now performing at a stable average of 67%.
- Average time to see a clinician remains in a natural variation pattern. Variability in demand continues to further challenge further improvements however there has been improvement in the long waiting times overnight.
- The number of patients spending more than 12 hours in the department is a key national focus. The last few months have seen a month on month increase.
- The Trust has set a standard to achieve zero trolley waits in line with national guidance, this has been achieved recently in a number of months, this is not the case over the last two months due to challenges around patient flow across the trust footprint.

Metric	Value	Target	Exec Lead	Ops Lead
4 Hour Performance (%)	65.0	80.0	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	123.3	60.0	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	3.2	2.0	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	6	0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Work continues to develop SDEC Pathways and improve efficiency within SDEC's
- Data quality and visibility of SDEC Dashboard
- Continued focus sessions on Radiology through the month of October to improve patient flow with further developments of Dashboards to improve visibility
- Review of options to improve fill rate of Minor Injuries rota
- Additional validation by senior operational team

What is the expected impact?

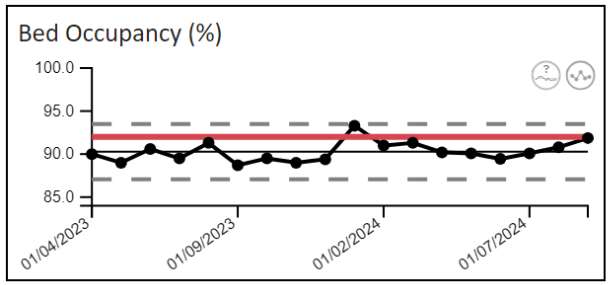
•Non-admitted performance for Primary Care, Minor Injuries and SDEC will continue to improve
•Visibility of all SDEC area via the new dashboard, to improve flow and support SDECs to remain open even at times of high demand
•Improvement in the total time patients spend in the department
•0 12 hour trolley Waits
•Improved time to be seen by a clinician

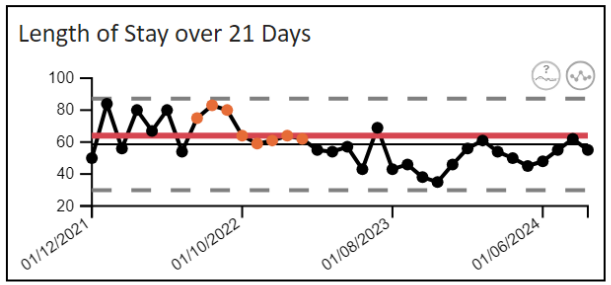
Potential risks to improvement?

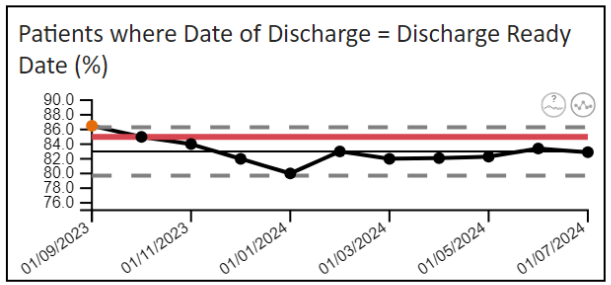
• Significant increased in demand will significantly impact the Trust ability to achieve the 4 hour performance standards.

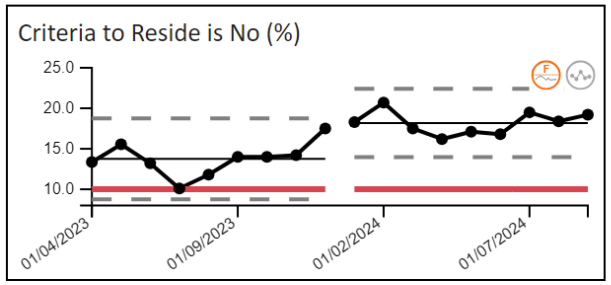
Subtheme: Inpatient Flow

Data, Context and Explanation









- Bed Occupancy for October was 91.9% this includes both core bed capacity as well as escalation capacity in line with national definition. Bed occupancy excluding escalation beds for October would have been 94.3%.
- 92% is recognised as optimum bed occupancy. Recent months have fallen below this, however throughout September we have been at the higher end of the target. It should be expected that we would see values fluctuate between 87% and 94% based on current patterns and Winter pressures.
- Length of stay >21 days remains in line with natural variation and achieving the target for the month
- Date of Discharge = Discharge Ready holds steady below target at around 83%.
- Criteria to Reside continues to fluctuate, showing natural variation between 22% and 14%, consistently not achieving the target of below 10%. Due to challenges experienced across all discharge pathways, more focused work is planned to take place to achieve the Trust standard of 10%.

Metric	Value	Target	Exec Lead	Ops Lead
Bed Occupancy (%)	91.9	92.0	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	55	64	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	82.9	85.0	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	19.2	10.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

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

What is the expected impact?

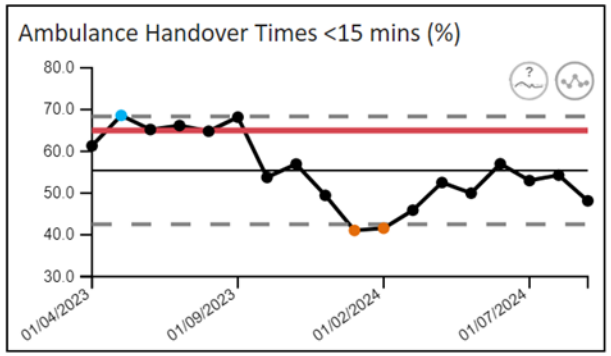
- Patients discharged on discharge ready date will reach target
- Continued reduction in patients in hospital over 21 days
- Reduction in those patients that have been an inpatient over 7 days
- Reduction in numbers of patients that are Out of Areas and an increased LOS
- Reduction in internal delays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

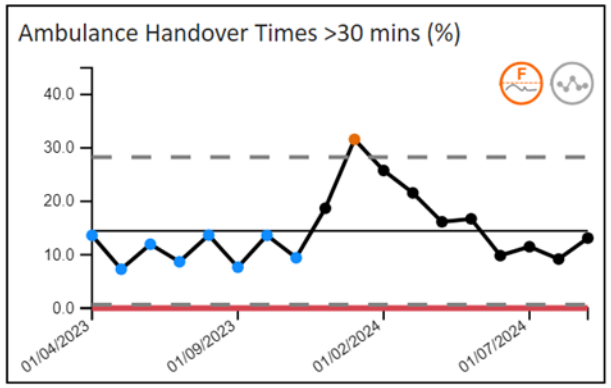
Potential risks to improvement?

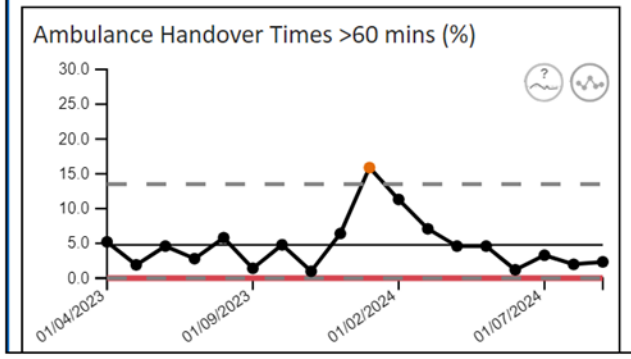
- Increase demand through UECC sustained
- De-escalation of inpatient beds not possible due to ongoing pressures
- Increased demands fails to reduce bed occupancy and additional beds will need to remain open

Subtheme: Emergency Care - Ambulance

Data, Context and Explanation







- The Operational Planning Guidance set an objective to achieve an average of 30 minutes to handover by March 2025.
- Achievement of this standard is dependent on compliance with two other standards; patients wait less than 15 minutes for handover and patients must not wait over 60 minutes for handover.
- The Trust compliance with Ambulance handover times <15 minutes remains below the standard of 65% and continues to perform in line with natural variation.
- For handover times >30mins, average times appear to be falling but we are not yet seeing sustained, significant improvement.
- Similarly, Ambulance handover times >60 did not meet the standard of 0.0%. Current performance levels indicate that we should expect an average of 5%, while some months will achieve 0%, that process is not currently sustainable.
- YAS has identified the Trust as benchmarking positively.

Metric	Value	Target	Exec Lead	Ops Lead
Ambulance Handover Times <15 mins (%)	48.1	65.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >30 mins (%)	13.1	0.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	2.3	0.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Ongoing focused work with the Yorkshire Ambulance Service to analyse and improve data validation will continue to ensure accurate reporting of TRFT ambulance data nationally by Q3 of 2024.
- YAS and the Trust particular Community and UECC are working together on Project Chronos
- Key focus on ambulance handover by Operational managers and Nursing workforce
- Text Messages will alert Operational Managers to delays with Ambulance Handovers

What is the expected impact?

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

Potential risks to improvement?

• A possible increase in ambulance attendances or batching of ambulances
•Ongoing demands for UEC services
•Peaks in demands for services
•Flow within the Trust/organisation and Place
• A possible increase in IPC during the winter which will require off load direct to cubicles

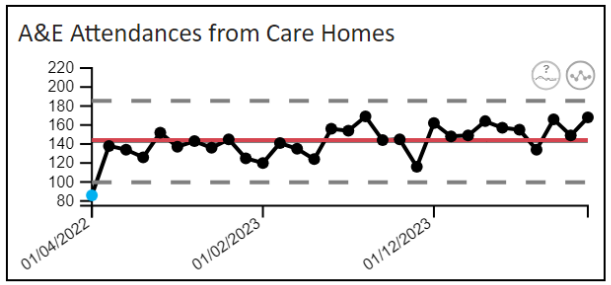
Community

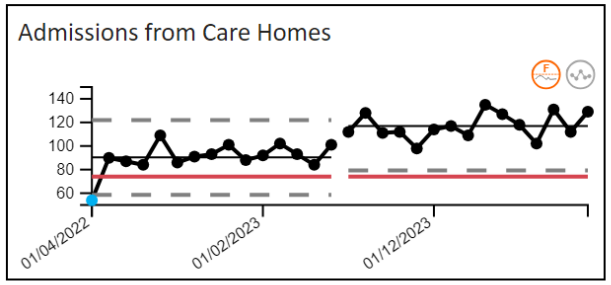
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	144	168	Sep-24	✗	?		-	S
Admissions from Care Homes	74	129	Sep-24	✗	F		-	C
Number of Patients on Virtual Ward	80	65	Sep-24	✗	?		-	S
Urgent 2 Hour Community Response (%)	70.0	72.0	Jul-24	✓	?		-	S

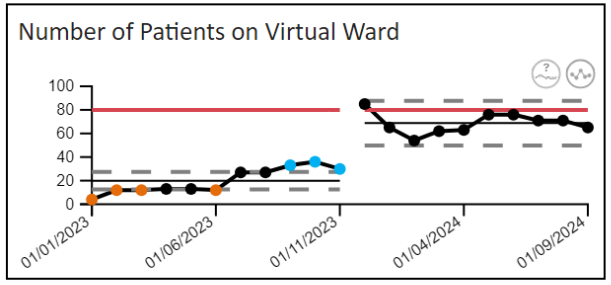
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

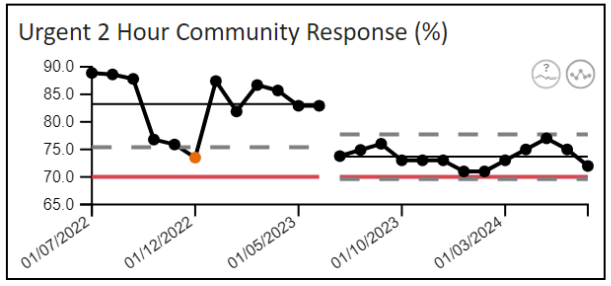
Subtheme: Community

Data, Context and Explanation









- Last month 168 patients attended UECC from Care Homes across Rotherham against the Trust standard of 144. The ICB have provided non recurrent funding for the recruitment of 2 Trusted Assessor for Care Homes. Both appointments commenced in post in August. They will be supporting training requirement in care homes as well as working alongside Trust colleagues to reduce attendances, admissions and LOS. It will take some time to see the impact of their posts.
- Admissions from Care Homes remain in line with natural variation. The community unplanned team in-reach into UECC to prevent any unnecessary admissions. The Trusted Assessor are also reviewing how they can impact admissions.
- The number of patients on Virtual Ward remain within normal variation at an average of 65 patients being cared for against a Trust standard of 80. Occupancy reached a peak of 86 on the 1 September. Capacity was impacted by sickness in month.
- The National standard for the 2 hour urgent community response is 70% of appropriate referrals. The trust is consistently meeting this target, however the variation pattern predicts it wouldn't be entirely unexpected if one month fell short of the target.

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances from Care Homes	168	144	Sally Kilgariff	Penny Fisher
Admissions from Care Homes	129	74	Sally Kilgariff	Penny Fisher
Number of Patients on Virtual Ward	65	80	Sally Kilgariff	Penny Fisher
Urgent 2 Hour Community Response (%)	72.0	70.0	Sally Kilgariff	Penny Fisher

What actions are planned?

- Embed the new role of Trusted Assessors and monitor impact.
- Development of a Virtual Ward Heart Failure pathway is ongoing.
- Introduction of a virtual ward assessment tool to assess the intensity of care required based on patient acuity is underway.
- Ongoing review of specialist planned nursing activity to identify any UCR activity, including a review of the Directory of Service and Data quality.

What is the expected impact?

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

Potential risks to improvement?

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

Productivity Priorities

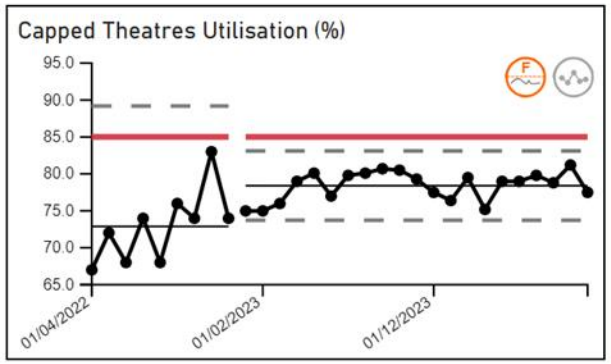
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%)	85.0	77.0	Sep-24	☒	F	H	-	CI
Capped Theatres Utilisation (%)	85.0	77.5	Sep-24	☒	F			C
Model Hospital Daycase Rate (%)	85.0	83.0	Jun-24	☒	?			S
Did Not Attend (%)	7.0	8.2	Sep-24	☒	F	L		CI
First Outpatients (% of Plan)	100.0	103.0	Sep-24	☑	?		-	S
Inpatients (% of Plan)	100.0	88.0	Sep-24	☒	?		-	S
Daycases (% of Plan)	100.0	101.0	Sep-24	☑	?		-	S
Length of Stay over 7 days	-	200	Sep-24	-	-		-	S
Mean Length of Stay (Non-elective)	-	5.1	Sep-24	-	-	L		GI
Mean Length of Stay (Elective excluding Daycases)	-	2.2	Sep-24	-	-			S
Discharged before 5pm (%)	70.0	61.3	Sep-24	☒	F		-	C

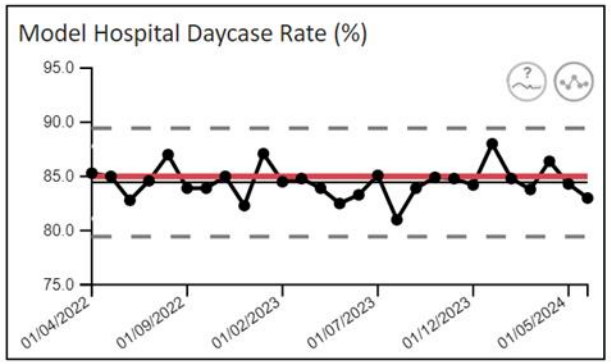
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

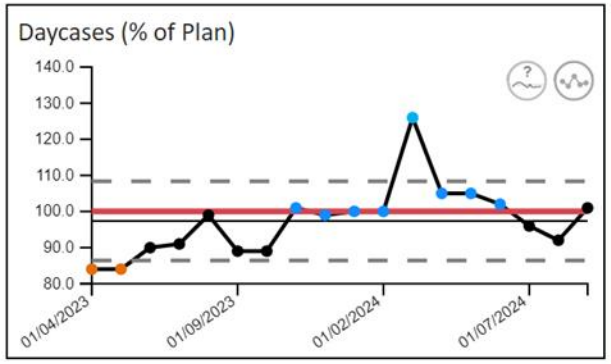
Plan is 19/20 + 3% i.e. *103% of 19/20*, therefore 100% achievement against Plan is 103% of 19/20

Subtheme: Theatres

Data, Context and Explanation







- National planning guidance has set a trajectory of 85% capped theatre utilisation (operating time of planned theatre sessions).
- Trust Capped Theatre Utilisation is consistent, with current utilisation at 77.5% against the 85% standard.
- The Trust MH Day Case rate remained stable at 83% against the 85% standard
- Day case activity achieved the target at 101% against Trust plan. Work continues to improve the day case activity further across a variety of targeted specialties.

Metric	Value	Target	Exec Lead	Ops Lead
Capped Theatres Utilisation (%)	77.5	85.0	Sally Kilgariff	Jodie Roberts
Model Hospital Daycase Rate (%)	83.0	85.0	Sally Kilgariff	Jodie Roberts
Daycases (% of Plan)	101.0	100.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increased pre-op assessment sessions have been agreed to support scheduling and utilisation following 6-4-2 principles and ensuring we are booking out to 6 weeks from September 2024.
- Increased focus on T&O day cases
- Enhanced analysis of work that has been transferred to MEOC
- Validation of patients that are not fit for surgery
- Trial of increased number of patients per list in Ophthalmology

What is the expected impact?

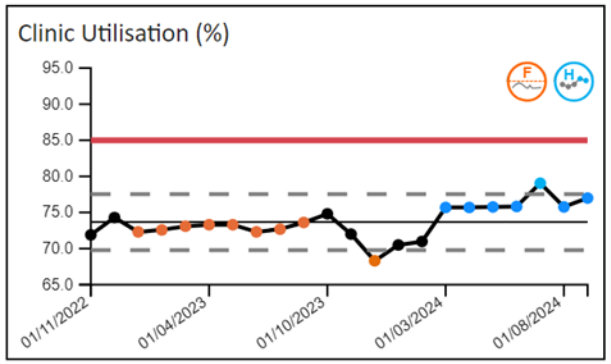
- Improvement in theatre utilisation
- Improved overall scheduling
- Increase in use of day cases theatres from T&O
- Increased day case rate in Ophthalmology
- Improvement in forward view and reducing on the day cancellations.
- Improved booking out to 6 weeks
- Positive impact on data quality

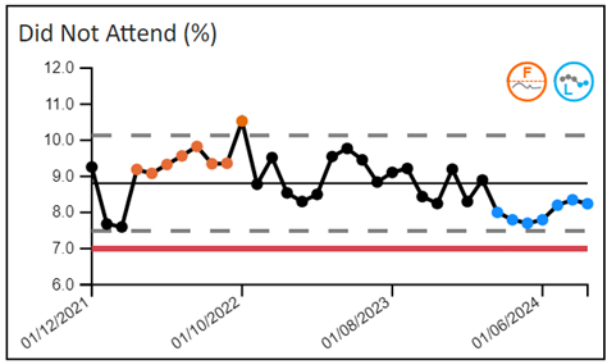
Potential risks to improvement?

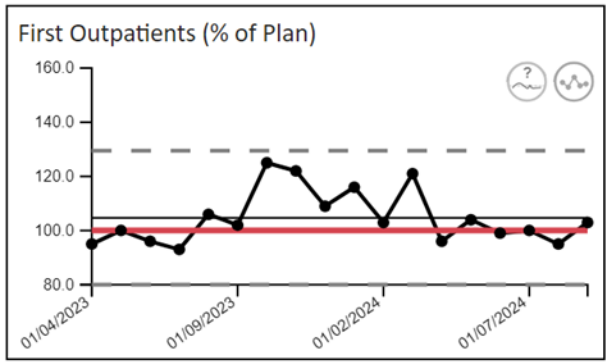
- Anaesthetic rotas may continue to impact on the ability to run theatre activity which significantly impacts on T&O
- Capacity to deliver pre-op assessment may impact on patients available and fit for surgery
- High levels of staff absence impacting on lists been used
- Theatre staffing remains a concern

Subtheme: Outpatients

Data, Context and Explanation







- Clinic Utilisation is key to productivity and underutilised clinics is a key focus for the Trust this year. The last 7 months have shown an 4% improvement step change, with some work still to do to achieve the standard of 85%.
- Trust DNA rates have shown sustained reductions over the last 7 months, holding steady around 8%, with more to do to get to the 7% target. Work is focused on meeting the needs of our local population when attending for outpatient appointments to improve attendance via digital reminders and targeted patient engagement.
- Outpatient productivity provides the organisation with the opportunity to increase activity levels and improve outcomes for patients, this month it has performed to plan.
- The Further Faster programme (GIRFT) supports each speciality in addressing their own specific productivity challenges in relation to outpatients in line with the GIRFT handbooks.

Metric	Value	Target	Exec Lead	Ops Lead
Clinic Utilisation (%)	77.0	85.0	Sally Kilgariff	Jodie Roberts
Did Not Attend (%)	8.2	7.0	Sally Kilgariff	Jodie Roberts
First Outpatients (% of Plan)	103.0	100.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increased capacity to deliver first outpatient appointments across numerous specialities to support activity levels are on-going. Funded via ERF.
- Ongoing work with the contact centre and specialities continues to ensure cancellations are backfilled timely to improve utilisation further through 2024/25.
- Review Utilisation capacity and understand un-booked slots.
- Review data on discharged at first appointment to understand where triage may have biggest impact.
- Text reminders is being piloted with time frame changing from 7 and 2 days to 10 and 1 day

What is the expected impact?

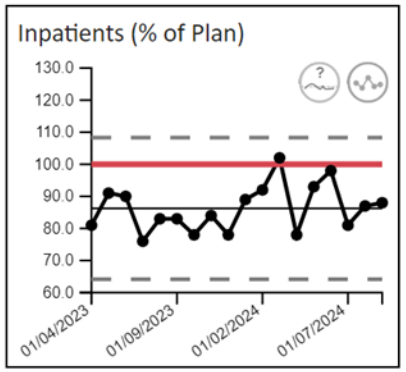
- Increase in clinic utilisation by 5% by Q3 2024/25.
- Reduction in patients that DNA to 7% by Q4 2024/25
- Increase in outpatient activity by 2% by Q3 2024/25.

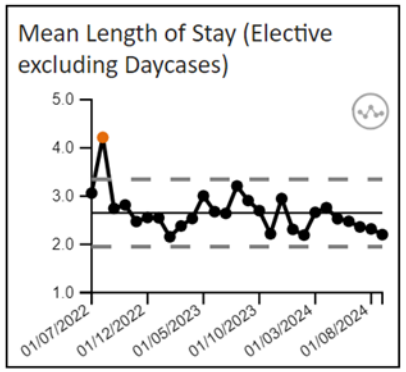
Potential risks to improvement?

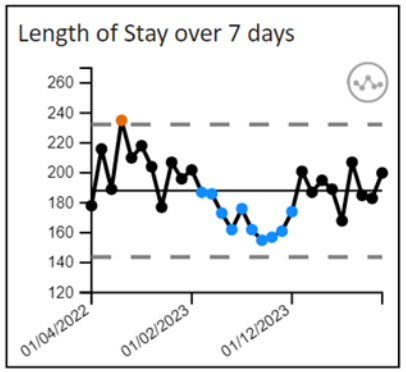
- Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
- Patient availability may impact on the ability to improve clinic utilisation, particularly short notice backfilled appointments.
- GP collective action and impact on referrals to specialities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

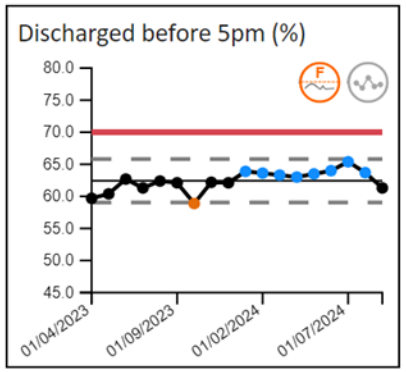
Subtheme: Inpatients

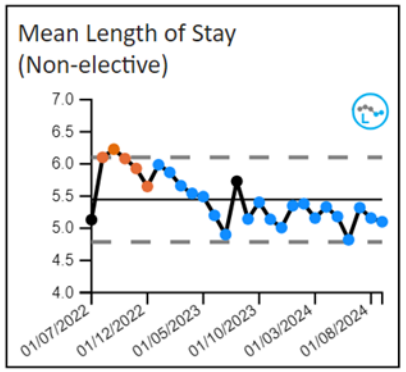
Data, Context and Explanation











- The % of elective inpatients was 88% against the Trust plan.
- Mean length of stay for **elective** patients is showing a continued downward trend. Focused work to decreasing length of stay on surgical wards is imperative to support the elective recovery programme.
- Mean length of stay for **Non-elective** patients has remained stable under 5.5 days over the last 12-18 months.
- Average Length of stay for any patient, over 7 days has remained static . Work continues to focus on getting patients to the right place and follow the home first approach.
- Patients discharged before 5pm was showing sustained improvement, although the current month has dipped. Work continues to focus on improving discharge rates earlier in the day. With a new discharge tracker implemented across the trust.

Metric	Value	Target	Exec Lead	Ops Lead
Inpatients (% of Plan)	88.0	100.0	Sally Kilgariff	Jodie Roberts
Length of Stay over 7 days	200	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	5.1	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	2.2	-	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	61.3	70.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increase daily numbers through the discharge lounge by 5 further patients.
- Ongoing LLOS reviews focusing on patients not known to IDT
- Focus on Internal delays to reduce non value adding activity
- Focus on LOS in surgical specialities
- Focus on patients waiting over 7 days to reduce LOS overall
- Opening of Community Ready Unit on Sundays through Winter to support earlier discharges
- Option to change transport times to support earlier discharges on a weekend

What is the expected impact?

- Increase number of patients discharged before 5pm to 70% by Q3 2024.
- Reduction of 7 day LOS patients by 10%
- Reduction in average LOS in elective patients
- Discharges earlier in the day supported by CRU opening on a Sunday and earlier transport

Potential risks to improvement?

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

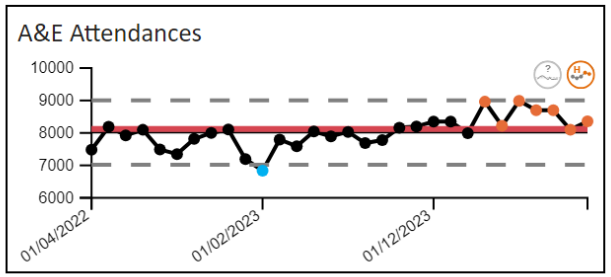
Activity

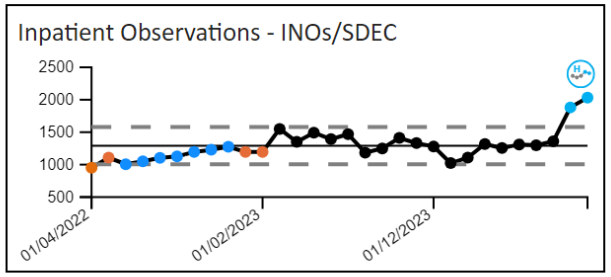
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances [Block]	8,124	8,359	Sep-24	☒	?	H	-	C
Inpatient Observations – INOs/SDEC [Block]	-	2,031	Sep-24	-	-	H	-	G
Non-Elective Inpatients [Block]	-	2,585	Sep-24	-	-	H	-	C
Outpatients Follow Up - Attendances [Block]	14,699	15,605	Sep-24	☒	?		-	S
Daycases [ERF]	1,999	2,012	Sep-24	☑	?		-	S
Inpatients - Electives [ERF]	352	309	Sep-24	☒	?		-	S
Outpatients New - Attendances [ERF]	6,049	6,254	Sep-24	☑	?		-	S
Outpatient Procedures - New and Follow Up [ERF]	4,767	4,486	Sep-24	☒	?		-	S
Referrals [Outpatient Demand]	-	8,082	Sep-24	-	-		-	S
2ww Referrals [Outpatient Demand]	-	1,073	Sep-24	-	-		-	S

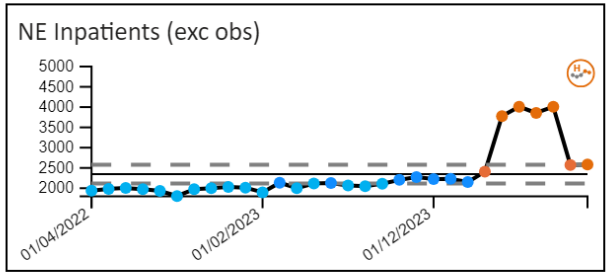
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

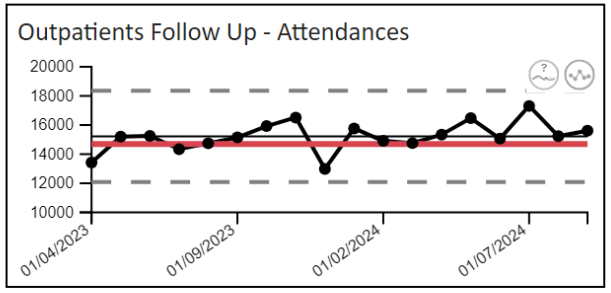
Subtheme: Block

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 admissions have seen a significant reduction in-month due to introduction of SDEC recording in the A&E data set
- Outpatient Follow-ups continue to significantly over perform both in-month (and year-to-date)
- The Trust has significant follow-up backlogs therefore over performance is expect to continue/increase whilst we look to clear these.

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances	8,359	8,124	Sally Kilgariff	Jodie Roberts
Inpatient Observations - INOs/SDEC	2,031	-	Sally Kilgariff	Jodie Roberts
NE Inpatients (exc obs)	2,585	-	Sally Kilgariff	Jodie Roberts
Outpatients Follow Up - Attendances	15,605	14,699	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Reconciliation of SDEC activity against Non-Elective under performance
- Review of un-coded A&E attendances
- Continue to monitor follow-up performance and benchmark new to follow-up ratios at specialty level
- Identify any areas of correlation between non-elective pressures and reduction in elective procedures (impacting ERF)

What is the expected impact?

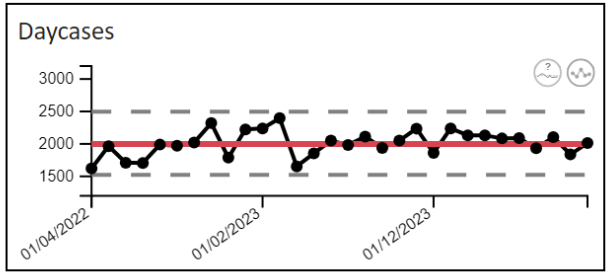
- Confirm SDEC/NEL activity is accurately being reflect in the data submission/contract monitoring. Fully understand the impact of EDS4.
- Ensure accurate record keeping for A&E attendances (should the contract mechanism change in the future this could potentially impact any re-basing)
- Identify areas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

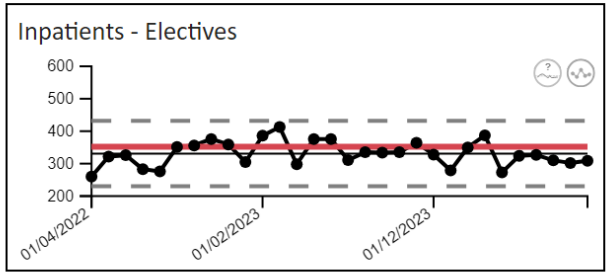
Potential risks to improvement?

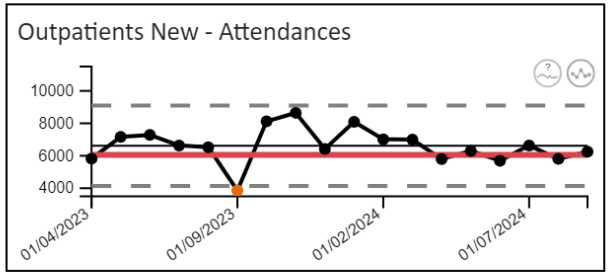
- Despite being on block, all key lines require scrutiny to ensure the Trust a) understands how this is impacting on financial performance b) we maintain an accurate position to safeguard changes to future contracting models
- Ongoing increasing non elective demand, which is unfunded due to block contract.

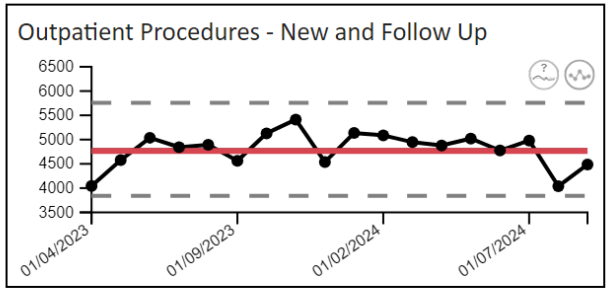
Subtheme: ERF

Data, Context and Explanation









•ERF contracted activity targets are based on 19/20 actuals + 3% (24/25 plans include the 3% increase)

•ERF lines operate on a cost and volume basis as per National Planning Guidance

•In-month Daycase activity is 13 above planned activity levels and casemix is significantly lower than planned levels

•In-month Elective activity is 42 below plan with income deteriorating from the August position

•Outpatient New Attendances are 205 above planned levels. The additional internal and insourced clinics are having a positive impact on the position

•Outpatient Procedures are 282 below plan. Work is continuing to address the Procedure recording/mapping issues.

•September Elective position has been impacted by reduced theatre sessions linked to workforce issues

•ERF Activity plans are aligned to NHSE planning assumptions to ensure consistency of reporting both internally and externally and are based on working days

•September saw a £400k deterioration on ERF and the cumulative year-to-date position continues to underperform

•Early indications show an increase in the number of theatre sessions delivered in October

Metric	Value	Target	Exec Lead	Ops Lead
Daycases	2,012	1,999	Sally Kilgariff	Jodie Roberts
Inpatients - Electives	309	352	Sally Kilgariff	Jodie Roberts
Outpatients New - Attendances	6,254	6,049	Sally Kilgariff	Jodie Roberts
Outpatient Procedures - New and Follow Up	4,486	4,767	Sally Kilgariff	Jodie Roberts

What actions are planned?

•Additional sessions to increase Elective, Day case and Outpatient first activity from September 2024
•Outsourcing of Hand & Wrist activity with further consideration for Hips & Knees
•Activity recording issues continue to be addressed and corrected
•Some issues with an external system data/coding mappings has been identified – this is being urgently addressed and is predominantly linked to Outpatient Procedures
•Analysis of Day Case activity by HRG

What is the expected impact?

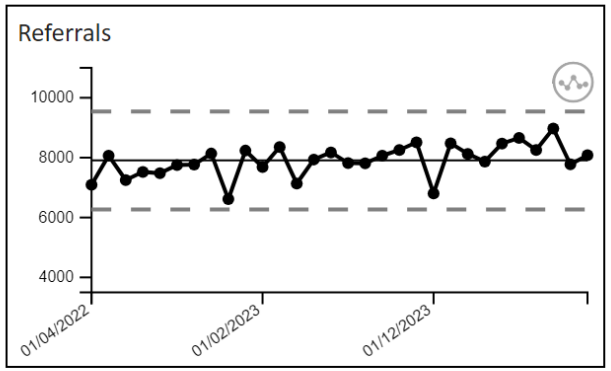
- Internal additional sessions and insourcing/outsourcing schemes will support delivery against the 24/25 ERF target and contribute to improving the income position.
- Correction of activity recording issues will ensure activity is correctly aligned and the appropriate income is received.

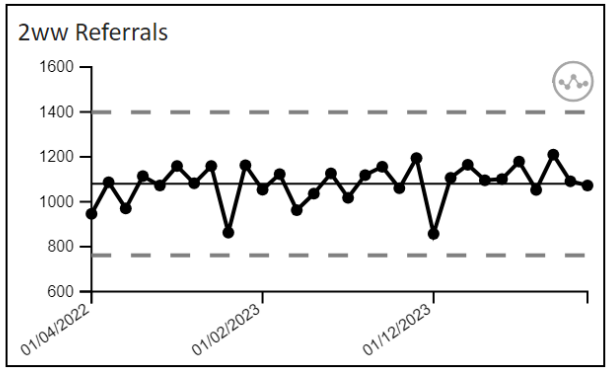
Potential risks to improvement?

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

Subtheme: OP Demand

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	Value	Target	Exec Lead	Ops Lead
Referrals	8,082	-	Sally Kilgariff	Jodie Roberts
2ww Referrals	1,073	-	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

What is the expected impact?

- Greater understanding of referral patterns internally
- Determine what discussions to have with Commissioners to identify potential solutions and work with Primary Care to ensure clinical referral protocols are being adhered to
- Agree approaches for Demand Management with Commissioners
- Communicate any new systems/processes

Potential risks to improvement?

- Analysis does not identify any inappropriate referrals (i.e. demand has genuinely increased)
- Lack of engagement from Commissioners/Primary Care

Finance

Apr 24 to Aug 24

Key Headlines	Month			YTD			Forecast Variance £000s	Prior Month Forecast variance £000s
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s		
I&E Performance (Actual)	3,531	2,972	(559)	(369)	(2,573)	(2,204)	(12,616)	(13,198)
I&E Performance (Control Total)	3,592	3,037	(555)	0	(2,180)	(2,180)	(12,591)	(13,176)
Efficiency Programme (CIP)	938	723	(215)	4,822	2,257	(2,565)	(5,657)	(5,895)
Capital Expenditure	912	865	47	4,124	2,996	1,128	0	0
Cash Balance	(2,975)	(3,444)	(469)	7,397	6,383	(1,014)	0	0

Performance Matrix Summary – People and Culture

The Rotherham NHS Foundation Trust

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

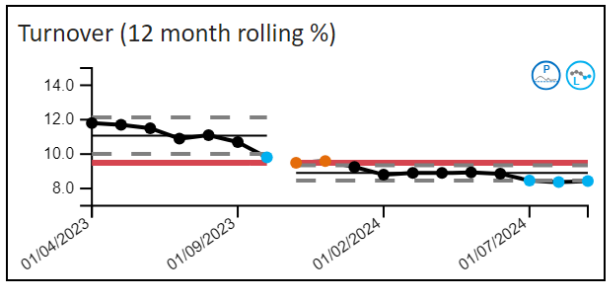
People and Culture

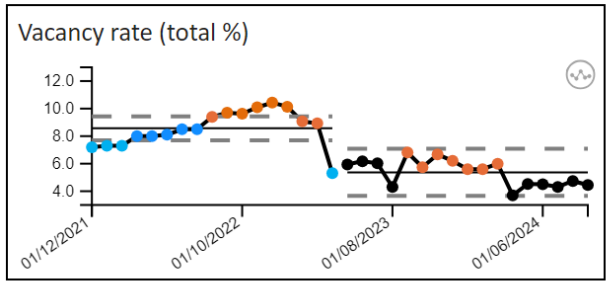
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	8.4	Sep-24	☑	P	L		VG
Vacancy Rate (total %)	-	4.5	Sep-24	-	-		-	S
Sickness Rates (12 month rolling %)	4.8	5.9	Sep-24	☒	F		-	C
Sickness Rates (%)	4.8	5.4	Sep-24	☒	F			C
Appraisal Rates (12 month rolling %)	90.0	76.9	Sep-24	☒	F		-	C
Appraisals Season Rates (%)	90.0	73.8	Sep-24	☒	F		-	C
MAST – Core (%)	85.0	90.8	Sep-24	☑	P	L	-	C
MAST – Job Specific (%)	85.0	88.5	Sep-24	☑	P		-	G

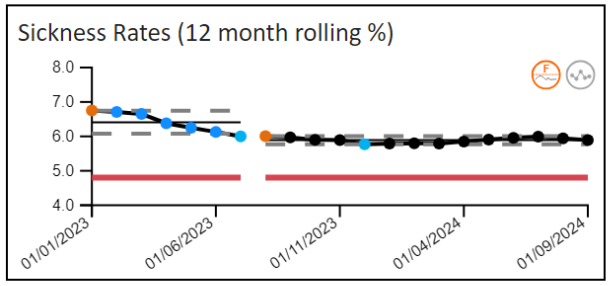
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

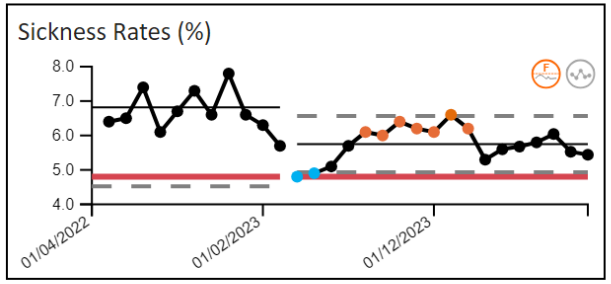
Subtheme: People

Data, Context and Explanation









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

Metric	Value	Target	Exec Lead	Ops Lead
Turnover (12 month rolling %)	8.4	9.5	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	4.5	-	Daniel Hartley	Paul Ferrie
Sickness Rates (12 month rolling %)	5.9	4.8	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	5.4	4.8	Daniel Hartley	Paul Ferrie

What actions are planned?

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

What is the expected impact?

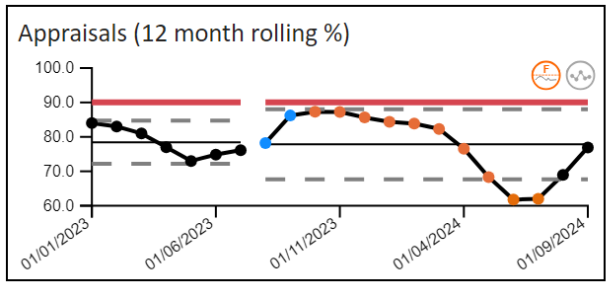
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

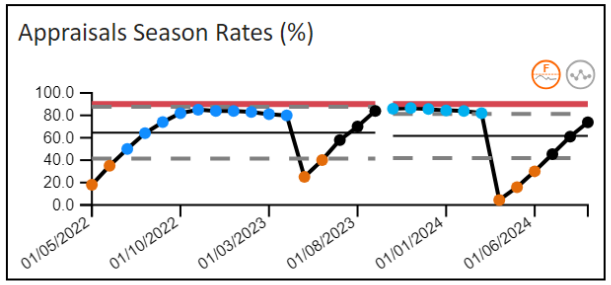
Potential risks to improvement?

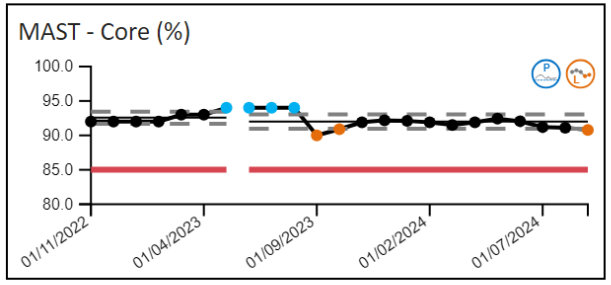
- Continued impact of ill-health of staff on attendance

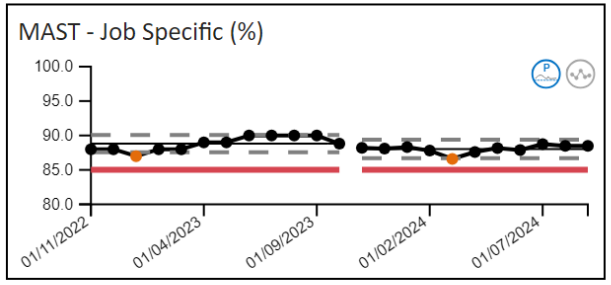
Subtheme: MAST & Appraisals

Data, Context and Explanation









- Rolling 12 month appraisal performance has begun to show an improvement as the appraisal season comes to a conclusion.
- New seasons appraisal completion rate performance is 73.8%, and is expected to improve further over the coming weeks as final appraisals are recorded onto ESR.
- This is a big focus for senior leaders and part of internal performance mechanisms.
- MAST performance is on track with more detailed breakdowns provided as part of operational management information for action where appropriate.

Metric	Value	Target	Exec Lead	Ops Lead
Appraisals (12 month rolling %)	76.9	90.0	Daniel Hartley	Paul Ferrie
Appraisals Season Rates (%)	73.8	90.0	Daniel Hartley	Paul Ferrie
MAST - Core (%)	90.8	85.0	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	88.5	85.0	Daniel Hartley	Paul Ferrie

What actions are planned?

- Focus on continued roll out and cascade of appraisals for this year using new suite of appraisal documentation which was improved based on feedback.
- Emphasis on senior leader accountability for Appraisal and MAST compliance

What is the expected impact?

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

Potential risks to improvement?

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

APPENDIX Assurance

Variation/Performance

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

APPENDIX: SPC Summary Icons Key

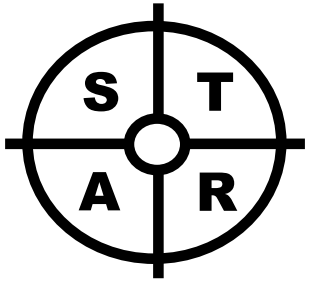
Assurance Icons

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

Variation Icons

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

Data Quality STAR Key



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

Metric Log

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

Metric Log

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

Metric Log

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

Metric Log

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

Metric Log

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

Metric Log

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

Metric Log

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

COUNCIL OF GOVERNORS MEETING: 20 November 2024

Agenda item: **COG/63/24**

Report: **Five Year Strategy, Six Month Review**

Presented by: **Dr Richard Jenkins, Chief Executive**
Author(s): **Michael Wright, Managing Director**

Action required: For assurance

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

As part of this development, it was agreed that a bi-annual update would be provided to the Trust Board on progress made in delivering these ambitions

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

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

'Our Journey to Excellence' does not replace but compliments and joins with the Trusts strategy.

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

Our New Journey, Together

Update to the Council of Governors: November 2024

1.0. Background

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

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

1.1. Our Journey to Excellence

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

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

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

2.0. Progress to Date

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

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

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

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

2.1. PATIENTS

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

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

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

2.2. ROTHERHAM

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

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

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

2.3. OUR PARTNERS

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

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

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

2.4. US

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

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

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

2.5. DELIVERY

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

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

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

Auditor's Annual Report

The Rotherham NHS Foundation Trust– year ended 31 March 2024

June 2024

Contents

01

Introduction

Introduction

Purpose of the Auditor's Annual Report

Our Auditor's Annual Report (AAR) summarises the work we have undertaken as the auditor for The Rotherham NHS Foundation Trust ('the Trust') for the year ended 31 March 2024. Although this report is addressed to the Trust, it is designed to be read by a wider audience including members of the public and other external stakeholders.

Our responsibilities are defined by the NHS Act 2006 and the Code of Audit Practice ('the Code') issued by the National Audit Office ('the NAO'). The remaining sections of the AAR outline how we have discharged these responsibilities and the findings from our work. These are summarised below.

Opinion on the financial statements
We issued our audit report on 25 June 2024. Our opinion on the financial statements was unqualified

Wider reporting responsibilities
In line with group audit instructions issued by the NAO, on 25 June 2024 we reported that the Trust's consolidation schedules were consistent with the audited financial statements, except for one matter.

Value for Money arrangements
We did not identify any significant weaknesses in the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources. Section 3 provides our commentary on the Trust's arrangements.

02

Audit of the financial statements

Audit of the financial statements

Our audit of the financial statements

Our audit was conducted in accordance with the requirements of the Code, and International Standards on Auditing (ISAs). The purpose of our audit is to provide reasonable assurance to users that the financial statements are free from material error. We do this by expressing an opinion on whether the statements are prepared, in all material respects, in line with the financial reporting framework applicable to the Trust and whether they give a true and fair view of the Trust's financial position as at 31 March 2024 and of its financial performance for the year then ended. Our audit report, issued on 25 June 2024 gave an unqualified opinion on the financial statements for the year ended 31 March 2024.

A summary of the significant risks we identified when undertaking our audit of the financial statements and the conclusions we reached on each of these is outlined in Appendix A. In this appendix we also outline the uncorrected misstatements we identified and any internal control recommendations we made.

Qualitative aspects of the Trust's accounting practices

We have reviewed the Trust's accounting policies and disclosures and concluded they comply with the Department of Health and Social Care Group Accounting Manual 2023/24, appropriately tailored to the Trust's circumstances

Draft accounts were received from the Trust on 24 April 2024 and were of a good quality.

Reporting responsibility	Outcome
Annual Report	We did not identify significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the Governance Statement had been prepared in line with Department of Health and Social Care (DHSC) requirements
Annual Governance Statement	We did not identify any matters where, in our opinion, the governance statement did not comply with the guidance issued by NHS Improvement.
Remuneration and Staff Report	We report that the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the National Health Service Act 2006.

03

Our work on Value for Money arrangements

VFM arrangements

Overall Summary

VFM arrangements – Overall summary

Approach to Value for Money arrangements work

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The NAO issues guidance to auditors that underpins the work we are required to carry out and sets out the reporting criteria that we are required to consider. The reporting criteria are:

Financial sustainability - How the Trust plans and manages its resources to ensure it can continue to deliver its services.

Governance - How the Trust ensures that it makes informed decisions and properly manages its risks.

Improving economy, efficiency and effectiveness - How the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

Our work is carried out in three main phases.

Phase 1 - Planning and risk assessment

At the planning stage of the audit, we undertake work so we can understand the arrangements that the Trust has in place under each of the reporting criteria; as part of this work we may identify risks of significant weaknesses in those arrangements.

We obtain our understanding or arrangements for each of the specified reporting criteria using a variety of information sources which may include:

- NAO guidance and supporting information
- Information from internal and external sources including regulators
- Knowledge from previous audits and other audit work undertaken in the year
- Interviews and discussions with staff and directors

Although we describe this work as planning work, we keep our understanding of arrangements under review and update our risk assessment throughout the audit to reflect emerging issues that may suggest there are further risks of significant weaknesses.

Phase 2 - Additional risk-based procedures and evaluation

Where we identify risks of significant weaknesses in arrangements, we design a programme of work to enable us to decide whether there are actual significant weaknesses in arrangements. We use our professional judgement and have regard to guidance issued by the NAO in determining the extent to which an identified weakness is significant.

We outline the risks that we have identified and the work we have done to address those risks on page 10.

Phase 3 - Reporting the outcomes of our work and our recommendations

We are required to provide a summary of the work we have undertaken and the judgments we have reached against each of the specified reporting criteria in this Auditor's Annual Report. We do this as part of our Commentary on VFM arrangements which we set out for each criteria later in this section.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust. We refer to two distinct types of recommendation through the remainder of this report:

- **Recommendations arising from significant weaknesses in arrangements -** We make these recommendations for improvement where we have identified a significant weakness in the Trust arrangements for securing economy, efficiency and effectiveness in its use of resources. Where such significant weaknesses in arrangements are identified, we report these (and our associated recommendations) at any point during the course of the audit.
- **Other recommendations -** We make other recommendations when we identify areas for potential improvement or weaknesses in arrangements which we do not consider to be significant but which still require action to be taken.

The table on the following page summarises the outcomes of our work against each reporting criteria, including whether we have identified any significant weaknesses in arrangements or made other recommendations.

VFM arrangements – Overall summary

Overall summary by reporting criteria

Reporting criteria	Commentary page reference	Identified risks of significant weakness?	Actual significant weaknesses identified?	Other recommendations made?
Financial sustainability	14 - 15	Yes – see risk 1 on page 12	No	Yes – see commentary on page 14
Governance	17 - 18	No	No	No
Improving economy, efficiency and effectiveness	20 - 21	No	No	No

VFM arrangements

Financial Sustainability

How the body plans and manages its resources to ensure it can continue to deliver its services

VFM arrangements – Financial Sustainability

Risks of significant weaknesses in arrangements in relation to Financial Sustainability

We have outlined below the risks of significant weaknesses in arrangements that we have identified as part of our continuous planning procedures, and the work undertaken to respond to each of those risks.

	Risk of significant weakness in arrangements	Work undertaken and the results of our work
1	**Financial sustainability – how the Trust plans to bridge its funding gaps and identify achievable savings** The Trust's financial plan at the start of the year was to achieve a deficit position of £6,726k. At 31 January 2024, the Trust reporting a forecast deficit position of £10,780k. The Trust's final outturn position was a deficit of £4,715k. The Trust has a Cost Improvement Target of £12,176k for the year. At 31 January 2024, the Trust had achieved £6,724k and forecast the outturn against the target is a £1,495k underachievement. The final outturn position was an underachievement of £1.2m. Of the forecast outturn against current year savings plans £7.5m is recurring. While the 2024/25 plan has not yet been set it is probable that this will include a similar level of CIP target. There is a risk to delivery of future financial targets if current year savings plans are not recurring in nature and fully delivered.	**Work undertaken** To establish if there is a significant weakness in arrangements we reviewed in year and year end financial monitoring reports for 2023/24, reviewing monitoring and delivery reports in respect of CIPs in 2023/24, reviewed the financial plans for 2024/25 and discussed arrangements for financial sustainability with management and the wider finance team. **Results of our work** Our work to address the risk has identified that the Trust has arrangements in place to identify plans to bridge fundings gaps and identify achievable savings. A review of financial and cost improvement monitoring reports in 2023/24 show consistency in the reporting of the financial position throughout the year. Arrangements that were in place in 2022/23 have continued. We have viewed examples of the work that the Delivery and Improvement Team are undertaking with divisions to assist divisions in identifying and achieving CIP plans. We have reviewed the minutes and agendas of the Efficiency Board in year which show that challenge and support continued through 2023/24 for divisional, procurement and cross cutting CIP schemes. The outturn position at the end of 2023/24 was £1.2m favourable against control total and an underachievement of £1.2m against the CIP target. The underachievement against CIP was due a delay in seeing the full benefits of a plans that were delayed, these savings have now been delivered against the 2024/25 target. The current plan submitted for 2024/25 includes a deficit plan as agreed with the ICB, and a CIP target of £13,937k. The Trust has plans in place to achieve this CIP target. Plans are at varying levels of progress with schemes currently progressing through the CIP governance process. £5.1m has already been achieved and £1m has been identified across services, the remaining savings will come from a range of cross cutting schemes.

VFM arrangements – Financial Sustainability

Risks of significant weaknesses in arrangements in relation to Financial Sustainability

.

Risk of significant weakness in arrangements	Work undertaken and the results of our work
	The Trust has begun a project aimed at bringing the Trust's financial position 'Back to Balance' over the next 2 years. The Back to Balance scheme has identified high level savings that can achieved through cross cutting plans. The plan includes both cost reducing and income generating initiatives with a planned overall savings of £11m across the next two years. The areas of work have been identified and an Executive Lead and SRO has been allocated to each theme. The Trust are continuing to use the CIP tracker to monitor service CIP plans and as the Back to Balance project develops further will also develop a reporting tool to monitor progress. Discussions with management have not identified any planned changes to the monitoring arrangements that are currently in place. Management are confident that the infrastructure is in place to allow the Trust to achieve its back to balance objective. **Conclusions** For 2023/24 we are satisfied that there is no significant weakness in arrangements to secure value for money. Further commentary is included on pages 14 to 15 on the Trust's arrangements in respect of financial sustainability

Value for Money

Overall commentary on the Financial Sustainability reporting criteria

Background to the NHS financing regime in 2023/24

In 2020/21 , NHSE established Integrated Care Systems (ICS) as the key unit for financial allocations. Moving into 2023/24, (ICSs) continued to be the key unit for financial planning purposes, with the aim of encouraging greater collaboration and collective responsibility for financial performance across local health care bodies.

The Covid-19 pandemic necessitated the implementation of interim 'block' funding allocations to ensure that systems had sufficient resource to respond to the pandemic. 2022/23 was the first full year where programme funding allocations were reset to move back towards a 'fair share' distribution of resource. The results of this exercise was used to adjust 2023/24 allocation baselines.
NHSE have updated Fair share allocations in line with the recommendation of the Independent Advisory Committee for resource allocation and policy updates. These allocations also include an updated approach, using a nationally consistent methodology to reflect the excess financing costs of historical private finance initiative (PFI) contracts on trusts. Historical PFI support payments were therefore wrapped up into system funding envelopes for 2022/23 onwards.

In 2023/24 to the majority of the Trust's income was earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare. The main mechanism for payment is Aligned Payment Incentive Contracts (API). API contracts included both a fixed and variable element. The fixed element included income for all services other than those covered by the variable element, fixed based on an agreed level of activity. The variable element included elective activity (both ordinary and day case), outpatient procedures, outpatient first attendances diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. Income is earned at NHSPS process prices on actual activity.

As under previous arrangements, systems were monitored on their combined financial outturn. This continued to necessitate further collaboration through the planning process, as individual organisations worked together to achieve system-level outcomes

The Trust's financial planning and monitoring arrangements

The Trust approved and submitted a financial plan for 2023/24 which included an overall deficit position of £5,977k. This plan was based on the Trust achieving Cost Improvement Plans (CIPs) of £12,176k. The outturn position for 2023/24 was a deficit of £4,715k, £1.2m favourable against plan, and a CIP delivery of £11,018k.

Through our review of Board, Finance and Performance Committee reports, meetings with Management, review of key documents and relevant work performed on the financial statements, we are satisfied that the Trust's arrangements for financial and CIP monitoring remain appropriate.

Monthly financial monitoring takes place at divisional level, at Finance and Performance Committee (FPC) and to Board. Monthly reporting to FPC and Board is through an Integrated Finance Report which includes explanations for variances against budget. The FPC take a deep dive into one division's performance each month, looking in detail at both its financial and non-financial performance, as well as progress against its CIP target.

Further oversight of CIPs is undertaken by an Efficiency Board (EB) who report to the Finance and Performance Committee. The EB meets on a monthly basis and reviews the CIP tracker, monitors progress in relation to Quality Impact Assessments (QIA's) completed for each identified opportunities, receives presentations from divisions in relation to performance and challenges attendees to identify additional opportunities for efficiencies to assist the Trust to achieve its CIP.

Additional support is provided to divisions by the Delivery and Improvement Teams, who work with divisions to help them to identify and deliver CIPs.

Reporting of financial performance and performance against CIPs in year has been consistent. The CIP tracker has been used to demonstrate progress against CIP plans which includes a risk assessment of the likelihood of achieving plans and includes a risk based forecast outturn, based on best case and worst case scenarios.

The Trust have arrangements in place for effective year end reporting. The statutory deadline for 2023/24 was met with the draft financial statements being provided to audit on 24 April, supported by good quality working papers. The Trust's finance team provided support to the audit team allowing the audit to be substantially complete by the end of May. As in previous years, we have not highlighted any significant concerns which adversely impact on this commentary in the main body of our Audit Completion Report.

Value for Money

The Trust's arrangements and approach to financial planning 2024/25

As was the case in 2023/24 the financial planning process of 2024/25 has been an iterative one. The initial financial plan submitted by the Trust included a planned deficit of £6,836k which was based on achieving efficiencies of £9,837k. Following work across the South Yorkshire Integrated Care Board (ICB) a revised plan was submitted in May reducing the Trust's planned deficit to £6,308k based on achieving efficiencies of £13,937k.

In 2024/25 the Trust has taken a slightly different approach to the identification of CIPs. The divisional level CIPs identified to date amount to £1m. CIPs have already been achieved in May of £5.3m. In addition, the Trust have developed a cross cutting CIP programme titled Back to Balance which is designed to bring the Trust back into financial balance over the next 2 years. Each of the areas within the Back to Balance Plan have an allocated Executive Lead and Senior Responsible Officer. As it is early in 2024/25 the detailed plans to support the Back to Balance project remain in progress.

The Efficiency Board (EB) and Delivery and Improvement Team are continuing to work with divisions to identify further opportunities for savings to be made and to support delivery of already identified CIPs.

Due to the Trust's forecast outturn position at the time of our VFM planning work and the probability that financial plans for 2024/25 would be based on a significant level of CIPs being required, we reported a risk of a significant weakness in arrangements for securing financial sustainability. The work we have completed to address this risk is set out on page x of this report. Our work has identified that the Trust have arrangements in place to identify plans to bridge savings gaps and achieve savings from. For 2023/24 we are satisfied that there is no significant weakness in arrangements to secure value for money That being said, consistent with our reporting in the previous year, and recognising the challenge associated with delivery of the challenging efficiency target, we have raised the following 'other recommendation':

Other recommendation		
1	The Trust have a CIP target in 2024/25 of £13,937k This will prove a significant challenge for the Trust and achievement of the overall financial plan is dependent on achieving the planned level of CIP. While the Trust has demonstrated over the past two years that it has arrangements I place to identify plans to bridge funding gaps and achieve savings plans, these will become increasingly difficult to achieve as opportunities to make savings reduce.	The Trust should ensure it continues its arrangements to identify how it will deliver unidentified efficiency savings included in the financial plan. It should also ensure that its scrutiny arrangements, to monitor and deliver its efficiency savings plans are maintained throughout 2024/25.

Based on the above considerations, we are satisfied that there is not a significant weakness in the Trust's arrangements in relation to financial sustainability.

VFM arrangements

Governance

How the body ensures that it makes informed decisions and properly manages its risks

VFM arrangements – Governance

Overall commentary on the Governance reporting criteria

The Trust's risk management and monitoring arrangements

The Trust's risk management system has remained in place during 2023/24. The Trust's approach to risk management is set out in the Risk Management Policy. The Trust has established its risk appetite, recognising that it is not possible to fully eliminate all risks. Risk are recorded in Trust wide, divisional and service level risk registers. An electronic risk register is used, Datix, which aides in the recording and monitoring of actions taken to address risks.
There is a Board Assurance Framework (BAF) in place which is incorporated into the Trust's risk management arrangements. The BAF provides a structure and process which enables the Board to review its principal objectives, the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. The BAF reflects the existing Trust Strategy. Risks within the BAF and Corporate Risk Register are allocated to each of the Board's assurance committees, these include:

- People Committee
- Finance and Performance Committee
- Quality Committee

The BAF and Corporate Risk Register are monitored on a monthly basis by each of the assurance committees, with each committee reviewing their aligned risks. There is quarterly reporting of the BAF and the Corporate Risk Register to the Audit and Risk Committee and the Board. Reporting on the Corporate Risk Register includes all risks with a score of 15+. We have reviewed minutes and reports presented on the BAF and Corporate Risk Register throughout the year. Through our review we have seen evidence of reporting on the BAF leading to the identification of controls and mitigation of risks. For example, the creation of the Quality Metrics Dashboard resulted in risk P1 moving from a risk score of 16 to 12.

The Trust carries out an annual review of its Committees, with each sub-committee completing an annual review of its effectiveness. The results of the reviews and any opportunities for improvement are reported to the Board.

The Trust have appointed Assurance 360 to provide internal audit and counter fraud services throughout the year. The Annual Internal Audit Plan is agreed in conjunction with management and subject to approval by the Audit and Risk Committee at the beginning of each financial year.

The plan is developed to provide assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud. The Annual Head of Internal Audit Opinion provides an assessed level of assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently. The Head of Internal Audit Opinion for 2023/24 provided significant assurance. Internal Audit report progress to each Audit and Risk Committee meeting. We have reviewed internal audits reports presented in year, the detailed reports issued in the year do not identify any significant weaknesses in the Trust's VFM arrangements.

The Trust's decision making and control framework
The Trust's governance structure is set out in its Annual Report and Annual Governance Statement. This is supported by a full suite of governance arrangements. We have reviewed these documents as part of our audit and confirmed they are consistent with our understanding of the Trust's arrangements. This includes arrangements such as:

- Maintenance of a register of interest;
- Completion of annual review and self-certification of compliance with conditions of NHS provider licence by the Board;
- Engagement of an internal audit function; and
- Use of risk management processes.

The Board of Directors meet on a monthly basis in order to discharge its duties effectively, including ensuring that systems and processes are maintained to measure the Trust's effectiveness, efficiency and economy as well as the quality of health care delivery. The Board of Directors has a balance of skills, independence and completeness appropriate for the requirements of the Trust, and a mix of Executive and Non-Executive Directors.

The Board has set up a number of Committees to aide in its discharge or responsibilities, these are detailed above with the addition of the Audit and Risk Committee. The terms of reference for these committees are reviewed on an annual basis. After each committee meeting the chair prepares a chair's log which is reported to the Board

VFM arrangements – Governance

We have attended all Audit and Risk Committee meetings in year and have reviewed the agendas, reports and minutes of the Board and each of the sub-committees. The meetings have focused on key elements of the relevant terms of reference.

The Trust have a number of policies and procedures in place which set clear expectations in terms of the standards that are required to be met and reporting of performance against these policies. There is a Standards of Business Conduct Policy in place and bi-annual reporting to the Audit and Risk Committee of any breaches. Reporting at the end of 2023/24 focussed on the rate of completion of annual declarations of interest with a 61% compliance rate for 2023/24, this is an improvement on the position at the end of 2022/23 and evidence of arrangements for follow up having a positive impact.

Based on the above considerations, we are satisfied there is not a significant weakness in the Trust's arrangements in relation to governance.

VFM arrangements

Improving Economy, Efficiency and Effectiveness

How the body uses information about its costs and performance to improve the way it manages and delivers its services

VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on the Improving Economy, Efficiency and Effectiveness reporting criteria

Trust's arrangements for assessing performance and evaluating service delivery

The Trust assesses performance on a financial and non-financial basis. Reporting to the Board is via a monthly the Integrated Performance Report and Integrated Finance Report. The sub committees of the Board monitor performance against the metrics relevant to the Committees terms of reference, this monitoring is on a more detailed level. Monitoring is primarily undertaken by the Finance and Performance Committee (FPC) and Quality Committee (QC). The Board receive a monthly Integrated Performance Report and Integrated Finance Report.

The Quality Committee are responsible for ensuring the highest standard of care is provided to patients, and that the Trust continually improves the standard of care delivered. The Quality Committee receive a monthly Integrated Performance Report focussing on the quality performance metrics. We have reviewed of the agendas, reports and minutes of the meetings held in year and seen appropriate challenge of performance taking place. As part of their role the Quality Committee are responsible for the review of the Quality Accounts, which reports externally on performance in year.

The Finance and Performance Committee is responsible for monitoring operational and financial performance and considers both financial and non-financial performance. Each month the Committee takes a deep dive into the performance of a division as well as receiving Trust wide performance reports. The Committee has standing item every month covering Divisional Performance Escalations, where these are required. The Committee also receive reports from the Efficiency Board who have specific responsibilities in relation to CIPs.

The Integrated Performance Report (IPR) provides a monthly summary of Trust Performance across the four domains of Operational Delivery, Quality, Finance and Workforce. It highlights performance against agreed national, local or benchmarked targets. Statistical Process Control charts are included against key metrics. The report includes sufficient information to understand performance trends and highlight potential issues. Our review of the Board minutes also demonstrates sufficient challenge from non-executive directors on the Trust's costs, performance and service delivery.

The Audit and Risk Committee reviews the Annual Report and Accounts, and the Annual Governance Statement before adoption by the Board. The Annual Report sets out the Trust's performance against key indicators, and how it evaluates and assesses performance and any identified improvement opportunities.

Care Quality Commission Inspections

The Care Quality Commission (CQC) independently assess the quality of patient care provided by the Trust. The last full inspection the Trust was undertaken in May and June 2021 and reported in September 2021. As a result of this inspection the CQC placed conditions of registration on the Trust. These conditions were successfully lifted on 9 May 2022.

Following the CQC inspection the Trust developed a Quality Improvement Plan to address each of the actions raised in the inspection. Monitoring of progress against these actions is undertaken by the Quality Delivery Group and the Quality Committee. We have reviewed the Quarterly Quality Assurance Reports received by the Quality Committee. The level of actions self-assessed as being delivered and embedded has increased from 51% at the beginning of the year to 93% at the end of Q4. The remaining 7% are completed but not yet fully embedded.

The Trust have completed self-assessments over the year covering 22 different areas and services including Outpatients, Community, Children's, Maternity, Critical Care, Therapies, Dietetics and Cardiology. This has included assessment against a range of area specific criteria and awarding of a rating of outstanding, good, requires improvement and inadequate. A total of 779 criteria have been assessed. Of the 779 areas, 651 are good or outstanding, 127 are requiring improvement, and only 1 area was assessed as inadequate. The inadequate score is in relation to the waiting time to access children's therapy services in the community. The Trust has developed an action plan to address this with local partners. While the Trust recognises these are self-assessments, and so cannot be taken as the definitive position, they do form a useful measure to drive the focus of attention.

As part of the Trust's response to the actions identified by the CQC, quality dashboards have been developed to assess performance and quality. This is in the process of being further develop into an internal accreditation system, which will directly link the performance of the division to the domains used by the CQC in their assessment

The Quarterly Quality Assurance Reports detailed above are also received by the Board.

VFM arrangements – Improving Economy, Efficiency and Effectiveness

Partnerships

The Trust is an active member of the South Yorkshire Integrated Care System (SY ICS) and Rotherham Place. Both are supported by the Trust's Executives and other colleagues as required through attendance at weekly/monthly meetings. The Board also reviews ICS and ICP reports on a regular basis, which cover any national updates, as well as developments across SY ICB and Rotherham Place.

The Trust has worked with the SY ICS to submit the 2024/24 financial plan, which required the trust to work collaboratively with ICS partners to ensure financial plans can be delivered within the system-wide allocated funding.

Rotherham is a member of a joint working agreement with a number of Trusts, referred to as the Acute Federation, formerly the Working Together Partnership. In March 2024 the Trust undertook a review of committees in common with other members of the Acute Federation, with the view that each partner should establish a Committee in Common. The Trusts involved are Barnsley Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Sheffield Childrens NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, and The Rotherham NHS Foundation Trust. The aims of this partnership are to work together to drive the quality of care , take proactive approaches to reduce health inequalities, collaboratively develop colleagues and teams, be great partners to the rest of the health and care system in SYB, support each other to achieve NHS waiting time standards, and seek innovative ways to more effectively use the NHS pound.

Procurement

The Trust has a Procurement Policy in place which requires all procurement to be undertaken in line with the Public Contracts Regulations 2015.
The Trust employs an internal professionally qualified procurement team who manage procurement activity across the whole organisation. The procurement team manage a tendering and contract management portal to identify contract renewals and advertise new opportunities. The Contracts Manager undertakes performance management on key contracts to ensure they deliver the benefits identified.
Regular reports are made to Audit and Risk Committee on any tender waivers and / or any breaches in financial regulations.

Based on the above considerations, we are satisfied there is not a significant weakness in the Trust's arrangements in relation to the improving economy, efficiency and effectiveness.

VFM arrangements

Other recommendations made in the prior year

Value for Money

Progress against other recommendations made in the prior year

In 2022/23 we reported one 'other recommendation' to the Trust. As part of our work in 2023/24 we followed up the progress made by the Trust against the recommendation made, our conclusions are shown in the table below.

Previously identified other recommendation		Reporting criteria	Our views on the actions taken	Overall conclusions
1	As at the end of June 2023, £6,427k of efficiency savings have been identified against a target of £12,176k. While the Trust is making progress towards its efficiency target and expects to deliver against the target, delivery is challenging and could be a potential risk to the planned financial position for 2023/24. The Trust should ensure it continues its arrangements to identify how it will deliver unidentified efficiency savings included in the financial plan. It should also ensure that its scrutiny arrangements, to monitor and deliver its efficiency savings plans are maintained throughout 2023/24	Financial sustainability	We have seen evidence via minutes and reports of the Efficiency Board, Finance and Performance Committee, and Trust Board of the monitoring and control arrangements operating throughout 2023/24. The Trust achieved CIPs of £11,080k against the target of £12,176k, an achievement of 91%. Overall, the Trust over performed against its control total by £1.2m. CIP plans were identified to meet the CIP target, delays in plans fully implemented resulted in the slight under performance. The outturn position is consistent with the forecast outturn reported in year, which further evidences monitoring arrangements have operated in year.	While this weakness in arrangements did not materialise in 2023/24 a similar other recommendation has been raised in 2024/25 recognising the challenge associated with delivery of the challenging efficiency target.

04

Other reporting responsibilities and our fees

Other reporting responsibilities and our fees

Other reporting responsibilities

Public interest reports

Auditors have the power to make a report if they consider a matter is sufficiently important to be brought to the audited body or the public as a matter of urgency, including matters which may already be known to the public, but where it is in the public interest for the auditor to publish their independent view.

We did not make a report in the public interest during 2023/24.

Schedule 10 referrals

Under Schedule 10 of the NHS Act 2006, auditors of a Foundation Trust have a duty to consider whether there are any issues arising during their work that indicate possible or actual unlawful expenditure or action leading to a possible or actual loss or deficiency that should be reported to the relevant NHS regulatory body.

We have not reported any such matters.

Reporting to the National Audit Office (NAO)

The NAO, as group auditor, requires us to report to them whether consolidation data that the Trust has submitted is consistent with the audited financial statements. The NAO also included the Trust in its sample of component bodies for the purpose of its audit of the DHSC group.

We reported to the NAO that there is one difference between consolidation data and the audited financial statements. The difference is in relation to the reporting of staff costs. The Trust have included details of the reason for the difference in their Certificate on Consolidation. We also reported to the NAO in line with its group audit instructions.

Fees for our work as the Trust's auditor

We reported our proposed fees for the delivery of our work under the Code of Audit Practice in our Audit Strategy Memorandum presented to the Audit and Risk Committee in 26 January 2024. Having completed our work for the 2023/24 financial year, we can confirm that our fees are as follows:

Area of work	2023/24 fees	2022/23 fees
Planned fee in respect of our work under the Code of Audit Practice	£115,000	£90,000
Additional fees in respect of additional work required to comply with revised ISA 315	-	£3,000
Additional fees in respect of implementation of IFRS 16	-	£3,000
Total fees	**£115,000**	**£96,000**

Fees for other work

We confirm that we have not undertaken any non-audit services for the Trust in the year.

Appendices

A: Further information on our audit of the financial statements

Appendix A: Further information on our audit of the financial statements

Significant risks and audit findings

As part of our audit, we identified significant risks to our audit opinion during our risk assessment. The table below summarises these risks, how we responded and our findings.

Risk	Our audit response and findings
Management override of controls This is a mandatory significant risk on all audits due to the unpredictable way in which such override could occur. Management at various levels within an organisation are in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Due to the unpredictable way in which such override could occur there is a risk of material misstatement due to fraud on all audits.	We addressed this risk through performing audit work over: • Accounting estimates impacting amounts included in the financial statements; • Consideration of identified significant transactions outside the normal course of business; and • Journals recorded in the general ledger and other adjustments made in preparation of the financial statements Our work has not identified any matters to report in respect of the management override risk.
Risk of fraud in revenue and expenditure recognition The risk of fraud in revenue and expenditure recognition is presumed to be a significant risk on all audits due to the potential to inappropriately shift the timing and basis of revenue and expenditure recognition as well as the potential to record fictitious revenues/expenditure or fail to record actual revenues/expenditure. For the Trust we deem the risk to relate specifically to: • Revenue cut off – recognition of income around the year end • Expenditure cut off – recognition of year end accruals	We have evaluated the design and implementation of any controls the Trust has in place which mitigate the risk of income being recognised in the wrong year. In addition, we have undertaken a range of substantive procedures including: • testing income, expenditure, receipts and payments in the pre and post year end period to ensure they have been recognised in the right year; • testing year end accruals to evaluate the data on which they have been based and ensure that the estimated accrual is reasonable; and • reviewing intra-NHS reconciliations and data matches provided by the Department of Health and Social Care. Our work has not identified any matters to bring to your attention.

Appendix A: Further information on our audit of the financial statements

Significant risks and audit findings

As part of our audit, we identified significant risks to our audit opinion during our risk assessment. The table below summarises these risks, how we responded and our findings.

Risk	Our audit response and findings
Valuation of land and buildings Land and buildings are the Trust's highest value asset accounting for £127.4m of the Trust's £184.5m property, plant and equipment balance. Management engages an external valuer as an expert to assist in determining the fair value of land and buildings to be included in the financial statements. Changes in the value of property may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Group Accounting Manual.	We evaluated the design and implementation of any controls which mitigate the risk. This included liaising with management to update our understanding of the approach taken by the Trust in its valuation of land and buildings. We: • assessed the scope and terms of engagement of management's valuation expert and the competence, skills and objectivity thereof; • reviewed the work of management's valuation expert and how these have been incorporated into the financial statements; • reviewed the valuation methodology used, including testing the underlying data and assumptions; and • considered the reasonableness of the valuation by comparing the valuation output with market intelligence and challenging the Trust and the valuer. A full valuation has not been completed in year, instead a revaluation was completed of the special care baby unit following completion of the programme of capital programme. For the remaining site the Trust applied indices to identify whether there was evidence of a material movement in asset values in year. The conclusion was that asset values had not moved materially. Our work in this area has not identified any matters to bring to your attention.
IFRS 16 implementation for PFI liabilities IFRS 16 is applicable for PFI liabilities from 1 April 2023 and is designed to report information that better shows PFI liability transactions and provides a better basis for users of financial statements to assess the amount, timing and uncertainty of cash flows arising from such agreements. For the Trust this requires the Carbon Energy Fund liability to be restated in line with the requirements of IFRS 16.	We have reviewed the accounting treatment and the approach taken by the Trust, to recognise the transition adjustments required under IFRS 16 for the Carbon Energy Fund. Our work has not identified any matters to report in respect of the IFRS 16 implementation for PFI liabilities.

Appendix A: Further information on our audit of the financial statements

Enhanced risks and audit findings

As part of our audit, we identified significant risks to our audit opinion during our risk assessment. The table below summarises these risks, how we responded and our findings.

Risk	Our audit response and findings
IFRS 16 implementation for PFI liabilities IFRS 16 is applicable for PFI liabilities from 1 April 2023 and is designed to report information that better shows PFI liability transactions and provides a better basis for users of financial statements to assess the amount, timing and uncertainty of cash flows arising from such agreements. For the Trust this requires the Carbon Energy Fund liability to be restated in line with the requirements of IFRS 16.	We have reviewed the accounting treatment and the approach taken by the Trust, to recognise the transition adjustments required under IFRS 16 for the Carbon Energy Fund. Our work has not identified any matters to report in respect of the IFRS 16 implementation for PFI liabilities.
PPE additions There is a risk that revenue expenditure is incorrectly classified as capital expenditure, understating the revenue expenditure charged in the year and that asset addition are included before recognition criteria have not been met.	We tested a sample of PPE additions in year and ensured that they were correctly classified as capital and that the asset recognition criteria has been met. An asset in our sample has not been received at the year end. Management had judged the asset to be covered by a vesting certificate. The vesting certificate required receipt of payment by the supplier for the asset to be vested in the Trust, this payment was made to the supplier on 3 April 2024. Therefore, the terms of the vesting certificate had not been met at the year end. Management have opted not to adjust the financial statements because the actual error is not material. The asset's value is £270k. In order for us to determine that there is no risk of material misstatement arising from the error we have calculated the extrapolated error over the remaining untested population. The projected misstatement over the untested population is 463k, therefore the total actual and projected misstatement is £733k. This remains below materiality. This is recorded as an unadjusted misstatement to the financial statements on page 30 of this report.

Appendix A: Further information on our audit of the financial statements

Summary of uncorrected misstatements

We set out below and on the following pages a summary of the misstatements we identified during our audit, above the trivial threshold for adjustment of £222k.

This section sets out the misstatements we identified which management has assessed as not being material, individually or in aggregate, to the financial statements and does not plan to adjust.

Our overall materiality, performance materiality, and clearly trivial (reporting) threshold were reported in our Audit Summary Memorandum, issued on 26 January 2024.

Unadjusted misstatements

Management has assessed the misstatements in the table below as not being material, individually or in aggregate, to the financial statements and does not plan to adjust. We only report to you unadjusted misstatements that are either material by nature or which exceed our reporting threshold.

Details of adjustment	SOCNE/SOCI		SOFP	
	Dr (£ '000)	Cr (£ '000)	Dr (£ '000)	Cr (£ '000)
Dr: Trade and other payables Cr: Property, plant and equipment Being the extrapolated error arising from an asset recognised in 2023/24 which had not been received. The actual error identified was £270k.			733	733
Dr: Trade and other payables Cr Operating expenses Being the extrapolated error arising from an accrual recognised in 2023/24 that should not have been recognised. The actual error was 15k.		309	309	
Aggregate effect of unadjusted misstatements	**0**	**309**	**1,042**	**733**

We will obtain written representations confirming that, after considering the unadjusted misstatements, both individually and in aggregate, in the context of the financial statements taken as a whole, no adjustments are required.

Appendix A: Further information on our audit of the financial statements

Unadjusted disclosure misstatements

We identified the following disclosure misstatements during our audit that have not been corrected by management:

- **Adjusted financial performance (control total basis)** – In the financial statements the adjusted financial performance has been disclosed on the face of the Statement of Comprehensive Income (SOCI), this is not in line with the requirements of IAS 1 Presentation of financial statements. The disclosure should instead be recorded in a standalone disclosure note. Management have opted not to adjust this misstatement on the basis that the Trust are monitored against the control total rather than total comprehensive income/expense in the SOCI, therefore including the information on the face of the SOCI improves readability for the users of the financial statements.
- **Note 1.3.2 Sources of Estimation Uncertainty** – This disclosure should include details of estimates in the financial statements that have a significant risk of resulting in a material adjustment to the carrying value of assets and liability. The disclosure includes estimates that are unlikely to result in a material adjustment to assets and balances. We have raised an internal control recommendation on page 33 of this report, recommending that the Trust review the disclosure when preparing the 2024/25 financial statements.

We will obtain written representations confirming that, after considering the unadjusted disclosure misstatements, both individually and in aggregate, in the context of the annual report and financial statements taken as a whole, the effect of the unadjusted misstatements are immaterial.

Appendix A: Further information on our audit of the financial statements

Internal control observations

Other deficiencies in internal control

In our view, there is a need to address the deficiencies in internal control set out in this section (which are not deemed to be significant deficiencies) to strengthen internal control or enhance business efficiency. Our recommendations should be actioned by management in the near future.

Description of deficiency

Our work on fixed asset disposals identified assets recorded as disposals in 2023/24 which had been disposed of in previous years. The assets were identified by management as part of a cleansing exercise performed on the fixed asset register.

Potential effects

There is a risk that the Trust overstates its asset position by not removing asset disposals on a timely basis.

Recommendation

Management should implement an annual review of the asset register to ensure that asset disposals are identified and processed at least annually.

Management response

Agreed – this was identified in 2023/24 as part of implementing an annual review, which we will continue to do every year going forward.

Appendix A: Further information on our audit of the financial statements

Internal control observations continued

Other recommendations – Disclosure amendments

We have identified two recommendations in respect of disclosures in the financial statements:

Description of disclosure amendment

Note 1.3.2 Sources of Estimation Uncertainty should include details of estimates in the financial statements that have a significant risk of resulting in a material adjustment to the carrying value of assets and liability. The current disclosure includes estimates that are unlikely to result in a material adjustment to assets and balances.

Potential effects

There is a risk the financial statements do not comply with accounting standards. The level of uncertainty in the financial statements is overstated by including in this disclosure items of account which do not include significant sources of estimation uncertainty.

Recommendation

The sources of estimation uncertainty disclosure be reviewed for the 2024/25 financial statements.

Management response

Agreed – will review for 2024/25 financial statements

Appendix A: Further information on our audit of the financial statements

Internal control observations continued

Other recommendations – Disclosure amendments continued

Description of disclosure amendment

The financial statements include a number of disclosure notes that are immaterial.

Potential effects

Readability of the accounts is diminished due to the level of unrequired disclosures.

Recommendation

The disclosure notes in the financial statements be reviewed for the 2024/25 financial statements.

Management response

Agreed – will review for 2024/25 financial statements

Appendix A: Further information on our audit of the financial statements

Follow up on previous years recommendations

We set out below an update on internal control points raised in the prior year.

Description of deficiency

The revaluation balance per the fixed asset module in the ledger does not agree to the revaluation reserve balance in the general ledger. The fixed asset module includes a revaluation reserve balance of £63,591k, whereas the general ledger includes a balance of £60,774k.

In addition, the revaluation reserve balances in the fixed asset module include negative revaluations to a value of £4,780k across 26 assets.

Potential effects

There is a risk that the general ledger does not accurately reflect the fixed asset position of the Trust which could result in the financial statements being materially misstated. In addition to this, there is a risk that the revaluation reserve balances are inaccurate which could lead to incorrect accounting treatment of valuation movements.

Recommendation

The Trust review the fixed asset module and update the entries to correctly reflect the revaluation reserve balances for the Trust's fixed assets.

2023/24 update

Management have worked with IT to review the parameters in the fixed asset register which has reduced the difference to £426k as at 31 March 2024. This work has also reduced the level of negative revaluation balances to £6k across 5 assets.

Management continue to work with IT to correct the remaining balances.

Appendix A: Further information on our audit of the financial statements

Description of deficiency

Right of use assets where the lease does not include review of the rental charge in line with market conditions have been subsequently valued using the cost model. Where there is no rent review in line with market conditions, it is not appropriate to use the cost model for subsequent revaluation of these assets. They should instead be valued using the revaluation model.

Potential effects

Right of use assets could be materially misstated.

Recommendation

The Trust reconsider its approach of the subsequent revaluation of right of use assets where the lease does not include a rent review in line with market conditions.

2023/24 update

The Trust has reviewed its approach to the revaluation of right of use assets, and has revalued a number of assets in year

Description of deficiency

Testing of the bank reconciliation identified unpresented cheques to the value of £1,111 that are in excess of 6 months old.

Potential effects

There is a risk that old unreconciled transactions are not written off on a timely basis.

Recommendation

The list of unpresented cheques be reviewed to ensure that cheques over 6 months old are written off and cancelled.

2023/24 update

Our review of the bank reconciliation has not identified unpresented cheques over 6 months old.

Appendix A: Further information on our audit of the financial statements

Description of deficiency

Our work on related parties identified instances of omitted declarations where there were interests held by a non-voting member of the Board.

Potential effects

There is a risk of the Trust entering into a transaction with a related party without knowledge.

Recommendation

An independent check be introduced to identify potential omitted declarations.

2023/24 update

We compared Board members disclosures against information held on Companies House. This identified one Board member has not declared interests held. The Trust did not have any transactions with these bodies. There is no impact on the accounts.

Contact

Forvis Mazars

Daniel Watson
Director – Public and Social Sector
Tel: 07909 985324
daniel.watson@mazars.co.uk

Calendar of Business for Council of Governors 2025

REPORT - ORDER		2025			
		Feb	May	Sep	Nov
		12	21	03	19
Procedural items					
Welcome and announcements	Chair	/	/	/	/
Apologies and quoracy check	Chair	/	/	/	/
Declaration of Interest	Chair	/	/	/	/
Minutes of the previous meeting	Chair	/	/	/	/
Matters arising and action log	Chair	/	/	/	/
Chairman's report	Chair	/	/	/	/
Report from the Non-Executive Chairs of Board Committees					
Report from Audit & Risk Committee	NED Chair	/	/	/	/
Report from Finance and Performance Committee (inc. Finance Report)	NED Chair	/	/	/	/
Report from Quality Committee	NED Chair	/	/	/	/
Report from People & Culture Committee	NED Chair	/	/	/	/
Report from Charitable Funds Committee	CFC Chair	/	/	/	/
Integrated Performance Report (for information)	Man. Dir.	/	/	/	/
Progress Report (for information)	Man. Dir.	/	/	/	/
Partnership Working	Man. Dir.			/	
Organisational Priorities 2024/25	CEO		/		
Five Year Strategy Update (every 6 months)	CEO		/		/
Quality Priorities	CN	/			
Quality Account	CN		/		
Annual Report (through Annual Members Meeting)	DoCA			/	
Annual Accounts (through Annual Members Meeting)	DoF			/	
Financial Plan	DoF				/
Governor Regulatory and Statutory Requirements					
Governance Report	DoCA	/	/	/	/
Constitution – formal review Last review February 2023	DoCA				/
Constitution – Partner Governors	DoCA				/
Governors Standing Orders (linked to Constitution review) To be reviewed every 3 years as a minimum or in conjunction with any changes to Constitution. Last review October 2018	DoCA				/
Appointment of Vice Chair (as needed)	DoCA			/	
Appointment of Senior Independent Director (as needed)	DoCA			/	
Appointment / Reappointment of NED's (as needed)	NomComm				
Appointment/Reappointment of Chair (as needed)	NomComm				
Outcome of Chair and NED Appraisals	NomComm			/	
External Auditors (contract renewal) Contract with Mazars LLP effective from 2024 for 3 years	DoCA				

Key:

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

Calendar of Business for Council of Governors 2025

External Auditors Engagement report to CoG following closure of annual audit	DoCA				/
Lead Governor Appointment (Annual)	DoCA		/		
Deputy Lead Governor Appointment	DoCA		/		
Governor Elections (part of Governance Report or Member Engagement Group Report)	DoCA	/	/	/	/
Council of Governors Annual Review of Effectiveness	DoCA				/
Governor Engagement Strategy (current Strategy 2021-2023)	DoCA				
Member Engagement Strategy (current Strategy 2022 -2025)	DoCA				
Sub Groups of the Council of Governors					
Member Engagement Group Report/Chairs Log	Group Chair	/	/	/	/
Member Engagement Group Terms of Reference	Group Chair				/
Governors Nominations Committee Terms of Reference	Chair			/	
Audit & Risk Committee Terms of Reference Annual Review	Chair				/

Key:

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

Calendar of Business for Council of Governors 2025

CONFIDENTIAL

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