The Rotherham NHS Foundation Trust

Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 5 September 2025, 9:00 AM — 12:00 PM BST
Venue	Boardroom, Level D
Organiser	Alan Wolfe

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P124/25.	Chairman's welcome and apologies for absence For Information - Presented by Dr Mike Richmond
	P125/25.	Quoracy Check For Assurance - Presented by Dr Mike Richmond
	P126/25.	Declaration of interest For Assurance - Presented by Dr Mike Richmond
	P127/25.	Minutes of the previous meeting held on 04 July 2025 For Approval - Presented by Dr Mike Richmond
	P128/25.	Matters arising from the previous minutes (not covered elsewhere in the agenda) For Assurance - Presented by Dr Mike Richmond
	P129/25.	Action Log For Decision - Presented by Dr Mike Richmond
9:10 AM	OVERVIEW AND CONTEXT	

	P130/25.	Board Committee Chair's Reports i. Quality Committee - Julia Burrows ii. Finance and Performance Committee - Martin Temple iii. Audit & Risk Committee - Kamran Malik For Assurance
	P131/25.	Board Assurance Framework For Decision - Presented by Peter Walsh
	P132/25.	Corporate Risk Register For Assurance - Presented by Peter Walsh
	P133/25.	Report from the Chairman (verbal) For Information - Presented by Dr Mike Richmond
	P134/25.	Report from the Chief Executive For Information - Presented by Dr Richard Jenkins
	P135/25.	Endoscopic Retrograde Cholangio-Pancreatography (ERCP) Update For Information - Presented by Jo Beahan
	P136/25.	YN Independent Patient Safety Investigation For Information - Presented by Jo Beahan
9:40 AM	CULTURE	
	P137/25.	Staff Story - Mobile X-Ray and Imaging presented by Katie Martin and Kelly Whittington For Information - Presented by Daniel Hartley
	P138/25.	Skills Street Update For Noting - Presented by Daniel Hartley
10:10 AM	STRATEGY AND PLANNING	

	P139/25.	Teaching Trust Status including Research and Development Report For Decision - Presented by Jo Beahan
	P140/25.	Bed Reconfiguration - Medical Bed Base at The Rotherham NHS Foundation Trust For Decision - Presented by Sally Kilgariff
	P141/25.	Green Plan 2025 - 2028 For Decision - Presented by Scott Dickinson
10:40 AM	SYSTEM WORKING	
	P142/25.	National, Integrated Care Board and Rotherham Place Update For Information - Presented by Bob Kirton
10:45 AM	BREAK	
10:55 AM	PERFORMANCE	
	P143/25.	Integrated Performance Report For Assurance - Presented by Bob Kirton
	P144/25.	Finance Report For Assurance - Presented by Chris Thickett
11:15 AM	REGULATORY AND STATUTORY REPORTING	
	P145/25.	Responsible Officer Statement of Compliance with Medical Appraisal and Revalidation - Annual Report For Assurance - Presented by Jo Beahan

	P146/25.	Emergency Preparedness Resilience & Response (EPRR) Annual Report For Assurance - Presented by Sally Kilgariff
	P147/25.	Maternity and Neonatal Safety Report Presented by Sarah Petty For Assurance
11:40 AM	ASSURANCE FRAMEWORK	
	P148/25.	Senior Information Risk Owner (SIRO) Annual Information Governance Report For Noting - Presented by Bob Kirton
	P149/25.	Safeguarding Annual Report For Assurance - Presented by Helen Dobson
11:50 AM	BOARD GOVERNANCE	
	P150/25.	Escalations from Governors Presented by Dr Mike Richmond
	P151/25.	Annual Planner For Information - Presented by Dr Mike Richmond
	P152/25.	Any Other Business For Discussion - Presented by Dr Mike Richmond
	P153/25.	Questions from Members of the Public on the Business of the Meeting For Discussion - Presented by Dr Mike Richmond
	P154/25.	Date of next meeting - Friday 07 November 2025 For Noting - Presented by Dr Mike Richmond

CLOSE OF MEETING

Draft until approved at the 5th Sept 2025 meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING
Friday 4th July 2025, 9:00 am – 1:00 pm
Boardroom, Level D & MS Teams

Present:
Dr M Richmond, Chairman
Mr B Kirton, Managing Director
Mr K Malik, Non-Executive Director
Mrs H Craven, Non-Executive Director
Mrs H Watson, Non-Executive Director
Mrs H Dobson, Chief Nurse
Dr J Beahan, Medical Director (from 11.10am)
Mr C Thickett, Chief Finance Officer
Mrs S Kilgariff, Chief Operating Officer
Mr M Temple, Non-Executive Director
Ms J Burrows, Non-Executive Director (via Teams)
Mr D Hartley, Director of People

In attendance:
Mr A Mondon, Associate Non-Executive Director
Mrs J Roberts, Director of Operations/Deputy COO
Mrs E Parkes, Director of Communications
Mr J Rawlinson, Director of Health Informatics
Mr A Wolfe, Deputy Director of Corporate Affairs
Ms C Rimmer, Corporate Governance and Risk Manager (minutes)
Karen Shay-Nutt, Lead Nurse Palliative Care (for item P106/25)
Ustadah Maysoon Shafiq, Chaplaincy Team Lead (for item P106/25)
Mrs S Petty, Director of Midwifery (for item P116/25)

Observers:
Rosamond Roughton, Vice-Chair, Sheffield Teaching Hospitals NHS FT
Professor Paul Hatton, Partner Governor, University of Sheffield

Apologies:
Dr R Jenkins, Chief Executive
Mr P Walsh, Interim Director of Corporate Affairs
Dr R Shah, Non-Executive Director
Professor S Congdon, Non-Executive Director
Mr S Dickinson, Director of Estates and Facilities

Item	Procedural Items	Action
P94/25	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE** Dr Richmond welcomed all those present to the meeting.	
P95/25	**QUORACY CHECK** The meeting was confirmed to be quorate.	
P96/25	**DECLARATIONS OF INTEREST**	

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	Dr Richmond, Mr Thickett and Mrs Parkes' interest in terms of their joint roles at both the Trust and Barnsley Hospital NHS Foundation Trust. Mr Malik's interest in terms of his Non-Executive Director role at Birmingham Hospital.	
P97/25	**MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 2ND MAY 2025 AND FRIDAY 6TH JUNE 2025** The minutes from 2nd May 2025 were agreed as a correct record. The minutes from 6th June 2025 were agreed as a correct record, following a small amendment to clarify that there was a review of non-medical consultant services within the Trust.	
P98/25	**MATTERS ARISING** There were no matters arising which were not covered by either the action log or agenda items.	
P99/25	**ACTION LOG** The Action Log was received and the following discussed: • Log no. 19 (2024) – Mr Kirton updated that work is in progress to take the report through the appropriate groups and committees. Mrs Craven added that she had met with the Director of Estates to provide further comments on the previous report. It was agreed to complete this action as soon as possible and aim to present at September Board. • Log no. 1 (2025) was agreed to remain open as the report would be presented at September Board. • Log no. 2, 5 and 6 were agreed to be closed. Dr Richmond reminded the Board that the Board visits were an integral part of proceedings, however, additional focus and time was needed on the agendas today.	
	OVERVIEW AND CONTEXT	
P100/25	**Board Committees Chairs Reports** **i. Quality Committee (QC)** Ms Julia Burrows provided an overview of the QC's discussions in May and June 2025, highlighting the following: • The presentation from Care Group 3, which highlighted a notable rise in HIV-related workload and the Committee recognised this as a sustained and long-term pressure requiring a permanent increase in capacity • Monitoring of the improvement in patient flow and the impact on quality metrics through the IPR and BAF • QC Annual Report and the improvements in committee effectiveness and strategic focus • Prevention of Future Deaths Notice (Regulation 28)	

- Care Group 4 presentation and the innovation through virtual ward and the mobile x-ray service
- Monitoring of pressure damage in the hospital and community
- Concerns around clinical effectiveness, noting that while there were strong officers and clinical leads in place, there remained a lack of organisational ownership and engagement. Ms Burrows stressed the need for a Trust-wide commitment to improving clinical effectiveness.

Mrs Craven echoed the importance of clinical effectiveness, acknowledging significant progress in recent years but emphasising that further work was needed. Mrs Dobson agreed, noting that while the Trust had established the necessary policies, processes, and structures, greater engagement with care groups was required, suggesting that performance meetings should place equal emphasis on safety, effectiveness, and patient experience.

On C.Difficile, Dr Richmond urged the Board to aim even higher by benchmarking against national performance. Mrs Dobson outlined several interventions that had contributed to the improvement and impact of reduced bed pressures enabling clinical areas to maintain higher standards of cleanliness.

ii. People & Culture Committee (P&CC)

Mrs Watson provided a summary of the chair's log on behalf of Dr Shah and reported that the Committee welcomed the development of "Skills Street", a new education centre focused on health and care sector skills. This initiative was seen as an excellent opportunity aligned with the Trust's objectives around teaching and learning, and members were encouraged to visit. The Trust reported the lowest long-term sickness absence rates to date, reflecting the positive impact of sustained workforce interventions, although it was acknowledged that continued vigilance was necessary. Mrs Watson noted a typographical error on the report and updated that the Committee agreed the BAF Risk at a score of 12, not 8.

Finally, Mrs Watson drew attention to the matter delegated from the Finance & Performance Committee regarding emerging risks linked to national legal rulings on biological sex. While the risk was assessed as low, it was recognised as a sensitive issue. Work was ongoing to operationalise policy changes, and in the interim, staff and patients were being treated on an individual basis. The Trust was awaiting further clarity in the autumn before finalising its approach. Mrs Dobson confirmed that preparatory work to separate staff and patient policies had already been undertaken but had been paused following the recent legal ruling. The Board expressed confidence in the Trust's handling of the changes and were reassured by the Committee's oversight.

iii Finance & Performance Committee (FPC)

Mr Temple provided an update on the FPC's May meeting; the Committee reviewed the Trust's financial position for the first month of the financial year. It was noted that the Cost Improvement Programme (CIP) had initially been reported as delivering zero savings, which was inaccurate and did not reflect the

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	continuous nature of the programme. Mr Rawlinson noted the discussions around cyber and digital, and the restructuring of the agenda to ensure focus and time on this constantly evolving landscape From June's meeting, Mrs Craven advised that Trust was unlikely to meet national cancer targets, although improvement work was ongoing. Mrs Kilgariff updated that these issues had been discussed at Executive level and were being closely monitored. Mrs Craven drew attention to various updates in the report including the impact of Virtual Ward, the new Urgent and Emergency care plan linking to the capital build, Gynaecology services with an in-depth review scheduled for September, the Draft Winter Plan and the input required from People and Culture Committee linking to staff sickness, and the importance of the multiyear approach to financial planning. Mr Temple was encouraged that care groups had responded positively to opportunity identification for savings. Mr Kirton acknowledged the challenging financial environment and described the cultural shift required to embed a multi-year mind-set. He confirmed that improvement plans were being developed and that work was underway with Mr Thickett to ensure business cases demonstrated a clear impact on the bottom line. Mr Mondon requested further information on how to accelerate delivery, expressing concern about the recurring nature of funding shortfalls shortly after financial plans were signed off. Mr Kirton explained that strategic planning had improved, particularly in relation to capital investment decisions, and that forward planning was helping teams make more informed choices. Mr Thickett added that changes to deficit support funding had introduced new risks as was no longer guaranteed, requiring further clarity in future planning. Dr Richmond concluded by emphasising the need to maintain close oversight of both the Trust's internal performance and that of the wider system.	
P101/25	**<u>Board Assurance Framework (BAF)</u>** Mr Wolfe presented the BAF report and confirmed that he had met with the BAF risk owners on a monthly basis to review and update the framework. He advised that all BAF risks were now aligned with the appropriate Board Committees, following the presentation of BAF risks O3 and R2 to the FPC. Cyber security had been formally incorporated into BAF risk D5, with Mr Rawlinson providing regular updates on developments in this area. On cyber, Mr James Richmond noted ongoing developments in the external threat landscape. He highlighted the introduction of mandatory multi-factor authentication (MFA) and password reset protocols as part of the Trust's response to national requirements. Dr Richmond suggested that the Board to receive quarterly updates on cyber security to ensure appropriate visibility of emerging risks and mitigation measures, as well as developments in security equipment and awareness of issues clearly escalated. It was agreed that this would be taken forward as an action, with further discussion outside of the meeting.	**JR**

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	The Board agreed the BAF risk ratings as detailed in the report.	
P102/25	**Corporate Risk Register Report** Mr Wolfe introduced the report, highlighting that there were 239 approved risks recorded, of which 23 were rated 15 or above. These high-rated risks had been reviewed through the Risk Management Committee (RMC) and were subject to ongoing oversight. Mr Wolfe noted that the Trust continued to strengthen its risk management processes, including the use of a Power BI dashboard—developed with input from Mr Rawlinson—which enabled real-time visibility of risk data. Care groups and individual risk owners were still being prompted to review and update their risks regularly to ensure accuracy and accountability. Dr Richmond drew attention to Risk 6692, which related to an inadequate nursing establishment in the Urgent and Emergency Care Centre (UECC) and sought clarity on how the issue was being addressed. Mrs Dobson confirmed that this matter was being addressed in the Safe Staffing and Establishment report and explained that the current establishment did not align with the number of patients being seen. Mr Temple noted that the UECC had experienced record levels of activity and emphasised the importance of understanding the drivers behind this pressure and whether it was likely to be sustained.	
P103/25	**Report form the Chairman - Verbal** Dr Richmond would provide a short summary in the confidential meeting.	
P104/25	**Report from the Chief Executive** Mr Kirton provided an overview of the report on behalf of Dr Jenkins, highlighting the breadth of collaborative work taking place across South Yorkshire and Bassetlaw. He commended the strength of regional partnerships and the Trust's active involvement in system-wide initiatives. Mr Kirton also reflected on the recent PROUD Awards, describing them as an exceptional celebration of staff achievements. Dr Richmond echoed this sentiment, agreeing that it had been a highly positive and uplifting event for the Trust. Dr Richmond queried the reported 5.74% increase in UECC activity, requesting that this figure be checked for accuracy and clarified in future reporting. *Post meeting note: It was clarified that May 2025 attendances showed a 3.09% increase in comparison to the same period last year, not 5.74% as detailed in the report.*	**BK**
P105/25	**Endoscopic Retrograde Cholangiopancreatography (ERCP) Update** Mrs Dobson provided an update on the Trust's ongoing response to the ERCP review including the contact made with the patients and families, responses received, face-to-face meetings and further calls planned for the following week. Mrs Dobson confirmed that the classification of harm was based on the clinical status at the time of the event, acknowledging that many patients had	

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	progressive illnesses. The Trust had reviewed up-to-date records and, where patients were deceased, had spoken with next of kin where possible. For the patient referenced in Section 1.3, it was clarified that the patient had died of unrelated causes. Mrs Watson commended the team for their sensitive and compassionate approach to patient contact, and thanked Mrs Parkes and colleagues for their efforts in managing a complex and emotionally challenging process. Dr Richmond requested that an after-action review be undertaken to capture lessons learned from the process, including what had worked well and what could be improved. Mr Martin Temple asked whether the process was likely to continue for some time, given the sensitivity of the issue. Mr Kirton confirmed that the matter remained ongoing and reiterated the Trust's public apology to all patients and families affected. He acknowledged that further individuals may come forward in light of recent publicity and that the Trust was committed to maintaining open communication and support.	**HD/EP**
	CULTURE	
P106/25	**Patient Story** Mrs Dobson introduced Karen Shay-Nutt and Ustadah Maysoon Shafiq to the meeting who shared some insights into their work to strengthen ties with the Muslim community, to gain trust, to listen and to act on the feedback. It was recognised that, out of circa 900 chaplains across NHSE, Maysoon was the first Muslim female lead chaplain. Karen and Maysoon shared some of the feedback they had received and individual patient stories. Mrs Craven applauded the work and linked to the progress in Organ and Tissue Donation Committee and the work by the team to break down taboos and preconceptions. Dr Richmond commended the team for demonstrating that, even in death, personal care is important and is provided. Mrs Kilgariff shared that the Trust had lost a number of staff recently and thanked the chaplain team for their work with the teams that needed support. Mr Malik reflected that the presentation clearly demonstrated a deep understanding and asked what specifically enabled such strong connections. In response, Karen emphasised the importance of not only listening but actively listening to individuals and communities. She shared an example of where it became evident that there was limited understanding of the legal framework surrounding care. While acknowledging that the law could not be changed, she highlighted the role of education and clear communication in bridging that gap. Maysoon reflected on her personal motivation, as a service and commitment to God, rooted in firm belief and lived experience. Maysoon also shared that they	

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	had been commissioned by the Integrated Care Board (ICB) to develop a guide on faith and healthcare, for which they had received additional funding. This work had laid important groundwork not only in Rotherham but also across the wider NHS. The Board thanked Karen and Maysoon for sharing their work, interactions with patients and families, and personal reflections.	
P107/25	**<u>Patient Experience Annual Report</u>** Mrs Dobson presented the Patient Experience Annual Report, which summarised data and insights from the previous year. The opening of the new PALS service was highlighted as a positive development, enabling more immediate resolution of issues and contributing to an overall improvement in patient experience. The most frequently raised themes across all feedback channels were information provision and waiting times. The Trust had responded to 100% of formal complaints within the required timeframe, demonstrating a strong commitment to timely resolution. Mrs Dobson outlined the plans for the next year and shared that the national publication of the Experience of Care Framework would help shape future work. Mr Mondon queried the data in section 6.3 of the report and Mrs Dobson clarified that the table referenced Emergency Department (ED) attendances and that the complaints were presented per 1,000 episodes. She confirmed that the absolute number of complaints had remained broadly consistent and it was suggested that the wording should better reflect the underlying trend. On the categorisation of complaints, Mr Malik queried whether subthemes such as medical and nursing issues were being actioned at an individual level. Mrs Dobson confirmed that trends in concerns and complaints were routinely analysed, and any individuals named in complaints were referred to supervisors for follow-up, with oversight from herself and the Medical Director. Mrs Watson reflected on the earlier patient story and noted that section 14.2 of the report showed a predominance of complaints from patients identifying as White British. She questioned whether this was representative of the hospital's population and asked how the Trust could ensure its complaints process was accessible to all. Mrs Dobson acknowledged that cultural and behavioural factors may influence reporting and confirmed that complaint information was now published in multiple languages. She also noted ongoing work with the Trust Engagement and Inclusion lead, to strengthen connections with seldom-heard groups. Mrs Craven observed that while the report referenced many initiatives undertaken for patients, it did not acknowledge the significant contributions made by the Trust's charity. She requested that future reports include public recognition of the charity's role. She also suggested that as the Trust evolves—particularly with the expansion of Virtual Wards—it would be helpful to consider patient experience across different care settings, including acute, community, and outpatient pathways.	**HD**

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	Staff attitude remained one of the top five concerns raised by patients and Mrs Dobson confirmed that this would be a key focus in the coming year, with greater emphasis on "You Said, We Did" reporting and executive input to ensure meaningful change. She shared that a joint event with Barnsley had been held to explore how to improve the experience of care for all, featuring a keynote speaker on customer service. The event encouraged staff to consider the impact of first impressions and non-clinical interactions on patient experience. Mr Hartley added that while negative attitudes were reported in a small number of interactions, they were nonetheless unacceptable. He confirmed that the Trust was refreshing its behavioural frameworks and linking them to the "We Said, We Did" approach, which had proven effective in driving improvements. Mr Kirton welcomed the positive developments outlined in the report and emphasised the importance of mainstreaming this work across the Rotherham borough, utilising successful models as a vehicle for change and encouraged further collaboration with partner organisations to take this work to the next level. Mr Malik concluded the discussions by expressing increased confidence in the Trust's complaints process and its ability to drive meaningful improvements. The Board noted the report.	
P108/25	**<u>End of Life Annual Report</u>** Mrs Dobson presented the report and linked back to the earlier patient story and the team that is the driving force behind improvements. Mrs Dobson summarised that the quality survey (completed by bereaved families) had seen an improvement in all areas with the exception of support for the dying person to eat or receive nutritional support. The staff survey reported confidence in dealing with end of life care but felt the organisation needed to offer more education on this subject, which the Trust was actively addressing. A dedicated webpage had been launched to provide accessible information on End of Life care, and positive links had been established with NHS Blood and Transplant, particularly in relation to organ and corneal donation. Mrs Dobson also acknowledged the support received from the charity, particularly in relation to the bereavement boxes, to be included in the report. Dr Richmond reflected on a recent Board visit to the palliative care team and commended the dedication and quality of work observed. For the number of patients given tailored care through the last days of life care plan, Mrs Craven queried the trajectory for reaching the national benchmark. Secondly, Mrs Craven raised concerns about the implementation of the ReSPECT process, emphasising that it must be fully completed and respected as a meaningful document. Mrs Dobson agreed and explained that much of the work around ReSPECT was being led at a South Yorkshire level, with Dr Kersh spearheading efforts in primary care, noting that the majority of ReSPECT conversations needed to take place outside the hospital setting. The Board noted the report.	

	STRATEGY AND PLANNING	
P109/25	**Quality Strategy** Mrs Dobson presented the Trust's new Quality Strategy, outlining its development, alignment with other strategic documents, and the engagement undertaken to shape its content. Each aim was supported by detailed objectives, success measures, and underpinning frameworks to guide implementation, with overall oversight to be maintained through the Quality Committee. Mrs Dobson detailed that the next phase would focus on effective rollout and embedding the strategy across the organisation. Dr Richmond thanked Mrs Dobson and the team for a well-considered and comprehensive strategy and noted the importance of ensuring the strategy remained relevant to community services, particularly as the Trust moved towards more fluid models of care and increased delivery outside of hospital settings. He requested that future updates include clearer trajectories, with supporting data and timelines to provide assurance. Mr Malik acknowledged the increased complexity and risk associated with delivering care in more mobile and flexible ways and asked how the Trust would ensure it remained agile in its approach. Mrs Dobson responded that the national Quality Strategy was also expected this year and confirmed that the Trust's strategy had been designed to be adaptable and would be updated as required to reflect national changes. Mrs Kilgariff highlighted the importance of executive leadership in delivering the strategy, noting that transformation programmes—such as those in cancer—should explicitly reflect the quality pillars outlined in the strategy. She suggested that this approach be extended to all major programmes, with quality considerations embedded in business case development. The Board approved the Quality Strategy and Mrs Dobson confirmed that an update would be brought back to the Board in six months' time.	
P110/25	**The Workforce Plan** Mr Hartley introduced the Workforce Plan, to be read in conjunction with the Trust's People and Culture Strategy and EDI Plan. The plan brought together multiple strands of workforce development into a single, cohesive framework designed to support the Trust's strategic objectives and reflected the Trust's growth and response to national changes. Mr Hartley highlighted that plan drew on key elements of workforce planning pathways and aimed to improve triangulation between financial, quality, and workforce goals. It set out a new approach to workforce planning, enabling services to move away from reactive staffing models and instead plan in a costed, strategic manner. It also reinforced the Trust's role as an anchor institution within the local community. Mrs Craven raised the importance of explicitly referencing education and development, particularly in the context of the Trust's ambition to achieve Teaching Hospital status. Dr Richmond supported this view, noting that the	

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	Teaching Hospital model should influence all levels of the organisation and Mr Hartley agreed to strengthen the plan in relation to this. Mr Malik linked the workforce plan to patient experience, highlighting the importance of job planning and the balance between clinical and administrative duties. Mr Hartley confirmed that this was addressed within the plan's actions, which included embedding job planning to inform capacity and planning. Mr Temple suggested that the plan could benefit from a simplified table outlining priorities, timelines, and key milestones to aid clarity and implementation. Mr Hartley welcomed the feedback and agreed to incorporate the comments. The Board supported and approved the Workforce Plan.	
P111/25	**<u>Teaching Hospital Status</u>** Dr Beahan presented the paper and provided an update on progress to date and next steps. Dr Beahan felt that the Trust had fulfilled the necessary requirements and had met with other local Trusts who had become Teaching Hospitals to learn from their experience. Dr Beahan emphasised that the ambition extended beyond the title itself; it was about embedding a culture of high-quality teaching and learning across the organisation. Other Trusts had reported significant benefits from Teaching Hospital status, including enhanced organisational culture, talent development, improved reputation, and better patient outcomes. Work had already commenced to strengthen the infrastructure required to support this ambition and a showcase document had been drafted but required further development, particularly to ensure a stronger emphasis on medical education moving forward. The Executive Team had reviewed the proposal and expressed their support. The next steps would involve completing the current work, deepening engagement with university partners, and identifying a Non-Executive Director to act as a champion for the initiative. Ms Burrows strongly supported the proposal, noting that the rationale must remain focused on improving the quality of care for patients. Mrs Watson agreed, suggesting that if positioned correctly, the initiative could serve as a springboard for broader organisational development. She highlighted the opportunity to consolidate learning budgets from across the system and direct them strategically, aligning with the Workforce Plan. She was particularly interested in how deliberate investment could support the Trust's ambitions. Mr Mondon supported the proposal but queried the financial implications, noting the importance of understanding the associated costs. Mr Martin Temple also expressed support and welcomed the links with the University of Sheffield. Mrs Craven recommended involving the project team early, particularly in relation to estates planning, as there was currently no capital allocation for a dedicated teaching facility. Dr Richmond noted that much of the teaching activity was already taking place within the existing estate. In response to financial queries, Dr Beahan explained that the Trust already received significant funding from the university and Continuing Professional	

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	Development (CPD) allocations, and noted that there were opportunities to generate further income through teaching activity. Early discussions with the Director of Medical Education and colleagues had also explored innovative approaches, including the use of artificial intelligence in education. Dr Richmond emphasised the importance of fully understanding the financial component and suggested that a business case should be developed alongside the proposal. He reiterated his full support, noting that the ambition aligned with the Trust's values. The item was presented for information, not decision. Dr Richmond confirmed that formal approval from the Council of Governors would be required in due course.	
	SYSTEM WORKING	
P112/25	**National, Integrated Care Board and Rotherham Place Update** Mr Kirton updated that the government 10-Year Health Plan had now been published, and this was alongside the regional Urgent and Emergency Care (UEC) Plan and the Spending Review; there is a wide range of national policy changes and implications for the region as detailed in the ICB CEO report. Mr Kirton shared that he, Mrs Kilgariff and Dr Jenkins had attended a Place review last month and there were constructive discussions around neighbourhood models of care and the Trust's role within them. Furthermore, Mr Kirton noted the significant investment in the Skills Street initiative, which represented a major development not only for Rotherham but for the wider South Yorkshire system.	
	PERFORMANCE	
P113/25	**Integrated Performance Report** Mr Kirton introduced the Integrated Performance Report (IPR), noting ongoing concerns regarding the Trust's financial position. Despite this, he highlighted encouraging signs of stability and sustained improvement across several operational areas. Executive leadership was clearly visible in driving progress, and the development of the new SDEC unit was commended as a particularly impressive achievement and extended thanks to Mrs Roberts for her leadership in this area. In relation to workforce, although long-term sickness trends had not yet fully reversed, there were early signs of improvement; Mr Kirton linked to the work of the People & Culture Committee and their focus on supporting staff health and wellbeing, renewed return-to-work processes, proactive engagement and the quality of weekly information provided by Mr Rawlinson's team. Mrs Dobson raised that some data in the report had not tracked through correctly to the performance summary matrix, but was correct on the individual matrix. Mrs Craven raised concerns that the summary matrix did not reflect issues flagged in the Finance & Performance Committee. Dr Richmond queried the number of overdue follow-ups, noting that this was contributing to a growing backlog. Mrs Kilgariff shared that the issue had been	

	raised at the Executive Team meeting and that she had met with Dr Beahan to agree a way forward. She explained that the national shift towards Patient-Initiated Follow-Up (PIFU) required a different operational approach and that clinical leads would need to work closely with operational teams to implement changes. Mrs Kilgariff added that a longer-term plan was being developed, particularly for patients with chronic conditions. She noted that some specialties were reliant on locum consultants, which added a layer of complexity.	
P114/25	**Finance Report** Mr Chris Thickett presented the Month 2 Finance Report, highlighting that the Trust had reported a control deficit position, with £242k adverse variance against plan. While the deficit had stabilised in-month, further investigation on increased costs was needed. The Trust had delivered £0.5m in Cost Improvement Programme (CIP) against a £2m plan, and reserves had been used to support the reported position. Cash position remained ahead of plan, largely due to slippage in the capital programme. Mr Thickett confirmed that he would be reviewing the capital plan with the finance team, particularly in relation to national funding schemes and business cases. Dr Richmond sought clarification on the use of reserves and Mr Thickett responded that this was being explored further. Mrs Craven noted the scale of capital expenditure planned for the year and stressed the importance of understanding the impact on both expenditure and depreciation and the cost pressures. Mr Kirton supported the need for further analysis, acknowledging the time required for Mr Thickett, as new to the role, to fully understand the financial position and reserve usage.	
P115/25	**Safe Staffing and Establishment** Mrs Dobson introduced the six-monthly review, providing an assessment of staffing levels against the Trust's funded establishment, as required by national guidance. Mrs Dobson explained that the review incorporated the first set of data from the new community staffing tool, although three data points would be required before trends could be reliably assessed. On the recommendations, HD noted that this was the first time in three years that the Chief Nurse has proposed an increase in the nursing establishment. Mrs Dobson detailed the proposed solutions linking to the bed reconfiguration programme and recognising the shortfalls in UECC nurse staffing, triangulating with the high risk on the risk register. In surgical areas, staffing levels were currently above requirement in some areas, while data emerging from Care Group 1 indicated deficits in medical wards. A further challenge was noted in paediatrics, where the ward is currently over-established. A proposal has been made to redistribute this workforce, which would result in a reduction in bed base with further exploration of term-time contracts and flexible use of staff to meet seasonal demand. Mrs Kilgariff emphasised the importance of aligning the findings with the bed reconfiguration programme. She noted that staffing pressures in the UECC were now impacting operational performance, with the current workforce model based	

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	on 260 attendances per day, whereas the actual average had risen to 300, and would support development of a business case to address this discrepancy. Mrs Kilgariff also highlighted the introduction of the new 'green area' within the UECC and the need to monitor patient flow through this space. Dr Richmond referred to the financial implications of staffing changes. He supported the recommendation to develop a business case to increase the establishment and stressed the need to consider the impact of Same Day Emergency Care (SDEC) in this context. Mrs Craven supported the review and noted that the impact of Virtual Wards (VW) on inpatient staffing should be revisited. Mrs Dobson confirmed that the review would be repeated every six months and that the long-term aim of the VW model was to reduce the need for inpatient beds. Dr Richmond reiterated his support for the VW model but cautioned that each new development brought the risk of service expansion. He stressed the importance of maintaining control and ensuring that growth was appropriately balanced The Board supported and approved the recommendations.	
	REGULATORY AND STATUTORY REPORTING	
P116/25	**Maternity and Neonatal Safety Report** The Board welcomed Mrs Petty to the meeting who highlighted key data, including perinatal mortality figures. While the Trust was still awaiting the national publication of 2024 data, local figures had been included for information. The cluster of stillbirths had been identified and fully investigated, as previously reported. On workforce, Mrs Petty reported that neonatal staffing levels were meeting national standards, and there was implementation of supernumerary coordination. For quality, Quality Improvement efforts were ongoing, with triage identified as a key area of focus. Mrs Petty also referenced the national Maternity Rapid Review, and the recently published 10-Year Plan which would inform further work in this area. A letter to Trust Boards had set out clear expectations, including benchmarking against national standards, assurance visits, and the use of staff, culture, and CQC surveys. There were also aims to consolidate and streamline reporting requirements; a further paper would be presented to the Board in September. Dr Beahan viewed the review as an opportunity for the Trust to showcase its maternity services, which had consistently performed well, and suggested that the Trust could position itself as a positive outlier and aim for recognition as an outstanding provider. Dr Beahan also referenced the letter's emphasis on addressing inequalities and the role of the Public Health Midwife was highlighted as a valuable addition, enabling deeper analysis of population health needs and service equity. Dr Richmond asked whether the national reviews would point to any systemic issues, and Mrs Petty responded that the challenges were multifactorial, including historic underinvestment, workforce shortages, and evolving models of care. She noted that while there had been significant cultural improvements,	

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	particularly in safety, the medical workforce remained under pressure. Mr Kirton reflected on a recent tour of the maternity unit and praised the dedication of staff and the bespoke nature of the service. He noted that expectations among service users had shifted, particularly around patient voice and choice, which was a key theme in the 10-Year Plan. Mrs Petty agreed, highlighting the importance of listening to all women and ensuring that service user voices were representative of the Trust's diverse population. She acknowledged that the landscape remained complex and evolving. Ms Burrows welcomed the appointment of the Public Health Midwife and reiterated the need for close working with council colleagues.	
P117/25	**Annual Data Security and Protection Toolkit/CAF 360 Audit Report** Mr Rawlinson presented the Annual Data Security and Protection Toolkit (DSPT) submission, which included the Cyber Assessment Framework (CAF) and findings from the mandatory internal audit. The audit reviewed eight mandatory assurance areas, with the Trust opting to include an additional four areas for review. The outcome was positive, with the Trust rated as low risk and four areas of good practice identified. Areas for improvement were noted, particularly around password management. Business continuity planning in relation to cyber security was being updated and would continue to be monitored through the relevant committees. Mr Mondon queried the Trust's cyber security capabilities and Mr Rawlinson explained that the Trust benefited from the NHS's national cyber security infrastructure, including monthly threat intelligence updates. He confirmed that the Trust received detailed information on emerging threats and had recently completed a penetration test. The Trust also ensured its supplier list remained current and aligned with the latest security methodologies. He acknowledged that cyber security remained a dynamic environment and that the Trust was continually adapting to new threats. Mr Kirton, as the Trust's Senior Information Risk Owner (SIRO), expressed his confidence in the team's approach and the rigour applied to the audit process. Mrs Roberts added that cyber security was also tested annually as part of the Trust's Emergency Preparedness, Resilience and Response (EPRR) programme, including table top exercises for the whole organisation.	
P118/25	**Mortality and Learning From Deaths Quarterly Report** Dr Beahan presented the report, confirming that Structured Judgement Reviews (SJRs) were now being completed in a more timely manner and emphasised that the focus had shifted to the "so what" element of the reviews, with learning being used to drive quality improvement work, particularly in collaboration with the Resus and End of Life Care teams. The use of ReSPECT forms was being promoted as a proactive planning tool, and the introduction of a medical examiner in the community was also noted as a positive development. Dr Beahan reported an increase in the Summary Hospital-level Mortality Indicator (SHMI) for the month, although still recorded 'as expected' and	

	highlighted that the Trust had recorded fewer deaths than the previous year. The increase in SHMI was attributed to changes in the Emergency Care Data Set (ECDS) and variances in national data with other Trust's not yet moved over to this data set. Dr Beahan drew attention to the VLAD alert triggered as detailed in the report; a coding review has been requested and completed SJRs will be reviewed for patients in this group. Dr Beahan acknowledged the complexity of interpreting this data and confirmed that Mr Rawlinson's team were supporting the analysis. Mr Rawlinson noted the time lag in SHMI data and advised the Board to remain mindful of this when reviewing trends. Mrs Craven queried how SDEC activity was being monitored now that it was excluded from SHMI, and also raised concerns about sepsis assurance, particularly in light of previous quality improvement efforts. Dr Beahan responded that the Trust was still determining how best to separate and monitor SDEC data and highlighted that sepsis-related deaths had decreased compared to the previous year, which was encouraging. The VLAD alerts would trigger further SJR reviews, and that the Trust continued to balance prompt antibiotic administration with the risk of C.difficile. Dr Richmond queried whether the 360 Assurance audit action had been completed and the ownership and accountability from SJR outcomes. Dr Beahan confirmed that the action point was passed and there is ongoing surveillance to ensure learning was embedded but acknowledged the challenge of cascading the learning to every individual team member. Dr Richmond noted the gradual increase in SHMI and questioned whether care groups were taking ownership of the issue and Dr Beahan suggested including this in the audit programme for the following year. Mrs Craven added that the Trust had previously achieved an "as expected" SHMI through a significant programme of work led by Dr Richard Jenkins, and that maintaining this position would require continued focus.	
	BOARD GOVERNANCE	
P119/25	**Well Led Development Review** Mr Kirton summarised that is was a positive report which included both areas of strength and opportunities for improvement. The plan developed had input from all directors and the outputs would be tracked through Board sessions. Mrs Craven noted that the key actions and milestones identified in the review aligned well with several strategic plans approved earlier in the meeting. Dr Richmond added that, with the national 10-Year review expected shortly, it would be helpful for the Board to remain mindful of how its development work might align with or be influenced by that in future. It was noted that this review would also be shared with the CQC.	

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P120/25	**Board Annual plan** The Board noted the annual planner. Mr Rawlinson highlighted the need to ensure inclusion of the SIRO reporting.	
P121/25	**Any other business** There were no other items of business.	
P122/25	**Questions from Members of the Public** No questions were received.	
P123/25	**Date of next meeting** Friday 5th September 2025	
	CLOSE OF MEETING	

Chair:

Date:

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Board Meeting; Public action log

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
2024								
19	08.11.24	Action Log	P158.24	The new Director of Estates and Facilities, when commenced in post, should undertake a further review of the fire safety position and a report should be brought back to the Board in early 2025	DofE&F	~~Jul-25~~ Oct-25	Action update is the paper is to be completely re-written to be a strategy, with underpinning policy and procedures backed up by evidentiary documentation. 04.07.25 - It was agreed to complete this action as soon as possible and aim to present at September Board. 29.08.25 - SD: Comments from HC accepted by DofE&F and referred back to the Trusts Independent Authorising Engineer (AE) for fire. The AE agreed and stipulated it needed to be written by an accredited fire engineer on strategy and principles as per HTM05, underpinned by a separate local operational policy. The Trusts AE is re-writing the whole document which will go through the governance process of ETM, F&P and then Board again. This will go through in September and then October Board.	**Open**
2025								
1	10.01.25	Board Committees Chairs Reports	P7/25	Consider how the Board has oversight of Research, as well as Medical Education, in the context of the objective around Teaching Hospital Status.	Jbe	Jul-25	27.06.25 - Research and Development Report scheduled to be presented at July Quality Committee and be presented at Board in September. 27.08.25 - Research and Development Report included in agenda for September Board.	Recommend to Close
7	04.07.25	Board Assurance Framework (BAF)	P101/25	Review Board oversight of cyber security to ensure appropriate visibility of emerging risks, mitigation measures and other developments.	JR	Sep-25	27.08.25 - JR: Currently, Cyber Security Update is a standing agenda item each month at FPC and any escalations are presented to Board through FPC Chair's Log. To increase visibility at Board, Cyber Security could become a standing item for the Chair's Log and the review room used for any committee/sub-committee reports as needed, to give further context. Cyber is also included in the Board Assurance Framework, presented to FPC & Board (BAF Risk D5, Control 6)	Recommend to Close
8	04.07.25	Report from the Chief Executive	P104/25	Review and clarify reported percentage figure on UECC activity.	BK	Sep-25	27.08.25 - Percentage figure was clarified to be 3.09% - post meeting note included in the minutes for item P104/25	Recommend to Close
9	04.07.25	ERCP Update	P105/25	Conduct an after-action review of the communications process to capture lessons learnt from the process, including what had worked well and what could be improved.	HD/EP	Nov-25	(Due November)	**Open**
10	04.07.25	Patient Experience Annual Report	P107/25	Ensure acknowledgement of the contributions of the Trust's charity in this report, as well as the End of Life Annual Report.	HD	Sep-25	29.08.25 Acknowlegements will be picked up in the sub-committee and committee quarterly reporting and future annual reports.	Recommend to Close

Open
Recommend to Close
Complete

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

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

Committee / Group: Quality Committee	**Date: 23rd July 2025**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Board Assurance Framework	The committee advised that the rating for P1 should remain at 12 and the risk is being reviewed in line with developments related to the upcoming industrial action, the rising SHMI rate and the Trust financial situation.	Board of Directors
2	Care Group 2 Presentation	The committee agreed to produce presentation guidance and a standard template for Care Groups that should link with the Trust Quality Strategy.	Board of Directors
3	Chief Nurse & Medical Director Monthly Highlights	The committee agreed to advise the Bard of the new staffing model, which will ensure consistent staffing across all areas, with the exception of UECC, and is expected to support a reduction in sickness absence and improve overall staff availability. Welcome events are planned to support this transition and embed the new approach.	Board of Directors
4	Integrated Performance Report (IPR)	The committee agreed that it should advise the Board on the increased SHMI rate, which is under review and may be due to a change in calculation, and it is being closely monitored and investigated. The ongoing deep dive into pressure ulcers from which a report will be brought back to the committee.	Board of Directors
5	Research and Development Report	The committee agreed to assure the Board and highlight the good work being undertaken by research, including being the highest recruiter in Yorkshire & the Humber for the second consecutive year, and having 3247 patients recruited, which is a 145% increase from 2023/24.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
6	Infection control Chairs log	The committee wished to alert the Board to the escalation from the Infection Control Committee of the lack of Estates & Facilities representation at ward safety meetings.	Board of Directors
7	Safeguarding Chairs log	The committee agreed to advise the Board that although the Trust has not yet received the NHSE Appreciative adult processes enquiry from last year, it is expected shortly; however it also agreed to assure the Board that most of the actions put in place at the time of the visit have now been completed.	Board of Directors

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

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

Committee / Group: Finance & Performance Committee	**Date:** 23rd July 2025	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Integrated Financial Performance Report	The Committee agreed to alert the Board to the current uncertainty around the true financial position and the risk to deficit support funding. The committee is not yet in a position to be assured about the current forecast or its likely outcome. However, the work underway is expected to provide a more accurate and transparent view of the financial challenge, which will be available in September.	Board of Directors
2	Bed Reconfiguration	Subject to final comments, this was supported and will be escalated given its operational and financial significance.	Board of Directors
3	Care Group 4 (Community, Therapies, Dietetics and Radiology, Medical Physics and Medical Illustration)	Hospital at Home: The Committee recognised this as a major development with strong team engagement and potential to reshape Trust wide service delivery.	Board of Directors
4	Corporate Services - Cyber Security & Health Informatics Update	The Committee agreed that it was assured with the global award recognition for its EPR Usability improvement journey for medics, and agreed to advise the Board as to concerns regarding future purchase of a new EPR system. Taking in to account the anticipated financial burden and damaging impact to Trust productivity and patient safety.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
5	Operational Priorities - Emergency Care	The Committee agreed to advise the Board of the improved Trust performance in respect to the 4 hour target.	Board of Directors
6	Operational Report	The Committee agreed to advise the Board of the Trust's intended journey towards reaching Segment 1 of the new Oversight Framework.	Board of Directors

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

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

Committee / Group: Audit & Risk Committee	Date: 11th July 2025	Chair: Kamran Malik

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Risk Management Report	The Committee agreed to advise the Board that the Risk Register would benefit from increased top down risk management with greater input form the Board and external risks. This would allow closer scrutiny of the risks as well as being more complete a picture.	Board of Directors
2	Internal Audit Progress Report	The Committee agreed to advise the Board that Governance within the Trust requires more efficiency and provide increased value for money when consideration is taken of the staff resource to attend such groups and committees across all Care Groups and the Corporate Services.	Board of Directors
3	Internal Audit Progress Report	The Committee wanted to assure the Board of the audit opinion of Significant assurance from 360 Assure relating to the recent Care Group governance, with a focus on PSIRF governance and Counter Fraud audits.	Board of Directors
4	Counter Fraud Annual Report	The Committee agreed to advise Board that Counter Fraud should working with Communications to reinforce that staff should not be working whilst signed off as sick.	Board of Directors
5	Annual Planner	The Committee agreed to advise the Board that there will be a review of annual planner to ensure correct synchronisation with Board	Board of Directors

The Rotherham NHS Foundation Trust

Agenda item	P131/25
Report	**Board Assurance Framework**
Executive Lead	Peter Walsh, Interim Director of Corporate Affairs
Link with the BAF	Links with all BAF risks
How does this paper support Trust Values	The Board Assurance Framework is a key element that provides evidence of good governance and therefore supports all three core values, Ambitious, Caring and Together.
Purpose	**For decision** ☒ **For assurance** ☒ **For information** ☐
Executive Summary	We present the latest Board Assurance Framework. The People & Culture Committee, Quality Committee and Finance and Performance Committee have each reviewed the Strategic Board Assurance Risks aligned to them. They are not recommending any changes to the ratings for any of the risks.

Due Diligence	The relevant sections of the Board Assurance Framework have been discussed at the relevant Board Committees during June and July 2025.
Who, What and When	The Director of Corporate Affairs will continue to work with Executive colleagues in order to review and update the BAF on a monthly basis thus highlighting any risks or issues that have the potential to disrupt achieving our Strategic Ambitions.
Recommendations	It is recommended that the Board of Directors: • Note the outcomes of discussions at board committees about each of the BAF risks • Agree the recommendations that there are no changes to risk ratings. ➢ The rating for BAF Risk P1 to remain at 12; ➢ The rating for BAF Risk R2 to remain at 8; ➢ The rating for BAF Risk O3 to remain at 8; ➢ The rating for BAF Risk U4 to remain at 12; ➢ The rating for BAF Risk D5 to remain at 12; and ➢ The rating for BAF Risk D9 to remain at 16.
Appendices	Appendix 1: Overall Board Assurance Framework for Quarter 2, month 2

1. Introduction

1.1 The Board Assurance Framework (BAF) was developed in 2022/23 to align with the trust's Five Year Strategy was commenced. It was reviewed following the strategy refresh in July 2024, and individual risks are reviewed by relevant Committees at each of their meetings. The BAF is presented at every full Board meeting held in public.

1.2 This report illustrates the discussion and decisions taken by the relevant Board Assurance Committees during July and August 2025.

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

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

1.4 For ease of reference, the attached BAF report contains all updates in red font, and where an action or gap is partially completed this appears in blue font.

2. Risk aligned to the Quality Committee

P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.

2.1 The Chief Nurse and the Medical Director are the Executive Director leads for Strategic Risk P1, and the risk is reviewed on a monthly basis with them.

2.3 The initial score agreed for Quarter 1 2022/23 was a score of 16 whereby the consequence was graded as a 4 (Major), defined in accordance with the 2008 Risk Matrix for Risk Managers as 'noncompliance with national standards with significant risk to patients if unresolved, low performance rating, critical report'. It is proposed the consequence score remains the same at 4 (Major).

2.5 The initial likelihood score agreed for Quarter 1 2022/23 was 4 (Likely) defined in accordance with the aforementioned matrix as 'will probably happen/recur but is not a persisting issue. This likelihood score was reduced in May 2023 to 3 (Possible) following the lifting of the CQC conditions in 2023. The likelihood was reduced further to 2 at the July 2024 Board of Directors, given the number of audit reports giving moderated and significant assurance.

2.6 However, following continued pressures on services, particularly UECC, and ongoing financial constraints, it was agreed to increase the scoring back to 12 in March.

2.7 Taking the above into consideration, it was recommended the risk score remains at **12** for Quarter 2 2025/26**.**

3 Risk aligned to the Finance & Performance Committee

O3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.

3.4 The risk was fully reviewed by the Managing Director at the beginning of August 2025. There have been a number of changes to the controls and gaps which are highlighted in red in the BAF report.

3.5 It is recommended that the score remains at **8** which sits within the target score, it will be further reviewed in September 2025.

4 Risk aligned to People & Culture Committee (P&CC).

U4: There is a risk that we do not create and maintain a compassionate and inclusive culture which leads to an inability to retain and recruit staff and deliver excellent healthcare for patients.

4.1 The Director of People is the Executive Director lead for the current BAF Risk U4. As part of the review process, the Deputy Director of Corporate Affairs meets with the Director of People in Quarter 2 to review the risk. The last review being in August 2025.

4.2 There were a number of updates relating to the Controls, Mitigations and Gaps during the quarter, these can be found in the BAF report highlighted in red.

4.3 The BAF Risk U4 was initially graded with a consequence of 4, which in accordance with the aforementioned risk matrix relates to uncertain delivery of key objectives/service due to lack of staff, unsafe staffing levels or competence (>5 days), very low staff morale and no staff attending mandatory/key training. The likelihood target score was rated at 2 which is 'unlikely, do not expect it to happen/recur but it is possible it may do so'. The likelihood current score was deemed to be a score of 3 which is 'possible, might happen or recur occasionally.'

4.4 Following review and further discussions in August 2025 it is recommended that BAF Risk U4 remains at **12.**

5. Risks aligned to Finance and Performance Committee

D5: There is a risk we will not deliver our performance priorities (Urgent Care, Elective Recovery and Cancer) because of insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.

5.1 The Director of Finance and the Chief Operating Officer are the Executive Director leads for Strategic Risk D5. The Deputy Director of Corporate Affairs has met with the Director of Finance and Chief Operating Officer monthly during Quarter 2 2025/26.

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

5.3 The risk was initially graded at 15, and was increased to 20 at the end of 2023 due to pressures of industrial action. This rating was reduced over the course of 2024 as industrial action abated.

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

D9: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2024-25 leading to further financial instability.

6.1 The BAF Risk D9 covers the financial situation for the Trust, 2025/26. The outstanding controls and gaps from the 2024/25 BAF risk D8 had been carried forward on advice of the Risk Owner.

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

6.3 A new gap was added at the July 2025 review meeting, this gap G7 relates to deficit support funding and system wide delivery of financial plan.

6.4 The risk was discussed at the May 2025 Board of Directors where it was agreed that the financial plan is in place and as such the rating should remains at **16**. Following review in August 2025 this is still the recommendation.

R2: There is a risk we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased health inequalities.

7.1 The risk was fully reviewed by the Managing Director at the beginning of August 2025. There have been a number of changes to the controls and gaps which are highlighted in red in the BAF report

7.2 It is recommended that the score remained at **8** which sits within the target score. It will be further reviewed in September 2025.

Recommendations

The Board of Directors is asked to:

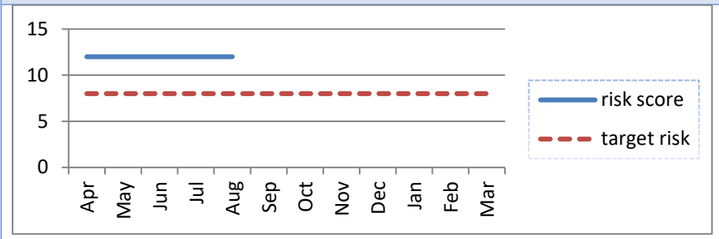
- Note the outcomes of discussions at board committees about each of the BAF risks;
- Agree the recommendations that there are no changes to risk ratings.

Alan Wolfe

Deputy Director of Corporate Affairs

August 2025

Ambition	Strategic Risk			Original Score LxC	Score Q1	Score Q2	Score Q3	Score Q4	Target Risk Score	Movement	Risk Appetite/
	There is a Risk that….	Because…..	Leading to…..								
Patients: *We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them.*	P1: we will not embed quality care within the 5 year plan	..of lack of resour ce, capacit y and capabi lity	..poor clinical outcomes and patient experience	4(L)x 4(C)=16	12	12			2(L)x4(C) =8	⇔	Cautious
Rotherham: *We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the*	R2:we will not establish ourselves as leaders in improving the lives of the population we serve	..of insufficient influence at PLACE	..increased ill health and increased health inequalities	2(L)x4(C)=8	8	8			2(L)x4(C) =8	⇔	Seek
Our Partners: *We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient*	OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system	..of lack of appetite for developing strong working relationships and mature governance processes	..poor patient outcomes	2(L)x4(C)=8	8	8			2(L)x4(C) =8	⇔	Seek
Us: *We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.*	U4: we do not create and maintain a compassionate and inclusive culture	..	.. to an inability to retain and recruit staff and deliver excellent healthcare for patients	3(L)x4(C)=12	12	12			2(L)x4(C) =8	⇔	Seek
Delivery: *We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation*	D5: we will not deliver our performance priorities (Urgent Care, Elective Recovery and Cancer)	.. of insufficient resource and increased demand	.. an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.	~~5 (L)x3(C) = 15~~ 4 (L)x3(C) = 12	12	12			2(L)x3(C)=6	⇔	Minimal
	D9: we will not be able to sustain services in line with national and system requirements	… of a potential deficit in 2025/26	… further financial instability.	5(L)x4(C)= 20	~~16~~	16			1(L)x4(c)= 4	⇔	Cautious

Strategic Theme: Patients	Risk Scores											
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2025-26					
Strategic Ambition: **Patients:** ***We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them***	**P1**	**4(L)x4(C)=16**	**12** **3(L)X4(C)**	**8** **2(L)X4(C)**	**CAUTIOUS**		**Previous Score Q4 2025-26**	**Q1**	**Q2**	**Q3**	**Q4**
Link to the Operational Plan: P1: Deliver care that is consistent with CQC 'Good' by the end of 2025/26.Ensure improved performance of at least one quartile in the National Inpatient and UECC CQC Patient Experience Surveys.							**12**	**12**	**12**			
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6630, RISK6762, RISK6284, RISK6888, RISK5967, RISK7325, RISK7290, RISK7084, RISK7164, RISK7076, RISK6912, RISK6692, and RISK6421**				**Assurance Committee & Lead Executive Director**		
P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.										**Quality Committee Chief Nurse and Medical Director**		
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**		**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*						
C1	Implementation of agreed Quality Strategy to provide quality assurance to the Board and external regulators	Established meeting structure reporting directly to Quality Committee on a quarterly basis to provide assurance with regards to Patient Safety, Patient Experience, Clinical Effectiveness, Infection Control, Safeguarding, Medication Safety and Health & Safety	July 2025	QC		L1				Chief Nurse		
		Quarterly report on Quality Assurance to Quality Committee and Board of Directors to provide update on all aspects of Quality Strategy. QC sub-committees Chair's Logs added to reading room for each Board.	November 2024 Board July 2025	QC		L1				Chief Nurse		
		Range of tools utilised to measure quality achievements including Tendable Audit programme and	March 2025	QC		L1				Chief Nurse		

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

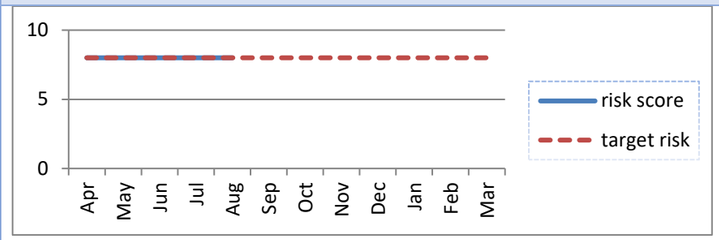
		action plans monitored by the Quality Governance and Assurance Team. Operation plan PSIRP next due for update Qtr3. PSIRF Plan and Policy completed. PSIRF plan now available on external Trust website and fully embedded with ongoing monitoring continuing and reported through Patient Safety Committee. Joint review of PSIRP with Barnsley being presented at joint ETM 06/08/2025	Annual Review November 2024 Joint ETM August 25						
C3	Mortality and Learning from Deaths	Reports detailing the completion rates and timeliness of SJRs remain as a standing agenda item at the Bi-Monthly Trust Mortality Group (TMG). All SJRs with a Poor Care or judged to have been preventable are logged as incidents on Datix. Following closure the Lessons Lean and Actions are discussed at the TMG. All completed SJRs are sent to the Care Group Mortality Leads, those with learning points together with those added to Datix should be discussed at the respective CSU Clinical Governance Meeting. Compliance for this is being reviewed twice yearly. QI review to thematic analysis to identify quality improvement priorities. Quarterly distribution to Care Groups. The SHMI continues to be monitored through the Trust Mortality Group. The response to any Diagnosis Groups Alerts, continue to be managed this Group. The reporting of the above is included in the quarterly Learning from Death report, which is reviewed at the Patient safety Committee, Quality Committee and Board.	March 2025 November2024 June 2025 QC - May 2025 June 2025	CEC QC Board	L1				Medical Director
C4	Ongoing monitoring of the effectiveness of the Clinical Effectiveness Strategy by the Clinical Effectiveness Committee.	The Care Groups report details of their Clinical Audits, Getting it Right First Time Programme (GIRFT), National Clinical Audits - Quality Accounts (NCAPOP & Other) relevant NICE guidance, National Confidential Enquiries into Patient Outcomes and Deaths studies (NCEPOD) to the Clinical	November 2024 March 2025	CEC QC	L1				Medical Director

		Effectiveness Committee. There is a Clinical Effectiveness Committee Report at the Quality Committee on a quarterly basis							
C5	Ongoing monitoring of Patient Experience through a variety of sources to ensure we are providing the best possible care and experience for our patients.	Monthly text surveys to a proportion of discharged patients asking questions related to lowest scores on most recent national survey. Results and actions will be presented to Quality Committee in quarterly Patient Experience Report	November 2024 QC September 2024	QC	L1				Chief Nurse
		Friends and Family Test offered to all patients. Results shared with Care Groups on a monthly basis and reported at Patient Experience Committee and Quality Committee quarterly	May 2025	QC	L1				Chief Nurse
		Report on Complaints including volume, themes and learning reported at Patient Experience Committee and Quality Committee quarterly	May 2025	PSC QC	L1				Chief Nurse
		Monitoring of PALs Key Performance Indicators through Patient Experience Committee and Quality Committee quarterly Results of 4 national surveys (inpatients, UECC, maternity and CYPS) now published by CQC. Improvement plans developed and progress monitored quarterly through Patient Experience Committee and Quality Committee New national neonates' survey to commence2025, dates to be confirmed.	May 2025 November 2024 - public - Inpatients Q1 25/26 - currently under embargo, UECC Nov24, Maternity Nov24. CYPS Published May 2025	In 2025	L1				Chief Nurse
C6	Three Quality Priorities have been agreed for 2025/26	Rolling monthly update report to Quality Committee resulting in an update being received for each priority quarterly. Template provides data in SPC format, supported by Qi, Effectiveness and Data Analysis teams. `	July 2025 Q1 - Q2 2025/26	QC QC	L1 L3				Chief Nurse
C7	Seek External Assurance to triangulate with internal assurance data	Quarterly reports on progress against self-assessment by Care Groups to Quality Governance & Assurance Group reported through Patient Safety Committee, Medication Safety Committee and Quality Committee quarterly	QC - July 2025	QGAG PSC QC	L2				Chief Nurse
		External body reports such as from NHSE or inspections	July 2025	SC QC	L3				Chief Nurse

		reported to Quality Committee via the appropriate sub group on quarterly basis								
		Quarterly Safety, Experience or Effectiveness reports to Quality Committee to provide updates on any partnership working with BDGH and details of associated actions. Meeting arranged July 2025.	February 2025	QC	L2				Chief Nurse	
		Annual audit reports commissioned within the Quality domain following agreement of Audit & Risk Committee received at both ARC and Quality Committee with action plans monitored to completion. Audits include Internal Audit of Clinical Audit and Nice Implementation, Safeguarding and Medication Safety. Safeguarding and Medication 360 audits completed	January 2025 ARC April 2025	QC	L3				Chief Nurse	
Gaps in Controls or Assurance Quarter 1 2025-26		**Actions Required**	**Action Owner**		**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Need for Quality Strategy to be approved and implemented	Quality Strategy due at QC June 2025 and Board of Directors July 2025.	Chief Nurse		January 2025				Update to QC and Board every six months - December 2025 QC and January 2026 Board. Approved Strategy, implementation ongoing.	
G2	Lack of assurance regards quality of end of life care	Completion of action plan that has been created in response to 360 assurance report and NACEL 2022 alarm outlier status report Strategy went to May 2023 Quality Committee and Board of Directors September 2023 Recruit additional palliative care consultant	Medical Director and Chief Nurse Medical Director		January 2023 September 2023 July 2024	~~May 2023~~ September 2023 May 2023 February 2025			Action plan created and shared internally and with external organisations Awaiting completion of NACEL and 360 audit action plan. NACEL to be four times per annum from 2024 NACEL 2024 has commenced, new Lead Nurse for End of Life now in post Paper to ETM regards restructure of team approved and End of Life will now sit Corporately - December 2023 NACEL to change to a rolling programme of audit All actions Completed - not archived as rolling programme The situation is ongoing and improving, awaiting a full year of improvement work and full report. Consultant Post recruited into, awaiting commencement into role - ~~interviewed and offered post~~ recruited and awaiting start date.	

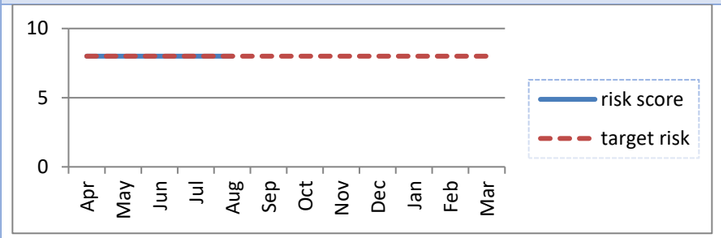
								Exec Team to Exec Team meeting TRFT and Rotherham Hospice held in January 2025. Commenced work with Barnsley to implement a peer review process. First domain to be reviewed is end of life care in Qtr2. Reporting to QC in October 2025.	
G3	Seek External Assurance to triangulate with internal assurance data	NHSE invited to undertake an appreciative inquiry into Adult Safeguarding. Report and any associated action plan will be presented to Safeguarding Committee and Quality Committee	Chief Nurse	**April 2024**	October 2024			Report complete and plan to be presented at next Safeguarding Committee November 2024 Awaiting report - Chief Nurse escalated to Deputy Nurse Director NHSE.	
		Benchmarking Data will be reviewed to enable relevant services to compare quality and learn from exemplar organisations. Reporting will be through relevant subcommittee and to Quality Committee quarterly. Reports to include increased comparison of data with external organisations and all associated actions.	Chief Nurse	**July 2024**	May 2025			Initial discussions have taken place between TRFT and Barnsley to look at commencing a peer to peer process in QI.	
		Commenced work with Barnsley to implement a peer review process. First domain to be reviewed is end of life care in Qtr2. Reporting to QC in October 2025.	Chief Nurse	**May 2025**					
G4	Qi work themed from Mortality	Work to be developed.	Medical Director/Head of Quality Improvement	**April 2024**	April 2025			To include as agenda item at QC February 25 and April 2025 Board	
G5	Medicines Management Limited Assurance at 360 Assure internal audit	Development and completion of action plan which will be monitored through the Medication Safety Committee and the QC	Medical Director	**May 2025**				Plan has been developed and is now being monitored through the MSC. New Chief Pharmacist started 20 January 2025 - Actions in progress and nearing completion.	
G6	CDiff rates	Development and completion of an antimicrobial action plan. Action plan reported on a quarterly basis through the Quality Priorities	Chief Nurse	**April 2025**	July 2025			For further development. Rates have started to plateau over last few months. Policies in process of review. Identified as a Quality Priority for 25/26. Meeting happened with external partners in Feb 25 to expand key actions for 2025/26.	
G7	360 Audit Care Group governance with a focus on PSIRF governance	Just agreed ToR for 360 Audit, to commence Q4	Chief Nurse/Medical Director	**Action plan completion due October 2025**				To be agreed at ARC April 2025 360 Assure Significant Assurance audit opinion - Gap closed pending action plan completion.	
G8	Need to recruit Patient Safety Partners	Scoping works to be undertaken in Qtr 1. Linked to C2 operational plan due for update November 2025	Chief Nurse	**May 2025**					
G9	Uncertainty around industrial action	BMA ballot 08/07/2025, nurses likely to ballot	Chief Nurse/Medical Director					First IA took place last week July 25 - impact being assessed.	
Archived Controls within month- Completed									

Archived Gaps within month - Completed									

Strategic Theme: Patients		**Risk Scores**										
		BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**	**Board Assurance 2025-26**				
Strategic Ambition: **Rotherham:** ***We will be PROUD to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve.***		**R2**	**2(L)x4(C)=8**	**8**	**2(L)x4(C) =8**	**SEEK**		**Previous score Q4 2024-25**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: R2: Ensure equal access to services								**8**	**8**	**8**		
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks**				**Assurance Committee**	
R2: There is a risk that we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities							**Risk**				**Trust Board Managing Director**	
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*		**Date Assurance Received**	**Confirmed By:**		**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*					
C1	TRFT is a member of a number of partnership meetings including: Place, Health and Wellbeing Board and Rotherham Together Partnership.	Trust Board receives reports from these key meetings, and there are weekly updates into Executive Team on Place.		**September 2025**	Board minutes		Level 1				**Control remains ongoing**	
C2	TRFT is developing its approach to reducing HI's including appointment of Public Health Consultant and production of a plan.	There are a number of examples of projects focused on reducing health inequalities. A presentation on progress is planned for October Board. For discussion on progress of objectives. Weekly updates to Executive Team		**September 2025**			Level 1				**Control remains ongoing**	
C3	Improved Board insight into Place through Board development session	Presentation delivered ib February 25, further paper with recommendations to following May 25 from Managing Director		**February 25**			Level 1				**Control remains ongoing**	
C4	**Archived - see version BAF R2 - Rotherham Version 4.1 Quarter 4**											
C5	**Archived - see version BAF R2 - Rotherham Version 4.1 Quarter 4**											
C6	**Archived - see version BAF R2 - Rotherham Version 4.1 Quarter 4**											

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

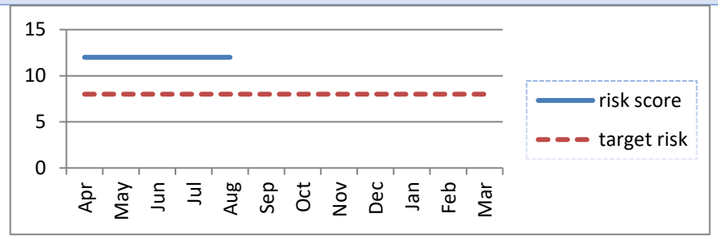
G1	Ethnicity details not on all electronic systems	Public Health Consultant identifying and working on solution. A working group has been established including the Public Health Consultant and the Director of Health Informatics	Managing Director	Ongoing	~~End of Quarter 1~~ End Quarter 4			Reporting improved so performance can be broken down by ethnicity as well as other protected characteristics	
G2	Non-elective activity continues to increase with a disproportionate number of people from higher deprivation areas attending UECC and more likely to be admitted	Working with Place colleagues on Place priorities including: Community Services review and the UECC plan (Rotherham and National)	Managing Director	Ongoing	End of Quarter 4			Ongoing with regular updates to the Board	
G3	Lack of a definitive Trust plan to support the reduction of HI's	A plan is in development linked to other key strategies including quality, performance and delivery. Being presented at October 25 Strategic Board forum.	Managing Director	End of Q1					
G4	Uncertainty around future commissioning and system support at PLACE level due to the proposed changes to ICB and NHSE as outlined in the NHS 10 Year Plan. Could lead to disruption to service and financial flow.	Work with partners to ensure service continuity at the Place level. Consultation process starting with ICB staff and workshop planned for the end of August 2025 to discuss progress and implications with partners. Full update taken to July Board session with further updates to follow. Place update to September 2025 Board.	Managing Director	Q2	End of Q3				
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

Strategic Theme: Patients	Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2025-26				
Strategic Ambition: **Our Partners: *We will be PROUD to collaborate with local organisations to build strong and resilient partnerships* that deliver exceptional, seamless patient care.**	**O3**	**2(L)x4(C) = 8**	**8**	**2(L)x4(C) =8**	**SEEK**		**Previous score Q4 2024-25**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***O3: Our Partners: Work together to succeed for our communities.***							**8**	**8**	**8**		
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**				**Assurance Committee**	
O3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.						**Risk**				**Audit & Risk Committee and Trust Board** **Chief Executive & Managing Director**	

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		Assurance Received *(what evidence have we received to support the control)*	Date Assurance Received	Confirmed By:	Assurance Level *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*				
C1	The Trust is a member of the South Yorkshire & Bassetlaw Acute Federation and executives contribute to all meetings	Reports received by the Trust Board every two months from Chief Executive Report. Weekly updates to Executive Team.	**September 2025**		Level 1				
C2	Existing collaboration with Barnsley on some clinical services. Board to Board, Joint Strategic Partnership and Joint Executive	Gastro service up and running, Haematology service in progress MEOC now embedded. Meetings of the Strategic Partnership every quarter, Monthly for Delivery Group.	**September 2025**	**Reports to Boards on progress**	Level 1				

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

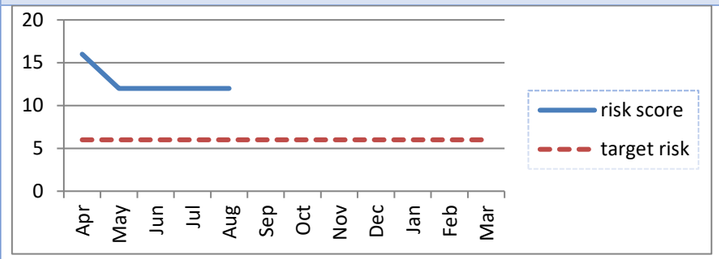
BAF Risk U4

Strategic Theme: Us	**Risk Scores**										
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**	**Board Assurance 2025-26**				
Strategic Ambition: **Us:** ***We will be proud to work in a compassionate and inclusive organisation that delivers excellent healthcare for patients.***	**U4**	**3(L)x4(C)=12**	**3(L) x 4(C) = 12**	**2(L)x4(C) =8**	**Seek**		**Previous score Q4 2024-25**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***P3: Supporting our People*** ***P2: Improve engagement with our medical colleagues***							**12**	**12**	**12**		
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK7338, RISK6888, RISK7182 and RISK6723**				**Assurance Committee**	
U4: there is a risk that we do not create and maintain a compassionate and inclusive culture which leads to an inability to retain and recruit staff and deliver excellent healthcare for patients										**People Committee Director of People**	
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*						
C1	People & Culture Strategy 2024-2027	There will be a Year 2 review presented to the P&CC. Year 1 review presented to P&CC in April 2025.	April 2026	P&CC Oct24	Level 1						
C2	Integrated EDI (Equality Diversity Inclusion) Plan	Current Board approved plan published and on website, was refreshed for November Public Board 2024. EDI plan 2024/27 underpins WRES and WDES signed off at Board EDI plan update to be presented with WRES and WDES TO Board November 2025.	EDI Plan to P&CC in October 2025 and Board November 2025	Board Nov24	Level 1						
C3	Delivery of the People Promise – staff experience	Review progress against the Trust 'We said we did' plan 2025/26 in October 2025. Care Groups to present progress on their 'We said we did plans' at their P&CC presentations.	October 2025 and April 2026 At Care Group P&CC presentations	P&CC Oct 24 Ongoing confirmation from Care Groups	Level 1						

		Regular Corporate Bulletins sent via Communications. June 2025 launched trust wide 'we said, we did' 2025/26. NHS Staff survey outcomes and 2025/26 People and Culture objectives will go to People and Culture Committee and then the March 2026 Board of Directors.	P&CC February 2026 Board Mar26		Level 3				
C4	Health wellbeing and attendance work	Deep dive presented to ETM and P&CC in April 2025 and provided assurance on overall approach. 360 audit gave limited assurance on how managers manage long term sickness, audit currently being rerun Qtr 1 2025/26 Health and Wellbeing Programme established with 5 working groups supporting work. Update in Qtr 2 to September 2025 P&CC Contract awarded and go live September 2025 for Occupational Health contract. Monthly sickness absence performance provided to P&CC at every meeting.	April 2025 Quarter 2 2025/26 Quarter 2 2025/26 April 2025	P&CC Feb25 and Apr25 updates Sep/Oct 25 P&CC Sep/Oct 25 P&CC	Level 1 Level 2 Level 1				
C5	Development of the Trust Workforce Plan	Existing Workforce Plan in place. New Trust Workforce Plan under development and to be presented to Board Qtr 2. Board strategy discussion Qtr 1 2025/26. Monthly turnover performance data provided to PAA at every meeting	June 2025 P&CC and July 2025 Board - approved April 2025		Level 1				
C6	Joint Leadership Programme	Programme complete Value Circle completed programme of work, formal evaluation and feedback awaited.	October 2024 P&CC		Level 2				

Gaps in Controls or Assurance Quarter 1 2024-25		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Challenges around sufficient workforce to support the recovery plan and	High level risks from Care Groups regarding exceptional workforce challenges monitored via P&CC.	Divisional Leads & FPC	As per each risk, further details can be found in the P&CC Risk Report				This Gap relates to three outstanding risks rated at 15 or above, please see Risk Report for further details:	

	mitigate industrial action.	Care Group 1 Care Group 2 Care Group 3 Care Group 4 Corporate Services Unexceptional workforce challenges are managed by the Care Group Management with risks escalated via Care Group Governance Committees and on to Risk Management Committee if rated 15 or above. No Industrial action at this time, but situation monitored, resident doctor action on pause currently.						Care Group 1 - Risk 6692 - Inadequate Nursing Establishment in the UECC - rated at 16 Corporate Services - Risk6888 - Lack of clinical psychology support for all services for which it is required. Rated 15 All Care Groups and Corporate Team - Risk7338 - New National Job Profiles for B4-9 - rated at 16 Paper taken to June 2025 P&CC.	
G2	Joint Leadership Programme	Programme of work to be completed with feedback report						Formal evaluation and feedback awaited	
Archived Controls within month - Completed									
Archived Gaps within month - Completed									
G3	Development of the Trust Workforce Plan	Development of Plan for approval in Quarter 2 2025/26.		Director of People			Completed		

Strategic Theme: Delivery		Risk Scores											
		BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2025-26					
Strategic Ambition: ***Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation***		**D5**	**4(L)x3(C)=12**	**5(L)X3(C)=15** **4(L)X3(C)=12** ~~**Recommend to reduce in line with performance against trajectories**~~	**2x3=6**	**MINIMAL**		**Previous Score Q4 2024-25**	**Q1**	**Q2**	Q3	Q4
Link to Operational Plan: ***D5: To deliver 4 hour performance in line with the Trust's trajectory and 78% by March 2026, to deliver the national standard for reducing long-waiting patients and increasing RTT performance by 5% and consistently deliver the Cancer Faster Diagnosis Standard.***								**15**	**12**	**12**			
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks**				**Assurance Committee & Lead Executive Director**		
D5: There is a risk we will not deliver our performance priorities (*Urgent Care, Elective Recovery and Cancer*) because of insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.							**RISK6762, RISK6888, RISK7084, and RISK6801 (currently rated at 12)**				**Finance and Performance Committee** **Director of Finance & Chief Operating Officer**		
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*		**Date Assurance Received**	**Confirmed By:**		**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*						
C1	**PERFORMANCE:** Care Group Performance meetings chaired by the Deputy CEO.	Performance Meeting minutes and chairs logs Monthly reports within IPR to Finance and Performance Committee and Board Care Group Performance meetings with each CSU		**July25** **July25 IPR**	**Minutes** **Chair's Log**		Level 1						Managing Director
	PERFORMANCE: Executive Team oversight via IPR	Weekly receipt of Performance IPR		**Aug25**	**ETM minutes Weekly** **ETM minutes Weekly**		Level 1						Weekly Executive Team Meeting Managing Director
C2	**URGENT CARE:** Monitoring waiting	Monthly TRFT Urgent Care Meeting		**Aug25**			Level 1						COO

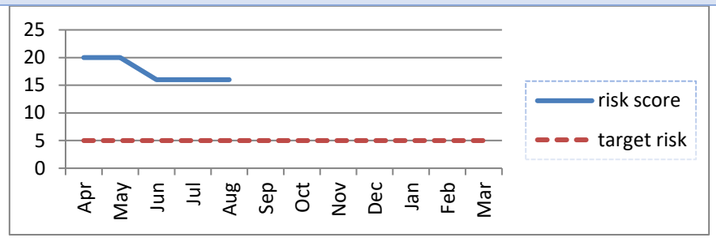
	times of patients in UECC	Metric included in the Integrated Performance Report Weekly report to ETM Daily review of position and weekly through the acute care performance meeting and ETM Weekly 4 hour performance emergency care target meeting chaired by COO. Waiting times have improved in UECC and monitored against trajectory		**Minutes of F&P** **ETM minutes** **ETM minutes** **ETM minutes** **Action log** **Daily performance report**					
	URGENT CARE: Monitoring Criteria to reside and Length of Stay data	Monthly TRFT Urgent Care Meetings Monthly reports to Finance and Performance Committee and Board Weekly Length of Stay reviews including Care Group Director Escalation meetings with external partners. Action plan in place in relation to recommendations in patient flow audit	**Aug25 IPR** **Aug25 IPR** **Aug25 IPR**	**Minutes of Urgent Care Meeting** **Weekly ETM minutes** **Weekly ETM minutes**	Level 1 Level 3 - 360 Assurance audit report Patient Flow – Limited assurance – action plan in place				COO
	URGENT CARE: Admission avoidance work remains ongoing	Acute Care Transformation Programme - monthly highlight report and minutes of meetings The Rotherham Urgent and Emergency Care Group chaired by the Deputy Place Director and deputy chair COO.	**Aug25**	**Minutes of Urgent Care meeting**	Level 1				ACT Steering Group – emergency pathway workstream Medical Director Rotherham Urgent and Emergency Care Group COO
C3	**ELECTIVE:** Weekly access meetings with tracker for elective recovery schemes	Elective Delivery Group Weekly Access Meetings Care Group PTL Meetings Outpatient, Theatre & Endoscopy Transformation Programmes External review of Trust PH processes via FF20 Programme - feedback report received	**Aug25**	**Monthly** **Weekly** **Weekly** **Weekly** **Monthly Highlight Report**	**Level 1** **Level 3 - 360 Assurance audit report - July24**				COO Ass Director of Operations Ass Director of Operations
C4	**CANCER:** Cancer PTL	Rotherham Cancer Strategy & Performance Meeting Cancer Services Quality, Governance & Business Meeting	**July25**	**6 weekly** **Monthly**					COO Ass Director of Operations

		Cancer PTL Meetings. Cancer Improvement Programme		**Weekly** **Monthly** **Highlight Report** **FPC 1/4ly**					Cancer Manager
C5	**WINTER:** **Winter planning**	Evaluation of 2024/25 Winter Plan Development of Winter plan for 2025/26 to commence earlier Evaluation and initial draft recommendations to June ETM and FPC Draft Plan to July ETM and FPC	**ETM and FPC mins** **Commenced August 24** **To go to September 2025 Board**	**Evaluation – FPC mins May 2024**					COO Dir Ops
C6	**CYBER**	Monthly / Quarterly/Yearly Updates to Digital Transformation Committee & F&PC Yearly updates to Trust Board Internal Audit programmes with finding to audit and risk Information Governance Committee with minutes chaired by SIRO DSPTK national submissions Monthly IT Security Group, with minutes 24x7 Carecert alert monitoring by NHS England Cyber teams Annual Internal and External Penetrations test	**Feb25** **Dec25** **Mar25**	**Minutes** **Audit** **Minutes** **Minutes** **tbc**					Director of Health Informatics

Gaps in Controls or Assurance Quarter 1 2025-26		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Insufficient funding to support increased levels of non-elective demand – both attendances at UECC and emergency admissions	Discussions with commissioners re funding Admission avoidance work with partners including ICB and YAS to reduce demand. Understanding and addressing increasing demand at UECC Work commenced with ICB to renew attendances in conjunction with care access and Healthwatch to understand patient behaviour.	DoF COO					No growth funding in 25/26 contract Project Chronos focus on reducing ambulance conveyances Community mobile x-ray pilot commenced June 2025 New SDEC opened 2nd July 2025 with direct pathways in place. **Increase in use of SDEC and direct attendances**	
G2	Lack of consistent SDEC model and trolley capacity across medical and surgical SDECs	ACT programme developing consistent models of care New purpose built medical SDEC to create ringfenced capacity Bed reconfiguration to create capacity to ring-fence trolleys in surgical and gynae SDEC	COO	Q1	Q3			Pathways and protocols being developed New SDEC open and operational July 2025 Trust-wide review of bed base to support SDEC trolley capacity being developed by Dir of Ops.	

								Bed reconfiguration paper approved July FPC and to go to Board Sept 25	
G3	Insufficient validation to support robust management of waiting lists	Review of validation capacity and resource required to support increased size of waiting list and maintain requirement to meet 90% validation Standardise validation processes and embed consistent ways of working Training of existing staff to support validation of waiting list Ensure oversight through regular audits and performance monitoring	Associate Director of Operations, Planning and Performance	Q1	Q2			Review of capacity completed and draft business case developed. Business case approved at ETM to increase validation resource. Increase in validation resulting in increased removals from the waiting list, monitored weekly. Text validation and admin validation in place, training of staff has been undertaken Awareness sessions with clinical leads and clinicians at CSY level taking place in relation to Access Policy and RTT rules Recruiting to increased validation team	
G4	Challenges around sufficient workforce to support the recovery plan and mitigate industrial action.	High level risks from Care Groups regarding workforce challenges monitored via P&CC. Risk of further Industrial action - where this does take place this will be subject to regular industrial action meetings to mitigate impact.	Care Group Leads & FPC					No IA planned currently but doctors balloting and is risk this may result in IA. Resident doctors voted in favour of IA, action planned for end of July 2025. AI taken place, no further dates announced.	
G5	Insufficient anaesthetic workforce to support elective recovery	Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the care group	Chief Operating Officer Care Group 2 Leadership team					Initial review of workforce has taken place, with support from national Clinical leads via GIRFT, with workforce plan in development Recruitment to additional Anaesthetic Consultant and new Specialist posts Insourced support in place as interim measure/mitigation Recruited to anaesthetic consultant post	
G6	Financial investment/resources to support recovery of waiting lists	Financial allocation identified in plan for 2025/26 – risk in allocation of ERF given overall financial position	Chief Operating Officer DoF					Plan and process for agreeing additional sessions in place for recovery schemes and investment in line with ERF allocation in 2025/26 plan	

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

Strategic Theme: Us	Risk Scores											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**	**Board Assurance 2025-26**					
Strategic Ambition: Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation.	**D8**	**5(L) X 4(C)=*20***	***~~5(L) X 4(C)=20~~*** ***4(L) X 4(C)=16***	***1(L)x4(C) =4***	***CAUTIOUS***		**Previous Score Q4 2024-25, as D8**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: D9: To deliver the financial plan for 2025/26 reducing our cost base and delivering a balanced financial position. Embed a multi-year approach to financial sustainability, delivering year one of this requirement in support of a recurrent balanced position.							**20**	**16** ⇩	**16** ⇨			
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks** **RISK7341, RISK7338 and RISK6801**				**Assurance Committee**		
D9: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2025/26 leading to further financial instability.						**Risk**				**Finance and Performance Committee** **Director of Finance**		

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*
C1	Improvement of clinical productivity to levels experienced in 2019/20 without central funding for outsourcing clinical activities	Monthly Elective Programme Meeting chaired by Chief Operating Officer	**July25 Board**		Level 1
C2	CIP Track and Challenge in place		**July25 Board**		Level 1
C3	Contingency of £3m in place.		**July25 Board**		Level 1
C4	Winter funding allocated in reserves of £1.2m.		**July25 Board**		Level 1
C5	Elective recovery fund in place		**July25 Board**		Level 1
C6	Financial plan submitted to NHSE by 30/06/2025	Submitted on time, still awaiting sign off by NHSE	**July25 Board**		
C7	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee	**July25 Board**		Level 1

C8	System wide delivery of Recovery On plan with mitigations in place to manage winter pressures.	Director of Finance attends South Yorkshire DoF Group	**July25 Board**		Level 1					
		Monthly Finance Report to CEO Delivery Group	**July25 Board**		Level 1					
		South Yorkshire Financial Plan Delivery Group			Level 1					
C9	Suitably qualified Finance Team in place	Team in place			Level 1					
C10	Established Capital Monitoring Group	Capital and Revenue Plan signed off by Board	Mar25							
C11	Current Standing Financial Instructions in place	Reviewed and approved by Board			Level 1					
C12	Internal Audit Reports	Internal Audit Financial Reports			Level 3					
		Review of HFMA Improving NHS Financial Sustainability checklist			Level 3					
		360 Assure Head of Audit opinion presented to Risk and Audit Committee initial indications show Significant Assurance overall			Level 3					
C13	Monthly challenge on performance	Monthly Divisional Assurance meetings	Aug25							
C14	Clarity on Financial Forecast	Financial forecast based on June financial position. Director of Finance in process of agreeing financial recovery plans with each accountable officer – these will be fed into monthly assurance meetings.			Level 1					
C15	Deloittes review of South Yorkshire system including investigation and intervention work.	I&I report finalised and presented to Senior Leadership Executive for South Yorkshire highlighting areas for improvement	August 24		Level 3					

Gaps in Controls or Assurance Quarter 1 2025-26		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Adherence to expenditure Run Rate as per financial plan	Monthly budget reports. Expenditure profile produced monthly throughout year. Reserves Policy in place. F&PC oversight. Internal audit systems budgetary control audit. External audit annual accounts.	Director of Finance	Q1	Ongoing				
G2	Potential reduction of cash balances due to expenditure higher than income which would result in late payments to suppliers. Impact to	Situation acceptable currently, future risk	Director of Finance					For Gaps G4-G7 awaiting further national guidance to fully assess the position.	

	invest in capital projects.								
G3	Increased cost improvement programme due to national reductions in funding to the South Yorkshire allocation linked to funding formula suggesting South Yorkshire is overfunded.	Future income risk	Director of Finance						
G4	Financial forecasts come to fruition	Monthly check and challenge with relevant Divisions and Corporate areas.	Director of Finance						
G5	Continuing industrial action leading to increased financial outlay in order to cover medical and clinical shifts. Also linked to challenges around sufficient workforce to support the recovery plan (including industrial action).	Regular industrial action meetings to mitigate impact. Finance team are currently working on a cost per day figure for future forecasting.	Director of Finance.	Reports to F&PC				Resident doctors voted in favour of IA, action planned for end of July 2025. AI taken place, no further dates announced, but unresolved further actions. NHSE advice that there is no funding for any impact experienced and this should be managed by individual trusts.	
G6	Additional bed capacity as a result of increased non elective demand, which is non-funded due to block contract arrangements.	External support through Place to control demand on non-elective pathway.	Managing Director						
G7	Deficit support funding now predicated around delivery with c£4m risk if system does not deliver.	Trust on track but likely not to get share as system off plan. 1) NHSE expect Trust and system to be on plan by month 5. 2) NHSE expect full identification of efficiency plan with no high or unidentified risks by month 5 for the Trust.	Director of Finance.	Reports to F&PC					
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

Board of Directors
5th September 2025

Agenda item	P132/25
Report	**Risk Register Report (including Corporate Risk Register)**
Executive Lead	Peter Walsh, Interim Director of Corporate Affairs
Link with the BAF	The following paper links with all BAF Risks.
How does this paper support Trust Values	This paper supports the Trust Value of 'Together'
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Summary (including reason for the report, background, key issues and risks)	This report provides an update to the Board of Directors for the review of all risks scoring 15 and above in addition to management information in relation to all open risks rated 8 and above. Key highlights include: **Overview:** The Trust currently has 239 approved risks rated between 8 and 25. Of these, 16 are high-rated risks (15–25) that have been approved by the Risk Management Committee. The report focuses on compliance with review dates, the status of action plans, and emerging risks that may affect the Trust. A review of the Corporate Risk Register was undertaken on the 26th August 2025 including the Chief Executive and other Executive Directors. The Chief Nurse and Corporate Affairs team have since undertaken a number of meetings with various risk owners in order to improve the clarity of risk descriptions and action plans. There will be increased scrutiny of these risks at future Risk Management Committee meetings and this will also revert to a face to face meeting in order to encourage increased participation of the Committee members. **Digital Innovation:** The integration of Power BI into the risk reporting process has delivered measurable efficiencies, notably a 50% reduction in time spent on data formatting and analysis. The Corporate Affairs team is collaborating with Health Informatics to develop dashboards that will support improved visibility and oversight of risk data. Engagement with Care Groups is planned to ensure the dashboards meet operational requirements and support strategic governance. **Risk Review Compliance**: Compliance with risk review dates currently stands at 83%. Corporate Services has the lowest compliance rate at 72%, while Care Group 3 demonstrates the highest at 95%. Risks overdue for review are being actively followed up by Corporate Affairs with relevant risk owners and governance leads.

	Action Plan Oversight: Enhanced scrutiny has been applied to action plans, particularly those marked as complete without corresponding risk rating reductions. Overdue action reminders in Datix and the development of a Power BI dashboard are supporting more effective monitoring. **Issues Register**: The updated Issues Register captures operational challenges requiring active management, including the ASU trolley area's impact on surgical SDEC operations. The report affirms that the Trust continues to embed a culture of proactive risk management, with ongoing efforts to ensure timely reviews, effective mitigation, and strategic oversight of emerging and high-impact risks.
Due Diligence	All risks scoring 15 and above have been presented to and approved by the Risk Management Committee. The relevant risks are presented to the appropriate Board Committees, Executive Team Meeting and finally the Board of Directors.
Board powers to make this decision	The Trust Board of Directors are required to have oversight of the Trust's risk management processes.
Who, What and When (What action is required, who is the lead and when should it be completed?)	Once presented, the Director of Corporate Affairs, as Executive Lead will continue to ensure that risks are appropriately identified, recorded, reviewed and managed.
Recommendations	It is recommended that the Board of Directors: • Note the content of the report; • Note the ongoing work carried out to further strengthen the risk register
Appendices	Appendix 1 - Trust Risks Rated at 15 and above

1. Introduction

1.1 This report to the Board of Directors is to provide assurance that the Care Groups are considering their risks, issues and emerging risks. The following information provides an update to the committee for the review of all Approved risks rated at 8 or above, there is also Appendix 1 which details all risks rated at 15 and above. The data analysed within this report was exported from Datix on 19th August 2025; any updates or changes subsequently within the database, may not be recorded in this report. Please note, regarding the data and graphs found relating to 'All Trust Risks', these risks have been approved at Care Group level not all have been considered or approved at the Risk Management Committee (RMC). This data includes all risks rated between 8 and 12 which are discussed and approved at Care Group Governance meetings.

1.2 As at 19th August the Trust had a total of 239 Approved risks recorded on Datix, these are risks rated between 8 and 25, as follows:

High Risks: rated 15 - 25 and RMC Approved: = 16

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

Moderate Risks rated 8 - 12 and Care Group Approved = 223

Low Risks: Controlled/Managed Risks: rated 1 - 6 = 384

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

2. Digital Innovation - Datix & Power BI

2.1 Despite being the core risk reporting system, Datix has usability challenges with risk data export and formatting, leading to excessive staff time spent on report preparation and inconsistent outputs across departments. This impacts

governance, timely risk escalation, and compliance, as staff are diverted from strategic reviews and improvement actions.

2.2 With Power BI already used for quality metrics and its integration of AI capabilities, there is clear opportunity to streamline and standardise risk reporting. The Corporate Affairs team has been working with the Director of Health Informatics to develop a Power BI dashboard aimed at enhancing the efficiency of the risk management function. This initiative focuses initially on reducing the time required for data formatting and analysis in reporting processes, with a longer-term goal of establishing a more accessible platform for overall risk reporting and risk themes and trend analysis.

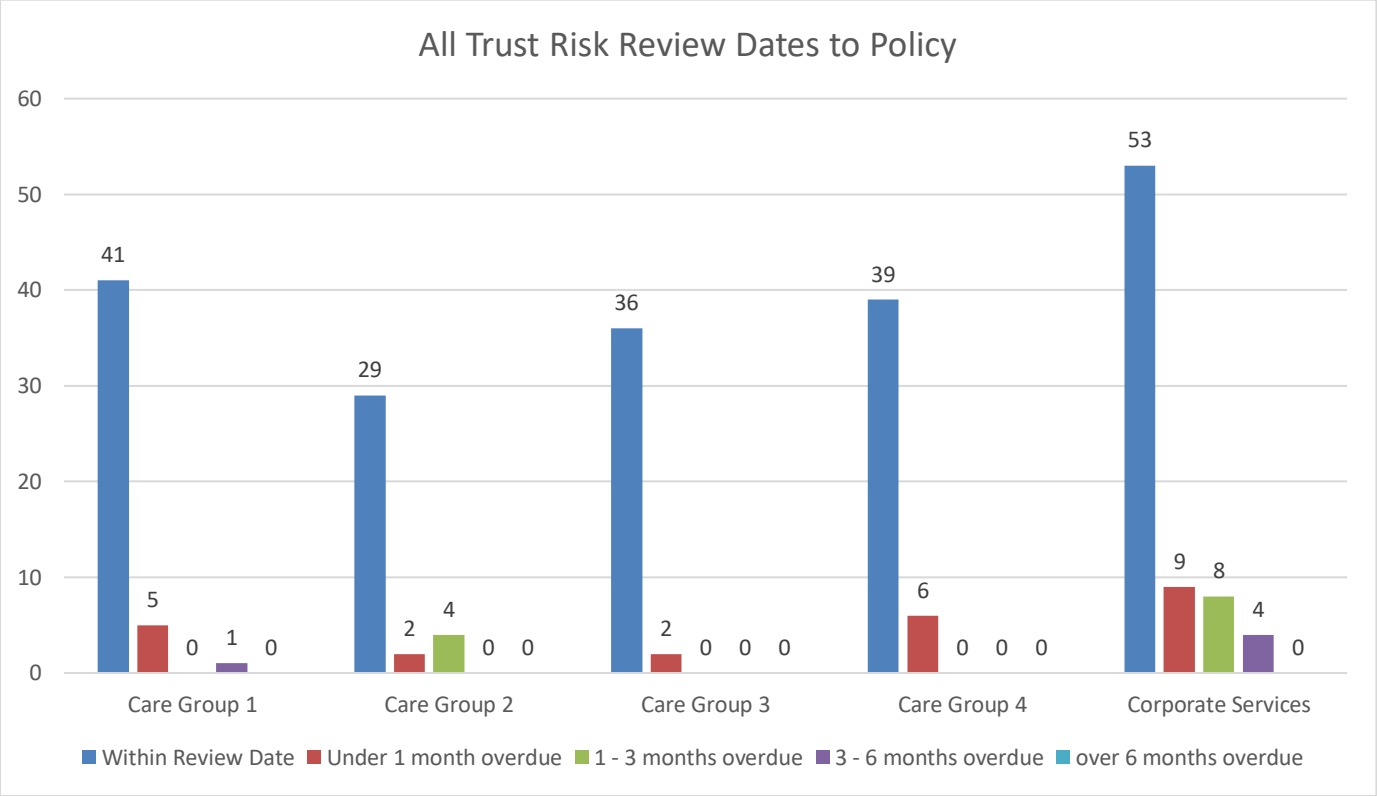
2.3 Efficiencies are already being reported and evidenced. For example, the data exported for this report was retrieved via Power BI, reducing data formatting and analysis time by 50%.

2.4 The next steps will be to engaged with key stakeholders in the Care Groups to gain further perspectives on Power BI and risk report requirements, to develop and share risk management dashboards. This collaborative approach would help shape and refine process improvements and monitor their effectiveness over time.

3. Risk Review dates

3.1 In terms of compliance with risk review dates, the graph below shows all risks rated at 8 and above for all Care Groups. This graph is to provide the Board of Directors with a view regarding the current Trust position for the management and review of risks. In accordance with the Risk Policy review dates are as follows:

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



3.2 Trust-wide compliance with risk review dates currently stands at 83%, showing a 5% decline comparing July's reporting (88%). Corporate Services has the lowest compliance at 72% and Care Group 3 leads with the highest compliance rate at 95%.

3.3 There were 5 risks out of date for review over three months and 12 risks that were out of date for review for between one and three months; these will be followed up directly with risk owners and governance leads by Corporate Affairs. 24 risks were overdue by less than 1 month, most likely due to annual leave hotspots.

4. Risk Action Plans

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

4.2 Efforts continue to strengthen this aspect of risk management with further scrutiny on areas of action plans that need to be addressed:

- Individual actions within an action plan that are overdue of completion

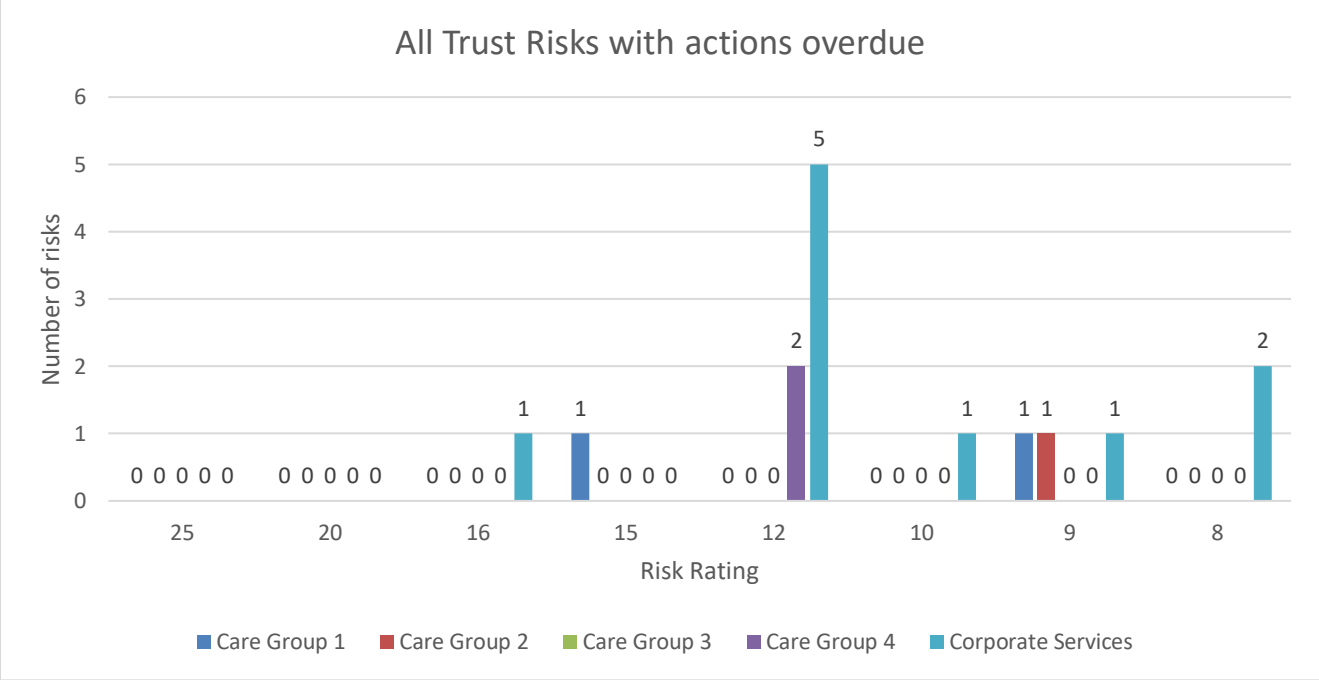
date with no recorded escalation.

- Risks with action plans that are recorded as complete, however there is no reduction of rating, closure of risk or a record of additional action to mitigate the risk

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

4.3 Overdue Actions

The graph below includes the data on risks with action plans only. All of these risks have action plans, however one or more individual action has been found to be out of date.



4.4 There are currently two High Rated risks across the four Care Groups that have individual actions that are overdue for review as per policy. Further details can be found in Section 4.5.

4.5 Care Group 1

Risk 6969, the risk relates to the lack of joined up IT (investigations/imaging going to wrong clinician) and is rated at 15. There is an overdue action (due end of June) in relation to the progression of electronic referrals across care groups and specialties, for which there have been challenges in the

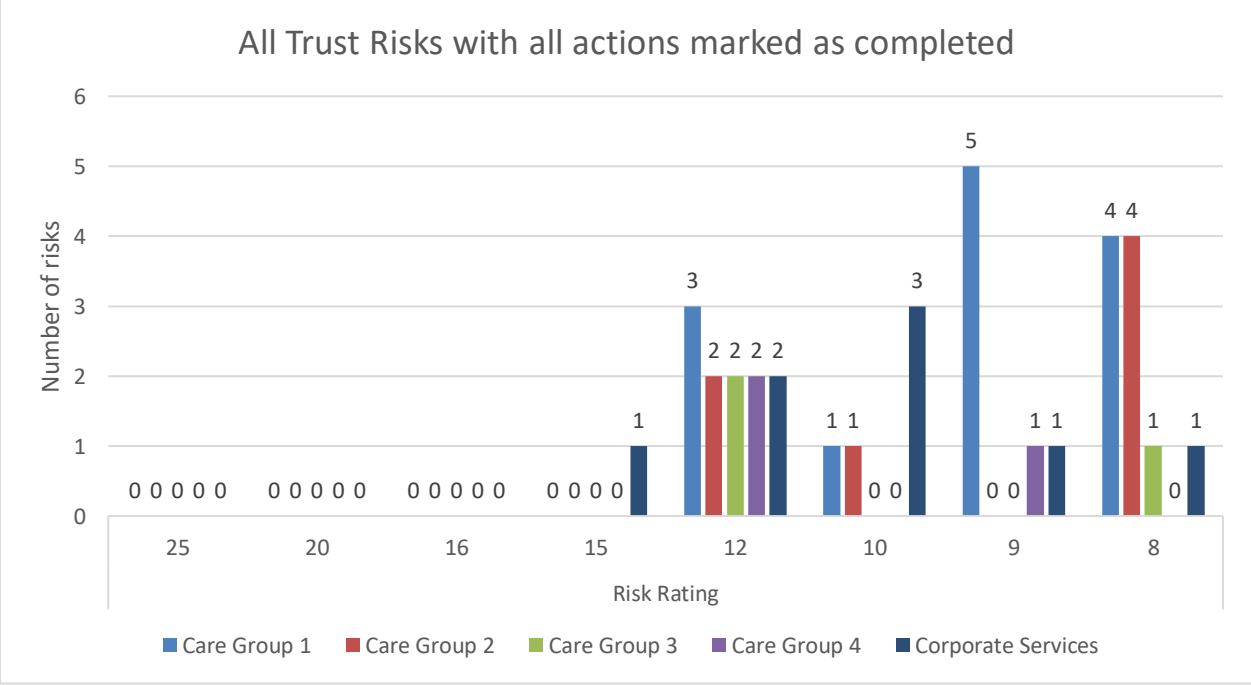
inability to generate alerts to specialty DECT phones. It is part of ACT work stream 6.

Corporate Services

Risk 7338, in relation to the nursing and midwifery Band 4-9 national review is rated 16 and has an action overdue. There is extensive work in progress as reported to June People and Culture Committee; this needs to be reflected in Datix and the Corporate Affairs team will work with the Deputy Chief Nurse to update the entry.

4.6 All actions closed

The graph below includes the data on risks with action plans only. All of these risks have action plans, however, all individual actions have been marked as complete with no subsequent reduction in rating or risk closure.



4.7 There is one High Rated risk across the four Care Groups that have all individual actions marked as complete, further details can be found below in section 4.8.

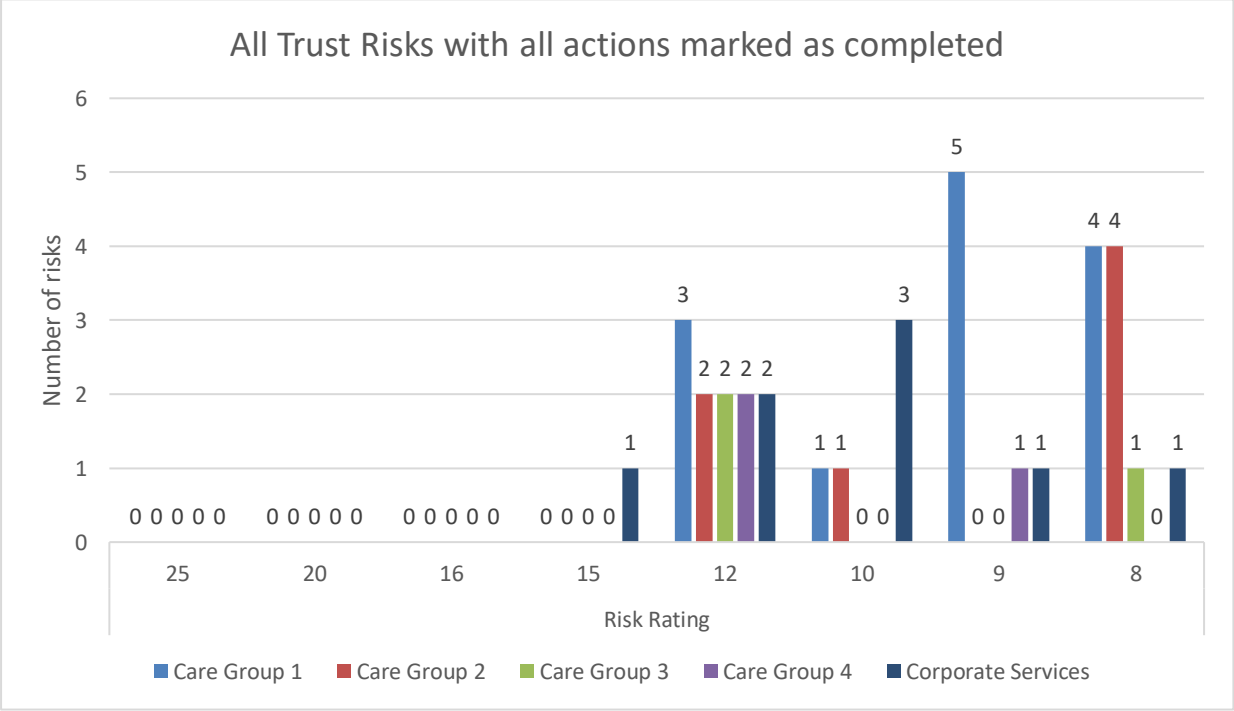
4.8 **Corporate Services**

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

4.9 No Action Plans in place

The graph below details the risks with No action plan from each Care Group and their rating.

Further details on risks with no action plan can be found in section 4.12.



4.10 As can be seen there are a total of 11 Approved risks with no action plan in place. These risks have not been approved at the Risk Management Committee as they are rated below 15 and as such according to policy are managed within the Care Group Governance structure.

4.11 All Approved risks with no action plan in place

Corporate Services – Risk 7024 - Approved Personal Emergency Evacuation

Plans Not in Place

Corporate Services – Risk 6938 - Shortfall for APs in Asbestos

Care Group 1 - Risk 7357 - No manual defibrillator in RAT

Care Group 1 – Risk 7350 - Video Laryngoscopes for Critical Care Unit

Care Group 2 – Risk 7172 - Availability of OCTa - NICE guidelines

Care Group 2 – Risk 7210 – Reputational and financial risk related to medical trainee claim for back pay in Trauma and Orthopaedics

Care Group 3 – Risk 7308 - Vascular Access reduced service due to staffing levels

Care Group 3 – Risk 7388 – Room 10 monitor

Care Group 3 – Risk 7214 - Breaches within SAR's team

Care Group 4 – Risk 7345 - Cross Border Arrangements Not Formalised For Care Group 4

Care Group 4 – Risk 7324 - Current Vacancies in the Community Diabetes Nursing Service

5. Emerging Risks

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

- UK Covid-19 public inquiry and the likelihood of claims against the NHS. The inquiry is expected to conclude its public hearings in 2026, with final reports published as each module is completed. Module 1 Report – The resilience and preparedness of the United Kingdom, has been published and found that the UK's approach to preparing for a pandemic had several serious weaknesses, which affected the ability to respond effectively (UK Covid-19 Inquiry, 2024). Whilst the Inquiry does not assign legal blame, its finding could have implications for claims.
- The Assisted Dying Bill could significantly impact the NHS by potentially causing resource strain, complex ethical decision-making processes, and potential staff concerns, whilst also raising questions about whether it would lead to improved or diminished access to quality palliative care. The Bill passed its third reading in the House of Commons on 20 June 2025 and it is

now undergoing scrutiny in the House of Lords, where it must pass through several stages.

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

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

6. Next Steps

6.1 The Committee should continue to monitor and provide scrutiny to all risks and action plans as well as increased focus on risks rated at 15 or above. The attention on action plans for all risks rated 8 and above includes scrutiny on fully completed action plans to address stagnation of risks and ensure reviews consider the work completed or still required. As well as the monitoring at the RMC, attention to the risk management process can be seen in other meetings such as the Board Committees and the monthly Care Group Performance Committee.

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

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

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

Alan Wolfe
Deputy Director of Corporate Affairs
26th August 2025

Corporate Risk Register

ID	Handler	Clinical Group	Opened	Title	DESCRIPTION	Initial Rating	Current Rating	Target Rating	Date Reviewed	Review Date	Latest progress note	Status	Action Description	Action Due Date	Action Done Date
6284	Miss Lucy Broadhurst	Care Group 4 (Community, Therapies, Dietetics & Medical Imaging)	16/09/20	Cardiac Physiology Staffing Levels	There is a risk of being unable to meet all of the needs of the service. This includes not meeting performance targets, training of students and governance responsibilities. This is caused by national long term workforce shortage in cardiac physiology and echocardiology. Continual staffing shortages across all areas and delays in recruitment are all a factor as well as increased demand and no increase of resources to meet this. This is resulting in use of high cost locum staff and insourcing companies. local and national KPIs are not being met in some areas . maintaining DMO1 is challenging in echo and breaches are expected. There is a patient safety risk with patients waiting for results and ambulatory monitoring not being maintained. There is a financial risk associated with the lack of staffing with increased costs of locum staffing who's pay rates is above the capped level. there is also a reputational damage risk for any delays in diagnosis and treatment as well as the patient safety risk of devices not being monitored and conditions not being identified early.	15	15	9	27/08/25	26/09/25	27/08/2025 - 27th august 25, reviewed the risk further detail added to the description section. This will be discussed at care group governance and at the risk management committee to close this risk and open individual risks divided into each clinical area. The level of these risks will be assessed individually. Allowing for specific reflections changes in the risk status. Business case is written and awaiting approval for echocardiography staffing and a service review is underway including capacity and demand to provide accurate data which can then be reflected in the risk score and associated actions. RB professional lead	Approved	Business case to increase staffing	01/12/25	
													Maintain grassroots development using external funding schemes	31/01/23	20/06/23
													Maintain efforts to fill staffing vacancies	31/03/23	20/06/23
													Cardiology Staff recruitment	30/03/23	20/06/23
													Echo staffing	31/03/23	20/06/23
													Prioritise training and retention of students/ existing staff	31/05/23	01/06/23
													Use of Echo locums & Elective Services	31/05/23	01/06/23
													Cardiac Physiology Recruitment	31/07/24	15/07/24
													Further outsourcing July 2023	17/09/23	05/09/23
													Plan for forthcoming vacancies in Echo team	07/11/23	19/12/23
													Proactively address potential burnout in the team	10/10/23	05/09/23
													Insourcing for Echo Wait List - Health Now	29/03/24	11/04/24
													Proposal for ICS funding for Echo Coordinator	31/07/24	28/05/24
													Increase non-clinical sessions to reduce burnout	31/07/24	15/07/24
													Source Additional capacity for planned staff absence	22/11/24	27/11/24
													Source Locum Support for Non-Invasive Team	03/11/25	
													Support Admin/ Reception Team	28/11/25	
6421	Vicky Whitfield	Care Group 3 (Family Health)	31/03/21	Backlog of children waiting to be seen for assessment Child Development Centre (CDC)	Delay in assessment and formulation of a care plan for children aged 0-5yrs with additional needs. This will impact on long term outcomes including health and fulfilling educational/developmental potential. Caused by year on year Increase in appropriate referrals due to increased demand, following national trends Covid-19 Pandemic has worsened and continues to worsen the waiting lists. Resulting in increased waiting time for children to see a consultant paediatrician Increased wait for children to see the MDT for assessment Impacting on referral to social communication pathway for diagnosis of autism Limited face to face follow up and school visiting to ensure 'team around the child' approach This effects NICE compliance for diagnosis times. There has already been one formal complaint via an MP about the current waiting times.	15	15	6	27/08/25	30/09/25	08/08/2025 - Risk reviewed at risk review group on 8th August - VW updated re new pathway introduced in April and additionally funded work to reduce the backlog on the old pathway. New assessment pathway - wait times are holding steady for last 3 months at approximately 60 weeks to assessment. Old pathway - total number of children on waiting list are 633 (in July) approximately 200 less than in Autumn 2024. There has been additional resource and streamlining efforts from the team to reduce the backlog. Current waiting time is 138 weeks (originally 156 weeks). Backlog project started in June and plans to increase assessment numbers over next 6 months. Children who turn 7 while on the waiting list will remain on CDC waiting list and will be prioritised to be seen. Agreed at risk review group that the risk should remain the same with monthly reviews to confirm trajectory is continuing as expected and to update re any issues. For review risk rating at end of next quarter. work ongoing to ensure adequate numbers of assessments are completed in both pathways. All posts have been recruited into, all posts should be filled in September/October.	Approved	Support without referral Pathway	30/09/24	30/08/24
													Funding for further staff	30/11/23	02/01/24
													Psychology Funding	28/06/24	03/06/24
													Joint working with RDASH	30/07/24	25/07/24
													Letter to ICB highlighting backlog and current demand versus funded capacity.	24/10/24	24/10/24
													Outcome from SEND inspection (inspection took place w/c 30th Sept)	31/12/24	29/11/24
													Meeting with ICB re recurrent funding	03/12/24	03/12/24
													Service delivery modelling	01/01/25	29/11/24
													To introduce the new streamlined assessment pathway	31/03/25	25/03/25
													To keep parents and partners informed about the changes	30/09/25	
													To reduce the overall number of children waiting for neurodevelopmental assessment through a 2 yr backlog project funded by commissioners	31/03/27	
													Bring data/pathway information to risk review group	30/11/25	

Corporate Risk Register

ID	Handler	Clinical Group	Opened	Title	DESCRIPTION	Initial Rating	Current Rating	Target Rating	Date Reviewed	Review Date	Latest progress note	Status	Action Description	Action Due Date	Action Done Date
6888	Victoria Hazeldine	Corporate Services	23/03/23	Lack of clinical psychology support for all services for which it is required	Not meeting national recommendations for the use of psychology support for patients receiving clinical care. Currently the workforce is not reflective of the demand for psychological support therefore creating gaps in service. This is caused by lack of funding which sits across SY ICB which then relates to staff required at each organisation, as well as, lack of clinical psychology support and availability. This results in the risk to patients' physical and psychological health and the Trust being non-compliant with national recommendations.	15	15	9	10/06/25	03/07/25	10/06/2025 - Discussed at RMC 03.06.25 - VH reported that the situation had worsened due to another psychologist leaving, leading to longer patient stays and a negative impact on recovery. The committee acknowledged the ongoing funding and service delivery challenges.	Approved	Escalate Lack of Psychological support for the breast cancer patients	23/12/24	14/08/24
													Review of all services which currently require psychology support	31/03/25	26/03/25
													Identify gaps in the provision (following the review) and escalate to ICB level	14/05/25	26/03/25
6912	Gemma Cross	Corporate Services	11/05/23	Long waits within UECC for mental health patients being admitted for detention under the Mental health act	Patients with mental health conditions presenting to UECC are experiencing long waits following assessment under the Mental health act which identifies them as requiring admission to RDASH (Mental health bed). Caused by a lack of onward beds (Mental health beds) and availability of staff to review. Resulting in poor experience for patient, and long delays in rooms which may not be suitable for their needs, and potential lack of staffing resources depending on their risk to self and others. Unpredictable cohort of patients resulting in potential harm to staff and other service users.	15	15	9	27/08/25	08/09/25	04/08/2025 - Data attached regarding patients' who need a mental health assessment and then require admission to a mental health bed showing 40% wait longer than 12 hours in the service in the last financial year. Ongoing challenges with escalation when incidents do occur between TRFT and RDASH.	Approved	meet with stakeholders to discuss problems	02/11/23	20/11/23
													Arrange task and finish group with stakeholders, including RDASH, to discuss and work through pathways and escalations for patients - awaiting outcome and decision	31/10/25	
													Working with RDASH around escalations (now linked to 855)	20/12/24	03/01/25
													Review data for MH presentations that have an admission as an outcome and establish average time in service	12/08/25	04/08/25
6969	Eamon Staunton	Care Group 1 (UECC and Medicine)	18/08/23	Lack of joined up IT (investigations/ imaging going to wrong clinician)	Key Issue 1: Imaging, not being seen or delay to be seen by correct speciality /consultant. Significant increased work to sort imaging and redirect Imaging to correct Consultant and speciality. With subsequent SI and incidents arising from specialities not seeing own imaging. Caused by imaging being requested on the wrong consultant, predominately the EM consultant, where imaging is requested by another speciality, but the patient is in the UECC or was recently; and also by not all specialities adopting the electronic referral process and remaining on paper or phone calls Result 1: Delay in reviewing X-rays by correct speciality, Addendums not getting reviewed, significant work and resource in sorting X-rays by secretarial staff and clinicians Resulting in many lost hours to senior members of staff waiting on phones to give referrals, lack of audit trails and 2 PAs of EM Consultant time a week sorting this, and 2 hrs a day of secretarial time used.	15	15	6	28/08/25	26/08/25	26/06/2025 - Discussed at CSU 1 governance. updated title to better explain issues with IT, particularly with investigations and results not moving to the correct medical teams. 29/08/2025 - Advised by the Care Group management that the risk had been back through CSU1 governance earlier this week and agreed at that meeting to stay at a scoring of 20, however Care Group will pick the risk up week commencing 01/09/2025 again as an SLT and will run it through Care Group overarching governance where we will review again through that meeting, the risk will obviously be picked up through RMC as well.	Approved	escalate to deputy medical director	05/09/23	05/09/23
													Results Acknowledgement Group	02/07/24	02/07/24
													Consultant Awareness of Issue	29/11/24	02/01/25
													progression of electronic referrals across care groups and specialities.	30/08/25	

Corporate Risk Register

ID	Handler	Clinical Group	Opened	Title	DESCRIPTION	Initial Rating	Current Rating	Target Rating	Date Reviewed	Review Date	Latest progress note	Status	Action Description	Action Due Date	Action Done Date
7001	Jeremy Reynard	Care Group 1 (UECC and Medicine)	12/10/23	In ability to get patients to CT in a timely manner	There is a risk from the delay to CT for patients in the UECC which significantly and frequently impacts the ability to achieve the 4 hour target, causing overcrowding in the department, as well as the risk with delays to getting CT results. This is caused by limited nursing, escort and portering capacity, alongside the high volume of CTs that are done in UECC that should be done in specialties. This results in delays to decisions based on CT results including delays to discharge, treatment and admission, which impact on the 4 hour target, patient safety and experience. It disrupts patient flow and can result in overcrowding in the UECC. 30% of majors and resus patients undergo a CT from the UECC, half of which are subsequently discharged. Only 50% of patients get a CT result within 2 hours of request. At 3hours 25% of patients who are discharged are still waiting for a result.	15	20	8	06/08/25	26/08/25	06/08/2025 - There has been a lot of work towards this, the last data sadly showed only a minimal improvement with this work. The issues are multifactorial. Portering and UECC Nurse capacity Transfer policy Reporting times Large number of trust CT imaging done from the UECC Uecc are working on improving Nursing And working to change the transfer policy The trust needs to be less reliant on the UECC to manage the CTing of acute patients Portering capacity needs to match demand. This issue limits our 4 hour performance, increases overcrowding in ED, and puts patients requiring time critical CT at risk 29/08/2025 - Advised by the Care Group management that the risk had been back through CSU1 governance earlier this week and agreed at that meeting to stay at a scoring of 20, however Care Group will pick the risk up week commencing 01/09/2025 again as an SLT and will run it through Care Group overarching governance where we will review again through that meeting, the risk will obviously be picked up through RMC as well.	Approved	QI Project	28/02/25	04/03/25
													Review Transfer & Escort Policy - Ongoing work with the portering service, policy author and nursing, to ensure all parties are happy with the policy to safely move patients to and from scan.	30/09/25	
													2nd CT scanner for Trust	30/08/24	28/08/24
													Review of Porter shift patterns for the core Porter-ing team	30/06/25	08/07/25
													discussions across divisions.	14/06/24	27/06/24
													Safer care nursing tool	31/12/24	06/01/25
													Teletracking	31/07/24	24/07/24
													Review appropriateness of scans requested in the UECC	23/12/24	02/01/25
													Review CT Trauma guidelines with Radiology	30/06/25	03/07/25
7076	Gemma Orr	Care Group 4 (Community, Therapies, Dietetics & Medical Imaging)	04/03/24	Pelvic Health Waiting List and Capacity to treat patients	1. Delayed patient care, 2. Patients condition deteriorating as a result of the delay, 3. Delay to Gynaecology consultants and urine incontinence pathway. Caused by Demand outweighing capacity & insufficient capacity to see patients within a timely manner. Resulting in potentially patients condition worsening and delaying external pathways and the treatment options for patients with regards to urinary incontinence. Patients experience and dissatisfaction with the service being offered and received at TRFT.	15	15	9	27/08/25	04/08/25	03/07/2025 - Waiting times remain static currently. An acknowledgment letter has been created for patients waiting on the list with signposting and advice on how to manage during the wait. The letter is going to Therapies Governance meeting in July for approval, which will then be rolled out. Recruitment was successful but the candidate is going on a career break, so an ECF is being submitted to backfill with a Band 5 for the duration of the career break.	Approved	Staffing	29/08/25	
													Templates	30/04/25	06/05/25
													Pathway	31/12/25	
													MSK Funding	31/12/25	
													Capacity & Demand modelling	29/08/25	
													Use of Technology	29/08/25	
5967	Lesley Hammond	Care Group 1 (UECC and Medicine)	27/10/19	Insufficient provision of medical cover within the UECC	The risk of the inability to fill the middle grade rota, particularly ST4s and especially at night (within UECC). There is a risk of not meeting the 4 hour target and delays to be seen by a clinician. Caused by insufficient clinical staff (UECC) to meet demands. Increased number of attendances, and gaps in the rotas. Resulting in excessive pressures and demands on staff filling shifts. This in turn results in less uptake of shifts. Poor patient experience and risk of harm. Financial overspend to fill gaps in the rota.	15	15	9	25/07/25	26/08/25	25/07/2025 - start dates confirmed for 6th August for new junior clinical fellows, the speciality doctors have a start date of 3rd September. therefore once all in post this risk can be closed. all staff are on a 12 month contract.	Approved	ACT programme	25/07/25	25/07/25
													Recruitment	03/04/23	18/05/23
													winter plan	31/03/24	25/04/24
													Review of rota	31/08/24	02/07/24
													Workforce plan from ACT work	30/04/24	30/04/24
													Senior clinical fellows	30/08/24	02/01/25
													Workforce Programme	30/09/25	
													Deanery Trainees	01/07/25	25/07/25
													consultant recruitment	30/04/25	25/04/25
6692	Lynsey Maton	Care Group 1 (UECC and Medicine)	28/04/22	Inadequate Nursing Establishment in the UECC	Not enough Nursing staff to safely manage the current demand in the department leading to poor patient outcomes, increasing incidents where harm has been caused, poor patient experience. The effect on nursing workforce morale, retention, recruitment and wellbeing. Based on April 2022 SEDIT data benchmarking for registered nurses is set at 82.5WTE. Current budget is 60.89WTE of which 56.17WTE are clinical. Failure to meet RCN/RCEM Nursing Workforce standards for Type 1 ED NHS Professionals only fill gaps to current WTE budgeted workforce this does not address the issue that budgeted nursing establishment is below national benchmarking as identified above Inability to undertake intentional rounding and risk assessments as per standard operating procedure	20	20	4	25/07/25	26/08/25	25/07/2025 - business case to go to ETM in early sept.	Approved	Proposed interim nurse staffing plan	30/06/22	15/05/23
													Safer Nurse Staffing Tool	29/11/24	02/09/24
													Nurse Recruitment to Budgeted Establishment	31/03/23	15/05/23
													Business case for Nursing establishment	31/07/22	18/12/23
													ACT programme	28/07/25	25/07/25
													Recruitment	28/10/22	15/05/23
													Over recruit by 3WTE Band 5 as a one time offer	15/02/24	15/02/24
													additional nurse to support winter pressures	31/03/25	31/03/25
													further SNCT collection	30/09/25	25/07/25
													Business case to increase nurse establishment.	30/09/25	

Corporate Risk Register

ID	Handler	Clinical Group	Opened	Title	DESCRIPTION	Initial Rating	Current Rating	Target Rating	Date Reviewed	Review Date	Latest progress note	Status	Action Description	Action Due Date	Action Done Date
7084	Jennifer Benton	Care Group 1 (UECC and Medicine)	13/03/24	Operational pressures, opening additional beds impact on patient safety, experience	Additional capacity beds opened within the Division. Caused by an increase in patients requiring a medical inpatient admission. Increased infection resulting in funded beds being closed from an IPC requirement. Increase in LOS and a requirement of IDT involvement. Resulting in adverse impact on patient safety, quality and experience - Increase noted in patient incidents, harm to patients (severity), judicial enquiries, concerns and complaints. Negative impact on Trust reputation/credibility.	16	16	9	16/07/25	15/08/25	16/07/2025 - Risk reviewed by PS - this risk will remain unchanged until the discussion of the bed reconfiguration business case at ETM on 17/07/2025	Approved	Completion of the SOP for opening a decommissioned area	01/05/24	13/06/24
													Identification of Golden patients	01/06/24	13/06/24
													Divisional representation at LLoS review	01/06/24	13/06/24
													Nurse staffing huddle	01/06/24	13/06/24
													SHOP Ward round principles	05/09/25	
													Bed Reconfiguration Work	29/08/25	
													Utilise Perfect Week to enact de-escalation	24/07/24	22/08/24
7164	Louise Smith	Care Group 1 (UECC and Medicine)	15/07/24	Provision of NIV (Respiratory) in an appropriate setting by suitably trained staff	Respiratory patients receiving suboptimal NIV care and treatment - led by Respiratory Physician. No suitable location of care for level 2 patients requiring NIV. All patients currently receive care in HDU due to no Respiratory Support Unit (RSU) leading to delay in treatment and positive patient outcome. Caused by a lack of suitable provision external to HDU. Inadequate location and up to date competently trained/ experienced medical and nursing staff to care for patients requiring NIV treatment. Currently there is no NIV Clinical Lead, therefore there is not always a clear medical plans / ceiling of care and treatment in place for patient receiving NIV. Resulting in suboptimal care being delivered to patients requiring NIV. All patients are managed in HDU beds resulting in suboptimal care being given to other patients who require HDU. This has an impact on the network critical care bed capacity. The threshold for Type 2 Respiratory failure patients requiring NIV is different within the critical care setting leading to suboptimal care for this group. This has an impact on the patient suitable pathway.	16	16	6	27/08/25	18/08/25	17/07/2025 - Working group in place, visits arranged for other areas	Approved	Advanced Care Planning for NIV patients	14/11/25	
													QI working group to be established to address NIV on medical area	30/09/25	
7290	Lilian Johnson	Care Group 4 (Community, Therapies, Dietetics & Medical Imaging)	26/02/25	Lack of Speech and language provision within the care homes team	Patients who reside in a care home not receiving timely interventions from speech and language therapy. Caused by no Speech and Language therapy service within the care homes team at present. Resulting in the possibility of patients, being severely unwell and deteriorating, which will result in an increased rate of admissions to hospital, increased A&E attendances and high use of secondary services.	15	15	6	28/08/25	24/09/25	25/07/2025 - Reviewed at Community Nursing and Audiology Governance Meeting, risk still remains due to vacancies within the team, risk to be re-assigned to Lillian Johnson once access has been given to Datix	Approved	To recruit new Speech and Language Therapist to existing funded vacancy	31/10/25	
													To employ a Speech and Language Therapist Locum until permanent position filled	31/08/25	
7325	Lindsay Farrow	Care Group 1 (UECC and Medicine)	08/05/25	Non compliance with Emergency Care Data Set	Non compliance with emergency care data set due to unfilled diagnosis data and completion of GP letters Caused by: Emergency Care Data Set V3 and diagnosis codes Clinicians not completing GP letters - not completed live, remain on worklist for 72hours then disappears Resulting in: Non compliance with emergency care data set due to unfilled diagnosis data and completion of GP letters No communication with our partners No communication to allow patients to obtain appropriate follow up in primary care letters Patients do not receive copy of discharge letter	20	20	8	25/07/25	26/08/25	02/07/2025 - 01.07.25 RMC - PS explained that delays in sending discharge information to GPs had been identified, with the system dropping cases after 72 hours, potentially impacting ECDS compliance and patient care continuity. PF noted that this issue had also been raised at the IG Committee, highlighting poor performance compared to other organisations and the likelihood of increased scrutiny. SD raised concerns about the impact of ECDS data challenges on mortality figures and requested clarity on the root causes of data quality issues. The committee agreed to approve the risk at a score of 20, noting the actions in place and the need for further system and process improvements. 29/08/2025 - Advised by the Care Group management that the risk had been back through CSU1 governance earlier this week and agreed at that meeting to stay at a scoring of 20, however Care Group will pick the risk up week commencing 01/09/2025 again as an SLT and will run it through Care Group overarching governance where we will review again through that meeting, the risk will obviously be picked up through RMC as well.	Approved	Escalation to senior leadership team in Care Group 1	31/05/25	31/05/25
													Set up regular data quality meetings with Health Informatics	30/06/25	25/07/25
													to review and load data quality for ECDS highlighting non compliance.	26/08/25	

Corporate Risk Register

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7338	Cindy Storer	Corporate Services	29/05/25	New National Job Profiles for Nursing and Midwifery Band 4-9	There is a risk that the workforce consultation process linked to the implementation of updated National Nursing and Midwifery profiles is not managed effectively or in line with Trust policy. This may be caused by delays in organisational consultation, lack of agreement on backpay arrangements, poor communication with staff and trade unions, and inconsistent application of new job descriptions and clinical skills frameworks. As a result, the Trust may face increased and unpredictable financial costs, trade union disputes, reputational damage through media attention, and reduced staff morale. There is also a risk that large sections of the workforce do not meet the minimum requirements of the new national profiles, affecting up to 1,600 nursing and midwifery staff across bands 4–9, with potential implications for pay banding and backpay.	20	16	4	28/08/25	29/09/25	28/08/2025 - Risk reviewed CS: Meeting infrastructure in place for proper governance and staff side fully engaged with trust plan. First wave of job descriptions written, pending approval process. Risk remains static due to changing national picture and the need to align with other acute providers.	Approved	Create project team to support the review	27/06/25	28/08/25
													Internal and External Operation and Steering Groups (ongoing action)	31/03/26	
7341	Chris Thickett	Corporate Services	03/06/25	Ability to deliver 2025/26 Financial Plan	Non delivery of the financial plan which is currently a £6.0m deficit. Caused by inability to deliver a £12.2m cost improvement programme or under recovery of elective recovery income (current target 103% of 2019/20 activity)or cost pressures exceed amounts set in reserve. Resulting in cash deficiencies limiting ability to pay suppliers and potential regulatory actions for failure to live within financial resources made available.	20	16	4	27/08/25	05/08/25	02/07/2025 - 01.07.25 RMC - MW shared that the risk was discussed at FPC last week, with a risk rating agreed at 16 and will also be taken to Board of Directors. Risk to be reviewed and reassigned to the new joint DoF.	Approved	Development of Winter plan.	01/10/25	
													Cost improvement Efficiency Board.	01/10/25	
													Development of robust capacity plans.	01/10/25	
													Outpatient utilisation programme.	03/11/25	

Board of Directors' Meeting
5th September 2025

The Rotherham NHS Foundation Trust

Agenda item	P134/25
Report	**Chief Executive Report**
Executive Lead	Dr Richard Jenkins, Chief Executive
Link with the BAF	The Chief Executive's report reflects various elements of the BAF
How does this paper support Trust Values	The contents of the report have bearing on all three Trust values.
Purpose	**For decision ☐ For assurance ☐ For information ☒**
Executive Summary (including reason for the report, background, key issues and risks)	This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest. It focuses on the following key areas: • NHS 10 Year Plan • Operational Matters and UECC Activity • Integrated Care Board (ICB), Acute Federation and Rotherham Place Development and Partnership Working • Finances • People • Other News
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper reports directly to the Board of Directors.
Board powers to make this decision	No decision is required.
Who, What and When	No action is required.
Recommendations	It is recommended that the Board note the contents of the report.

Appendices	1. NHS 10 Year Plan 2. Letter from the Secretary of State for Health and the Chief Executive Officer of NHS England 3. NHS England Planning Framework

1.0 NHS 10 Year Plan

1.1 The Government's 10 Year Health Plan has now been published (Appendix 1). This has been informed by the biggest conversation about the NHS in its history and has been shaped by the experiences and expectations of members of the public, patients, partners and the Health and Care workforce across the county.

1.2 To accompany this, the Secretary of State for Health and the Chief Executive Officer for NHS England has written an open letter to all staff (Appendix 2) to support the launch. NHS England has also developed a planning framework (Appendix 3) which sets out a clear expectation that all organisations must prepare robust five-year plans to address the delivery of core quality and performance standards including Financial sustainability alongside the actions to drive the reforms set out in the plan to support these.

2.0 Operational Matters

2.1 The Trust continues to make good progress in elective recovery and reducing waiting times. However, the waiting list grew slightly in July 2025, increasing by 352 taking the total waiting list size to 31,310. The Trust continued to maintain zero patients waiting over 65 weeks and delivered a further reduction in the number of patients waiting over 52 weeks, with 599 patients reported against a trajectory target of 723.

2.2 Referral to Treatment (RTT) performance was 66.5% in July, ahead of our trajectory of 64% with a number of specialties achieving the 92% constitutional compliance standard. These included General Medicine (92.5%), Geriatric Medicine (100%), Clinical Haematology (97.1%), Paediatrics (95.3%) and Paediatric Cardiology (92.5%). The clinical and operational teams continue to focus on recovery through both efficient use of capacity, as well as optimising pathways as part of the transformation programme and Getting it Right First Time (GIRFT) further faster programme.

2.3 Diagnostic performance has remained strong, with compliance against the DM01 standard maintained with only 0.80% of patients breaching the 6-week standard in July 2025, with the Trust remaining in the top decile nationally on latest benchmarking data.

2.4 In June 2025, performance against the Faster Diagnosis Standard (FDS) stood at 78.0%, whilst this was below the Trust's trajectory of 80%, it was above the national target of 77%. The 62-day referral to treatment standard was not met, with performance reported at 67.6% against the Trust trajectory of 77%. This was largely due to challenges in the lower GI, gynaecology and Urology pathways. The Trust remains focused on recovery of cancer performance and work is ongoing to reduce waiting times through both increased capacity as well as improvement work to optimise pathways. Performance against the 62-day target is expected to recover from September onwards.

3.0 Urgent and Emergency Care Delivery

3.1 Performance against the 4-hour access standard in July was 71.3% performance which exceeded the Trust trajectory to achieve 66% in July 25. Nationally, there is

an increased focus on reducing the number of patients spending over 12 hours total time in emergency departments. The Trust continues to ensure this is a key focus and performs well against this metric, with 1.3% of patients spending over 12 hours in the UECC in July, resulting in the Trust benchmarking 10th nationally.

3.2 Attendances at the Urgent and Emergency Care Centre (UECC), remain high with 9264 attendances in the month against a plan for this year of 8512. This equates to an average of 299 attendances per day and is a 6.49% increase on July 2024 when attendances were 8699.

3.3 The new urgent care facilities adjacent to UECC opened on 2nd July 2025, following £7M national investment into the Trust to support these new facilities and a relocated fracture clinic. The provision incorporates the new UECC Green area providing additional capacity to UECC to see patients in Primary Care, Minor Injuries and GP Out of Hours. Adjacent to this is the new purpose built Medical Same Day Emergency Care (SDEC). The opening has been successful with positive feedback from colleagues and patients in relation to the new environment.

3.4 Industrial Action by BMA resident doctors took place for 5 days in July. Detailed plans were enacted to support wards and department and to maintain patient flow. I would like to thank colleagues working through this period of industrial action, the commitment to patient care, even with increased pressure, is deeply appreciated.

4.0 Finances

4.1 The 2024-25 financial planning round included provision of deficit-support funding for the South Yorkshire (SY) system with this being provided to Trusts on a Quarterly basis. The Quarter 2 component for SY has been withheld by NHSE in relation to the system being in an adverse position against its financial plan; at month 4 the Trust was on plan. The situation will be reviewed by NHSE after the SY Month 5 financial results are available, and in the light of work done in SY ICB, so it is possible that the monies will then be made available. This represents a material risk to delivery of the Trust's financial plan.

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

5.1 Representatives from the Trust have continued to attend several Place meetings including the Health and Well-Being Board, the Health Select Commission, and the Place Board. Rotherham Place has submitted an application to the Department of Health and Social Care (DHSC) to take part in the National Neighbourhood Health Implementation Programme. This is a place-wide bid to work with national large scale change experts overseen by a joint task force between DHSC and NHS England with a focus on adults with long-term conditions and rising risk. There will be two half day workshops at the beginning of September ('Shared understanding and vision') and towards the end of September ('Progress and next steps') which all stakeholders are expected to attend. Further detailed information on Rotherham Place is provided by the Managing Director in his report to the Board of Directors.

5.2 The Barnsley and Rotherham partnership continues to grow and the Trust continues to work with partners locally, regionally and at a national level

to deliver a co-ordinated and consistent approach to the effective management of services.

5.3 The new Chief Executive for Rotherham Metropolitan Borough Council, Mr John Edwards, has now commenced in post.

6.0 People

6.1 Following a number of successful recruitment interviews, I am pleased to report that we have a number of Consultants joining the Trust as below:

- Mr R Elayyan, General Surgery, Breast (August 2025)
- Dr A Watkin, Aneasthetics (August 2025)
- Dr S Bukhari, Acute Medicine (September 2025)
- Dr A Hussain, Radiology (September 2025)
- Dr P Arora, Rheumatology (October 2025)
- Dr M Davidson, Palliative Medicine (October 2025)
- Dr J Wright (Barlow), Community Paediatrics (November 2025)

6.2 I am pleased to report that the Royal College of Physicians has presented the Trust with a prestigious Developing Workforce Award which is in recognition of work undertaken on a three-year project to deliver improvements to resident doctor wellbeing, rota design, staffing levels and patient care. This work was delivered by colleagues from Care Group 1, Medicine Senior Leadership, Medical Workforce, Finance and Education teams. I am sure you will join me in congratulating them on their success.

6.3 The Trust has been shortlisted in four categories of this year's Nursing Times Awards; Patient Safety Improvement, Virtual Ward, Technology and Data in Nursing and Nursing in the Community. Congratulations to the teams shortlisted and winners will be announced later in the year.

6.4 The Trust has also been shortlisted for three HSJ Patient Safety Awards; Best use of integrated care and partnership working, Harnessing a human factors approach to improve patient safety and Virtual or remote care initiative of the year. Well done to our shortlisted colleagues, winners will be announced mid-September.

6.5 Following the Trust gaining Veteran Aware accreditation back in September 2022, I am very pleased to report that we have now achieved a Silver Award for the Employer Recognition Scheme. This is fantastic news and shows our commitment to ensuring that those who serve or have served and their families are not at a disadvantage when using our services and that we can best support their needs.

6.6 The Trust monthly Excellence Award Winners, since my last reporting period are as follows:

April 2025

- INDIVIDUAL AWARD: Dr Muhammad Waqas, Surgery
- INDIVIDUAL AWARD: Lee Moran, Matron for Patient Flow Projects and Community Ready Unit
- TEAM AWARD: Gary Gaunt and Claire Stockwell, Delivery and

Improvement
- PUBLIC AWARD: Robyn Carr, 0-19 Service
- PUBLIC AWARD: Richard Gale, Radiology

May 2025
- INDIVIDUAL AWARD: Charley Fox, Acute Surgical Unit
- INDIVIDUAL AWARD: Ghulam Adel, Pharmacy
- TEAM AWARD: Trauma Team, Surgery
- PUBLIC AWARD: Children's Ward

June 2025
- INDIVIDUAL AWARD: Maysoon Shafiq
- INDIVIDUAL AWARD: Danielle Mills, Public Health Nursery Nurse
- TEAM AWARD: Continence Advisory Service, Rotherham Community Health Centre
- PUBLIC AWARD: Ward B10

July 2025
- INDIVIDUAL AWARD: Melissa Peters, Pulmonary Rehabilitation
- INDIVIDUAL AWARD: Darren Robson, People Team
- TEAM AWARD: Post Room, Estates and Facilities
- PUBLIC AWARD: Nikhil Nanavati, Surgeon

7.0 Other News

7.1 The Trust Annual Members Meeting will be held on Tuesday 23rd September 2025 from 2:00pm to 4:00pm in the Boardroom here at the Trust.

7.2 As a result of the 2022 Manchester Arena Bombing in which 22 people lost their lives, the new Terrorism (Protection of Premises) Act 2025, also known as Martyns law has now become legislation. The new law aims to ensure venues/premises across the UK consider the security of the public and take steps to protect them from harm. The Government intends for there to be an implementation period of at least 24 months before the Act comes into force. It is expected that compliance with the Act will be included in this year's reviewed EPRR core standards awaiting publication. With regard to the Trust's current position, given specific requirements to comply with the Act have not yet been released, a risk assessment has not been undertaken however this will be enacted once requirements are published.

Dr Richard Jenkins
Chief Executive
September 2025

UK Government

NHS

FIT FOR THE FUTURE

10 Year Health Plan for England

Executive Summary



July 2025

Executive Summary

The National Health Service (NHS) is at a historic crossroads. Lord Darzi's Investigation revealed the sheer extent of its current failings, concluding the NHS was in 'critical condition'. He set out in stark terms that this government's inheritance is an NHS where:

- many cannot get a GP or dental appointment
- waiting lists for hospital and community care[1] have ballooned
- staff are demoralised and demotivated[2]
- outcomes on major killers like cancer lag behind other countries[3].

That is why the NHS now stands at an existential brink. Demographic change and population ageing[4] are set to heap yet more demand on an already stretched health service. Without change, this will threaten yet worse access and outcomes - and even more will opt out to go private if they can afford to. People will increasingly wonder why they pay so much tax for a service they do not use, eroding the principle of solidarity that has sustained the NHS. We will be condemned to a poor service for poor people.

The choice for the NHS is stark: reform or die. We can continue down our current path, making tweaks to an increasingly unsustainable model, or we can take a new course and reimagine the NHS through transformational change that will guarantee its sustainability for generations to come. This Plan chooses the latter. It represents a break with the past.

That choice has been informed by the biggest conversation about the NHS in its history. Over the past 8 months, we have spoken to thousands of staff and members of the public and considered the 250,000 contributions to the Change.NHS website. The conclusion was clear: no one defends the status quo. Staff and patients are crying out for change.

This is a Plan to create a new model of care, fit for the future. It will be central to how we deliver on our health mission. We will take the NHS' founding principles - universal care, free at the point of delivery, based on need and funded through general taxation - and from those foundations, entirely reimagine how the NHS does care so patients have real choice and control over their health and care.

Science and technology will be key to that reinvention. Today the NHS is behind the technological curve. This Plan propels it to the front. The NHS of the future will be a service that offers instant access to help and appointments. One that predicts and prevents ill health rather than simply diagnosing and treating it. A patient-controlled system, in place of today's centralised state bureaucracy, and one where frontline staff are empowered to reshape services. A service with the core principles and values of the NHS but with the know-how of a wider network of technology, life sciences, local government, civil society and third sector organisations, working in partnership to improve the nation's health.

It will be a service equipped to narrow health inequalities. Evidence[5] shows that people in working class jobs, who are from ethnic minority backgrounds, who live in rural or coastal areas or deindustrialised inner cities, who have experienced domestic violence, or who are homeless, are more likely to experience worse NHS access, worse outcomes and to die younger. This is an intolerable injustice. Our reimagined NHS will be designed to tackle inequalities in both access and outcomes, as well as to give everyone, no matter who they are or where they come from, the means to engage with the NHS on their own terms.

Despite the scale of the challenge we face, there are more reasons for optimism than pessimism. The NHS is the best-placed system in the world to harness the advances we are seeing in artificial intelligence (AI) and genomic science. This Plan describes how we will use these advantages to propel the NHS into a position of global leadership. When coupled with our country's excellence in science, innovation and academia, the UK can lead the world in developing the treatments and technologies of the future[6].

This Plan will put the NHS at the front of the global genomics revolution and make the NHS the most artificial-intelligence -enabled care system in the world. We will get upstream of ill-health and make a reality of precision medicine. We will put the NHS on a sustainable footing by adopting a new value-based approach, that aligns resources to achieve better health outcomes. In turn, we will unlock broader economic benefits for the UK, helping to get people back into work and providing a bedrock for the industries of the future. This Plan will transform the NHS into an engine for economic growth rather than simply a beneficiary of it.

We will reinvent the NHS through 3 radical shifts - hospital to community, analogue to digital and sickness to prevention. These will be the core components of our new care model. To support the scale of change we need, we will ensure the whole NHS is ready to deliver these 3 shifts at pace: through a new operating model, by ushering in a new era of transparency; by creating a new workforce model with staff genuinely aligned with the future direction of reform, through a reshaped innovation strategy; by taking a different approach to NHS finances.

From hospital to community: the neighbourhood health service, designed around you

If the NHS does not feel like a single, coordinated, patient-orientated service, that is for a simple reason: it is not one. It is hospital-centric, detached from communities and organises its care into multiple, fragmented siloes. We need to shift to provide continuous, accessible and integrated care.

The neighbourhood health service is our alternative. It will bring care into local communities, convene professionals into patient-centred teams and end fragmentation. In doing so, it will revitalise access to general practice and enable hospitals to focus on providing world class specialist care to those who need it. Over time, it will combine with our new genomics population health service to provide predictive and preventative care that anticipates need, rather than just reacting to it.

At its core, the neighbourhood health service will embody our new preventative principle that care should happen as locally as it can: digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, in a hospital if necessary. To make this possible we will:

- shift the pattern of health spending. Over the course of this Plan, the share of expenditure on hospital care will fall, with proportionally greater investment in out-of-hospital care.
- This is not just a long-term ambition. We will also deliver this shift in investment over the next 3 to 4 years as local areas build and expand their neighbourhood health services

- end the 8am scramble by training thousands more GPs and building online advice into the NHS App. People who need one will be able to get a same-day GP appointment
- introduce 2 new contracts, with roll-out beginning next year, to encourage and allow GPs to work over larger geographies and lead new neighbourhood providers
- support people to be active participants in their own care by ensuring people with complex needs have an agreed care plan by 2027
- at least double the number of people offered a Personal Health Budget by 2028 to 2029, offer 1 million people a Personal Health Budget by 2030, and ensure it is a universal offer for all who would benefit by 2035
- through the NHS App, allow patients to book appointments, communicate with professionals, receive advice, draft or view their care plan, and self-refer to local tests and services
- establish a neighbourhood health centre in every community, beginning with places where healthy life expectancy is lowest - a 'one stop shop' for patient care and the place from which multidisciplinary teams operate
- neighbourhood health centres will be open at least 12 hours a day and 6 days a week
- increase the role of community pharmacy in the management of long-term conditions and link them to the single patient record
- improve access to NHS dentistry, improve children's oral health and increase the number of NHS dentists working in the system by making the dental contract more attractive, and introducing tie-ins for those trained in the NHS
- deliver more urgent care in the community, in people's homes or through neighbourhood health centres to end hospital outpatients as we know it by 2035
- end the disgraceful spectacle of corridor care and restore the NHS constitutional standard of 92% of patients beginning elective treatment within 18 weeks
- expand same day emergency care services and co-located urgent treatment centres. We will support patients to book into the most appropriate urgent care service for them, via 111 or the app, before attending, by 2028
- invest up to £120 million to develop more dedicated mental health emergency departments, to ensure patients get fast, same-day access to specialist support in an appropriate setting
- free up hospitals to prioritise safe deployment of AI and harness new technology to bring the very best of cutting-edge care to all patients. All hospitals will be fully AI-enabled within the lifetime of this Plan.

From analogue to digital: power in your hands

Modern technology has given us more power over our everyday lives. But that same scale of change has yet to come to the NHS. This Plan will take the NHS from the 20th century technological laggard it is today, to the 21st century leader it has the potential to be.

To do this, we will use the unique advantages of the NHS' healthcare model - world-leading data, its power in procurement and its means to deliver equal access - to create the most digitally accessible health system in the world. Patients will have a 'doctor in their pocket' in the form of the NHS App, while staff will be liberated from a burden of bureaucracy and administration.

By harnessing the digital revolution, we will be able to:

- ensure rapid access for those in generally good health

- free up physical access for those with the most complex needs
- help ensure the NHS' financial sustainability for future generations.

To make the move 'from bricks to clicks' we will:

- for the first time ever in the NHS, give patients real control over a single, secure and authoritative account of their data with a single patient record to enable more co-ordinated, personalised and predictive care
- transform the NHS App into a world leading tool for patient access, empowerment and care planning.

By 2028, the app will be a full front door to the entire NHS. Through the app, patients will be able to:

- get instant advice for non-urgent care and help finding the most appropriate service first time, through My NHS GP
- choose their preferred provider, whether it delivers the best outcomes, has the best feedback or is simply closer to home, through My Choices
- book directly into tests where clinically appropriate through My Specialist, and hold consultations through the app with My Consult
- manage their medicines through My Medicines and book vaccines through My Vaccines
- manage a long-term condition through My Care, access and upload health data through My Health or get extra care support through My Companion

- manage their children's healthcare through My Children, or co-ordinate the care of a loved one or relative through My Carer
- allow patients to leave feedback on the care they have received - compiled and communicated back to providers, clinical teams and professionals in easy-to-action formats
- use continuous monitoring to help make proactive management of patients the new normal, allowing clinicians to reach out at the first signs of deterioration to prevent an emergency admission to hospital
- build 'HealthStore' to enable patients to access approved digital tools to manage or treat their conditions, enabling innovative businesses to work more collaboratively with the NHS and regulators
- introduce single sign on for staff and scale the use of technology like AI scribes to liberate staff from their current burden of bureaucracy and administration – freeing up time to care and to focus on the patient.

From sickness to prevention: power to make the healthy choice

People are living too long in ill health, the gap in healthy life expectancy between rich and poor is growing[7] and nearly 1 in 5 children leave primary school with obesity[8]. Our overall goal is to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and to raise the healthiest generation of children ever. This will boost our health, but also ensure the future sustainability of the NHS and support economic growth.

We will achieve our goals by harnessing a huge cross-societal energy on prevention. We will work with businesses, employers, investors, local authorities and mayors to create a healthier country together. Specifically, we will:

- deliver on our world-leading Tobacco and Vapes Bill, which will mean that children turning 16 this year (or younger) can never legally be sold tobacco. The number of 11 to 15 year olds who regularly vape has doubled[9] in the last 5 years, and to crack down on this unacceptable trend, we will also halt the advertising and sponsorship

of vapes and other nicotine products

- launch a moonshot to end the obesity epidemic. We will restrict junk food advertising targeted at children, ban the sale of high-caffeine energy drinks to under 16-year-olds, consider reforms to the soft drinks industry levy to drive reformulation; and - in a world first - introduce mandatory healthy food sales reporting for all large companies in the food sector. We will use that reporting to set new mandatory targets on the average healthiness of sales
- restore the value of Healthy Start from financial year 2026 to 2027, expand free school meals so that all children with a parent in receipt of Universal Credit are eligible, and update school food standards to ensure all schools provide healthy, nutritious food.
- harness recent breakthroughs in weight loss medication and expand access through the NHS. We will negotiate new partnerships with industry to provide access to new treatments on a 'pay for impact on health outcomes' basis
- encourage citizens to play their part, including through a new health reward scheme to incentivise healthier choices. We will also work with the Great Run Company to set up a campaign to motivate millions to move more on a regular basis
- tackle harmful alcohol consumption by introducing new standards for alcohol labelling. We will support further growth in the no- and low- alcohol market
- join up support from across work, health and skills systems to help people find and stay in work. We will work with all ICBs to establish Health and Growth Accelerators models
- expand mental health support teams in schools and colleges – and provide additional support for children and young people's mental health through Young Futures Hubs
- increase uptake of human papillomavirus (HPV) vaccinations among young people who have left school, to support our ultimate aim to eliminate cervical cancer by 2040. We will fully roll out lung cancer screening for those with a history of smoking
- create a new genomics population health service, accessible to all, by the end of the decade. We will implement universal newborn genomic testing and population-based polygenic risk scoring alongside other emerging diagnostic tools, enabling early identification and intervention for individuals at high risk of developing common diseases.

A devolved and diverse NHS: a new operating model

To realise the ambition of this Plan, we will create a new NHS operating model, to deliver a more diverse and devolved health service. Today, power is concentrated in Whitehall, rather than distributed among local providers, staff and citizens.

Our reforms will push power out to places, providers and patients - underpinned by an explicit goal to make the NHS the best possible partner and the world's most collaborative public healthcare provider. To achieve this, we will:

- combine the headquarters of the NHS and the Department of Health and Social Care, reducing central headcount by 50%
- make ICBs the strategic commissioners of local healthcare services. We will build ICB capability, and close commissioning support units
- introduce a system of earned autonomy and, where local services consistently underperform, step in with a new failure regime. Our priority will be to address underperformance in areas with the worst health outcomes. Our ambition over a 10-year period is for high autonomy to be the

norm across every part of the country

- reinvent the NHS foundation trust (FT) model for a modern age. By 2035, our ambition is that every NHS provider should be an FT with freedoms including the ability to retain surpluses and reinvest them, and borrowing for capital investment. FTs will use these freedoms and flexibilities to improve population health, not just increase activity
- create a new opportunity for the very best FTs to hold the whole health budget for a defined local population as an integrated health organisation (IHO). Our intention is to designate a small number of these IHOs in 2026, with a view to them becoming operational in 2027. Over time they will become the norm
- set higher standards for leaders, with pay tied to performance, and good work rewarded
- continue to make use of private sector capacity to treat NHS patients where it is available and we will enter discussions with private providers to expand NHS provision in the most disadvantaged areas
- work in closer partnership with local government and other local public services. We will streamline how local government and the NHS work together and make ICBs coterminous with strategic authorities by the end of the Plan wherever feasibly possible
- introduce a new patient choice charter, starting in the areas of highest health need. This will ensure the NHS is receptive and reactive to patient preference, voice and choice
- trial new 'patient power payments', which are an innovative new funding flow in which patients are contacted after care and given a say on whether the full payment for the costs of their care should be released to the provider.

A new transparency and quality of care

The NHS' history is blighted by examples of systematic and avoidable harm. The commonality in these tragedies has been a fundamental lack of transparency. We will make the NHS the most transparent healthcare system in the world.

From this foundation, we will reintroduce a new, rigorous focus on high-quality care for all. Specifically, we will:

- publish easy-to-understand league tables, starting this summer, that rank providers against key quality indicators
- allow patients to search and choose providers based on quality data on the NHS App, including length of wait, patient ratings and clinical outcomes. The App will also show data on clinical teams and clinicians
- use patient reported outcome measures and patient reported experience measures to help patients when choosing their provider on the NHS App
- set up a national independent investigation into maternity and neonatal services. We will also establish a national maternity and neonatal taskforce, chaired by the Secretary of State for Health and Social Care, to inform a new national maternity and neonatal action plan, co-produced with bereaved families
- reform the complaints process and improve response times to patient safety incidents and complaints
- change the time limit for the Care Quality Commission (CQC) to bring legal action against a provider and review how to improve patients' experience of clinical negligence claims
- reform the National Quality Board (NQB) with all other bodies, including Royal Colleges, feeding into it. We will task it with developing a new quality strategy as well as the development of modern

service frameworks. Early priorities will include cardiovascular disease, mental health, frailty and dementia.

- give all providers new flexibilities to make additional financial payments to clinical teams that have consistently high clinical outcomes and excellent patient feedback or are significantly improving care
- reform CQC towards a more data-led regulatory model. When concerns are identified, CQC will rapidly assemble inspection teams of highly qualified staff to assess service quality in greater detail
- make sure persistent poor-quality care results in the decommissioning or contract termination of services or providers, no matter the setting, no matter whether the provider is in the NHS or independent sector, and no matter whether they are a GP practice or an individual NHS trust.

An NHS workforce, fit for the future

It will be through the workforce that our 3 shifts are delivered. Because healthcare work will look very different in 10 years' time, we will need a very different kind of workforce strategy.

While, by 2035, there will be fewer staff than projected in the 2023 Long-Term Workforce Plan, those staff will be better treated, more motivated, have better training and more scope to develop their careers. The NHS will be not only the country's biggest employer but its best. To achieve this, we will:

- ensure every single member of NHS staff has their own personalised career coaching and development plan, to help them acquire new skills and practice at the top of their professional capability
- make AI every nurse's and doctor's trusted assistant - saving them time and supporting them in decision making. Over the next 3 years we will overhaul education and training curricula with the aim of future-proofing the NHS workforce
- work with the Social Partnership Forum to develop a new set of staff standards, which will outline minimum standards for modern employment. We will introduce these standards in April 2026 and publish data on them at the employer level every quarter
- continue to work with trade unions and employers to maintain, update and reform employment contracts and start a big conversation on significant contractual changes that provide modern incentives and rewards for high quality and productive care
- reduce the NHS' sickness rates from its current rate of 5.1%[10] - far higher than the average in the private sector[11] - to the lowest recorded level in the NHS
- give leaders and managers new freedoms, including the power to undertake meaningful performance appraisals, to reward high performing staff, and to act decisively where they identify underperformance
- develop advanced practice models for nurses and other professionals, and work across government to prioritise UK medical graduates for foundation and specialty training
- increase the number of nurse consultants, particularly in neighbourhood settings
- over the next 3 years, create 1,000 new specialty training posts with a focus on specialties where there is greatest need
- accelerate delivery of the recommendations in General Sir Gordon Messenger's review of health and care leadership[12] and establish a new College of Executive and Clinical Leadership to define and drive excellence
- introduce new arrangements for senior managers' pay to reward high performance and to withhold pay increases from executive leadership teams who do not meet public, taxpayer and

patient expectations on timeliness of care or effective financial management

- reorientate the focus of NHS recruitment away from its dependency on international recruitment, and towards its own communities - to ensure sustainability in an era of global healthcare workforce shortages. It is our ambition to reduce international recruitment to less than 10% by 2035
- create 2,000 more nursing apprenticeships over the next 3 years - prioritising areas with the greatest need. Expansion of medical school places will be focused on widening access to talented students from underprivileged backgrounds.

Powering transformation: innovation to drive healthcare reform

Our aim is to be in the driving seat of the biggest industrial revolution since the 19th century as we harness technology to create a new model of care in the NHS. We will use the UK's competitive edge - NHS data, life sciences prowess, world leading universities - to lead the world on the innovation that will most accelerate reform.

We have identified 5 transformative technologies - data, AI, genomics, wearables and robotics - that will personalise care, improve outcomes, increase productivity and boost economic growth. We will:

- create a new Health Data Research Service in partnership with the Wellcome Trust and backed by up to £600 million of joint investment
- make the NHS the most AI-enabled health system in the world with AI seamlessly integrated into clinical pathways
- support the Generation Study as it sequences the genomes of 100,000 newborn babies. This study will inform our longer-term ambition to make genomic sequencing at birth universal
- launch a new large-scale study to sequence the genomes of 150,000 adults this year - and assess how genomics can be used in routine preventive care. A new globally unique set of studies will explore personalised prevention of obesity, applying genomic and other insights to identify people who are at the highest risk of developing obesity
- make wearables standard in preventative, chronic and post-acute NHS treatment by 2035. All NHS patients will have access to these technologies, which will be part of routine care. We will provide devices for free in areas where health need and deprivation are highest
- beginning next year, expand surgical robot adoption in line with National Institute for Health and Care Excellence (NICE) guidelines
- establish new global institutes with the ambition to help the UK lead the world on science and innovation
- speed up clinical trial recruitment. By March 2026, clinical trials setup time will fall to 150 days
- expand NICE's technology appraisal process to cover devices, diagnostics and digital products. NICE will also be given a new role to identify which outdated technologies and therapies can be removed from the NHS to free up resources for investment in more effective ones
- introduce multi-year budgets and require NHS organisations to reserve at least 3% of annual spend for one-time investments in service transformation, to help translate innovations into practice more rapidly
- expand the role life sciences and technology companies can play in service delivery. We will streamline procurement of technology, and we will move to a single national formulary for medicines within the next 2 years.

Productivity and a new financial foundation

Today the NHS accounts for 38% of day-to-day government spending - a figure projected to rise to nearly 40% by the end of the Parliament[13]. While the NHS will need investment in the future, it is now self-evident that more money alone has not always led to better care.

The era of the NHS' answer always being 'more money, never reform' is over. It will be replaced with a new value-based approach focused on getting better outcomes for the money we spend. Our new financial flows will incentivise innovation to support the flow of money from hospital into community and reward best practice across the NHS.

Our three shifts each help secure financial sustainability. More care in the community is cheaper and more effective than care in hospitals. Digitalisation, as in other industries, will deliver far more productively for far lower cost. Prevention bends the demand curve. We will:

- urgently resolve the NHS' productivity crisis. For the next 3 years we have set the NHS a target to deliver a 2% year on year productivity gain
- restore financial discipline by ending the practice of providing additional funding to cover deficits. Over time, our aim is for the NHS to move into surplus, with the majority of providers achieving that by 2030
- break the old, short-term cycle of financial planning, by asking all organisations to prepare robust and realistic five-year plans, demonstrating how financial sustainability will be secured over the medium term
- deconstruct block contracts - paid irrespective of how many patients are seen or how good care is - with the intention of realigning the activity delivered and funding being provided by an ICB. Payment for poor-quality care will be withheld and high-quality care will attract a bonus. In addition, we will introduce new incentives for the best NHS leaders, clinicians and teams
- move from national tariffs based on average costs to tariffs based on best clinical practice that maximises productivity and outcomes. We will also test the development of 'year of care' payments starting in financial year 2026 to 2027. This will drive the shift of activity and resource from hospital to community
- distribute NHS funding more equally locally, so it is better aligned with health need. In the meantime, we will target extra funding to areas with disproportionate economic and health challenges.
- ensure all trusts have the authority to retain 100% of receipts from the disposal of land assets they own, and are able to use the proceeds from disposals across multiple financial years
- develop a business case for the use of Public Private Partnership (PPP) for Neighbourhood Health Centres, ahead of a final decision at the autumn budget
- explore a new mechanism for the NHS to access low risk pension capital
- in the longer-term, move to a new NHS financial model, where money will increasingly follow patients through their lifetime. Providers will be rewarded based on how well they improve outcomes for each individual, as well as how well they involve people in the design of their care, not solely on whether they provide episodic instances of care on demand.

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Department of Health & Social Care

NHS

Dear colleague

Fit for the Future: 10 Year Health Plan for England

Today we are setting out a bold, ambitious and necessary new course for the NHS, with 'Fit for the Future', our 10 Year Health Plan for England.

Throughout our discussions over the last few months, we have heard time and time again from you about the importance of reviving real ambition for our NHS, making sure it will be there for generations to come.

We know from our many conversations with you as NHS staff, along with our wider health and social care workforce, that you are up for the challenge. You are the people driving innovation on the frontline and your fingerprints are all over some of the best ideas in the 10 Year Health Plan.

For too long, too many of you have suffered the frustration of turning up, working incredibly hard, only to leave at the end of the day feeling exhausted and demoralised by the conditions that patients are being treated in because of circumstances beyond your control.

This is a pivotal moment for our health service, and we need the whole team to be on board. In order to move forward, we will need to work together with decisiveness, energy and focus.

We can only do that by getting the foundations right. That means pushing forward with our current reset, prioritising financial discipline, delivering our commitments and keeping a relentless focus on preparing for winter this year. For our part, as we move into medium term planning, we will work quickly to align the centre and regions, so they work to support you better. Simplifying rules and accountability remain absolute priorities for the months ahead.

We know that many of you feel overwhelmed by bureaucracy and exasperated when you can't deliver the quality of care our patients need and deserve. We also know there is more work we need to do to support every member of our staff to fulfill their potential.

There is a whole generation of NHS staff who we know have never had the chance to work in the NHS when it's been working at its best. They have not had the experience of working in a system that delivers the highest possible care for patients, that meets its targets and has the space and time to innovate further. That is why a clear aim of this plan is to make the NHS the very best place to work – setting new

standards for flexible, modern NHS employment, expanding training opportunities and reducing the burden of admin.

This is now our opportunity to deliver the care that patients deserve, and build a workplace where staff can thrive. It falls to our generation to rebuild our National Health Service to protect the provision of high-quality healthcare, not according to wealth, but according to need.

Through our three shifts – from hospital to community, from analogue to digital, and from treatment to prevention – we will personalise care, give more power to patients, and ensure that the best of the NHS is available to all.

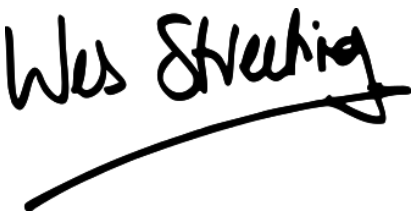
We have asked NHS leaders across the country to work closely with you over the summer to align all of these priorities and agree our collective delivery approach for Fit for the Future – focusing on those elements of the plan that will have the most immediate impact on our staff and patients, whilst looking ahead at the more medium and long-term changes we need to make.

The reason we know we can deliver the change set out in this 10 Year Health Plan is because it is built on the success of those who are already showing us what the future looks like. We have toured the length and breadth of the country and scouted the world for the best examples of innovation and reform, and we are going to seed them across the NHS together.

Delivering this plan will not be easy, but neither was the creation of the National Health Service.

Thank you for everything you do, each and every day, on behalf of our patients. You are the people who make the NHS so special and, through your commitment, compassion and creativity, we will take this plan and create an NHS that is truly fit for the future.

Yours sincerely



RT HON WES STREETING MP



Sir James Mackey
Chief Executive Officer, NHS England

Planning Framework for the NHS in England

DRAFT version 1.0



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Introduction

The Ten Year Health Plan (10YHP) sets out the need for a significant change to the way we organise, deliver and fund services. To support this, a new model of planning is required to meet the challenges and changing needs of England's population and, crucially, build the foundation for the transformation of our services.

The 10YHP makes clear that change needs to be delivered at scale, embedding new ways of working that transform the experience of staff and patients alike. This can only happen through coordinated bottom-up action. Leaders will need to come together alongside the citizens they serve and all those with a role in delivering improved health outcomes, to plan and transform services.

Delivering this change needs a different approach to planning across the NHS and with its partner organisations. Annual funding settlements and planning cycles have made it difficult to focus on thoughtful, long-term strategic planning of services. To break this cycle, this framework shifts the focus towards a rolling five-year planning horizon. Planning across the NHS needs to become a continuous, iterative process that supports transformational change, delivering the three shifts set out in the 10YHP and taking full advantage of breakthroughs in science and technology.

All organisations will be asked to prepare credible, integrated five-year plans and demonstrate how financial sustainability will be secured over the medium term. This means developing plans that:

- build and align across time horizons, joining up strategic and operational planning
- are co-ordinated and coherent across organisations and different spatial levels
- demonstrate robust triangulation between finance, quality, activity and workforce

We have been working closely with colleagues across the NHS to shape a shared view of what effective multi-year planning should look like in the current context. In response to the initial questions and feedback received, we are pleased to share the first draft version of a Planning Framework to support the development of five-year plans covering the period 2026/27 to 2030/31.

This draft framework is intended as a guide for local leaders responsible for shaping medium-term plans. It provides clarity on roles and responsibilities within the context of the new NHS operating model outlined in the 10YHP. It sets out core principles and key planning activities, which should be adapted based on local needs and circumstances.

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Annex A outlines national expectations and an indicative timetable for plan development. We will continue to refine specific requirements and ways of working in collaboration with you.

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Principles for effective, integrated planning

Planning should be a collective activity which draws input from staff, patients, people and communities. It is also a cumulative process, with each stage building on previous work. This framework is built around the five core principles shown below.

Table 1: Principles for effective, integrated planning

	Principle	Description
1	**Outcome-focused**	Planning should be anchored in delivering tangible and measurable improvements in outcomes for patients and the public, and improved value for taxpayers. Involving patients, carers, and communities is critical for ensuring that plans deliver better outcomes and services that are responsive to local needs.
2	**Accountable and transparent**	Effective planning requires clarity on roles, responsibilities, and accountabilities. Governance structures must support transparent decision-making, provide regular oversight and constructive challenge, and ensure alignment with strategic objectives at organisation, place and system level.
3	**Evidence-based**	The decisions made as part of planning should be underpinned by robust analytical foundations, including population health analysis, demand and capacity modelling, workforce analytics, and financial forecasts. This should be informed by best practice and benchmarking.
4	**Multi-disciplinary**	Planning must bring together staff from across different functional areas (finance, workforce, clinical etc) to ensure that work is co-ordinated and that those responsible for delivery have shaped its content.
5	**Credible and deliverable**	Plans must set ambitious yet achievable goals. They should clearly articulate the resources required, realistically reflect workforce and financial constraints, and include mitigation strategies for key risks. Robust triangulation between finance, performance, workforce and quality is critical.

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Roles, responsibilities and accountabilities

In line with the new NHS operating model signalled in the 10YHP, the diagram below summarises the core planning roles, responsibilities for:

- A smaller centre focused on setting strategy, establishing clear priorities and mandating fewer targets, and equipping local leaders to improve outcomes.
- ICBs as strategic commissioners, with a core focus on improving the population's health, reducing health inequalities, and improving access to consistently high-quality services.
- Providers focused on excellent delivery on waiting times, access, quality of care, productivity and financial management, as well as working partnership to improve health outcomes.

The role of the Board

The boards of individual ICBs and providers are ultimately accountable for the development and delivery of their plans. Boards are expected to play an active role in setting direction, reviewing drafts, and constructively challenging assumptions – rather than simply endorsing the final version of the plan. Boards should ensure that the plan is evidence-based and realistic in scope, aligns with the organisation's purpose and the wider system strategy, and supports the delivery of national ambitions

Boards should also set the conditions for continuous improvement, ensuring there is a clear data-driven and clinically led improvement approach in place. A systematic approach to building improvement capacity and capability at all levels is essential. This is vital to ensure organisations are ready to both deliver plans and lead wider transformation, including shifting more care from hospital to community, expanding digitisation, and driving year-on-year improvements in productivity.

Accountability at the level of individual organisations sits alongside the duty to collaborate. Effective planning requires organisations to work constructively across the system to deliver shared objectives. ICBs and providers can achieve this by:

- Engaging early and consistently in the planning process, ensuring alignment on priorities, assumptions, and planning parameters.
- Sharing data, forecasts and risk insights to build a common evidence base and support transparency in decision-making.

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- Jointly developing scenarios and trade-offs, particularly where financial, workforce, or capacity constraints exist.
- Identifying and agreeing key system priorities and setting out clearly how each organisation's plan contributes to their delivery.
- Identifying and assessing improvement capability and ensuring there are clear roles in leading improvement across the system.
- Using system governance mechanisms, such as partnership boards or planning groups, to manage dependencies and resolve tensions.
- Ensuring mutual assurance, where ICBs and providers understand and can explain how their plans both stand alone and integrate into the wider system plan.

This will help deliver the ambition for integrated, place-based care while maintaining clear lines of statutory accountability.

We will continue to develop this picture as new ways of working take shape (Neighbourhood Health Providers and Integrated Health Organisations).

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Key NHS planning roles and responsibilities

Providers:

- Develop strategic, operational and financial plans to deliver on national and local priorities, including pathway redesign and service development.
- Develop and continuously improve the foundations for integrated planning including robust demand and capacity modelling and triangulation across quality, finance, activity and workforce plans.
- Ensure strong clinical leadership in plan development and linked decision making.
- Collaborate with system, place and provider collaborative partners to ensure plans support the delivery of the best outcomes for local populations and the most effective use of collective resources.
- Work with ICBs to ensure plans reflect agreed commissioned activity levels and align to the overall system strategy.

Regions:

- Support ICBs and providers to 'create the conditions' for effective, integrated planning across the region, including assessment of planning maturity.
- Lead those planning activities where a regional or cross-system response is required e.g. strategic infrastructure planning, long term workforce planning, education and training capacity planning.
- Support and assure ICB and provider responses to nationally mandated elements of NHS planning including risk assessment, coordinating appropriate support, and plan acceptance.
- Work closely with national teams to design national planning products and processes and support capability and capacity building.

ICBs:

- Set overall system strategy to inform allocation of resources to improve population health outcomes and ensure equitable access to healthcare.
- Lead system level strategic planning, ensuring effective demand management and optimal use of collective resources.
- Set commissioning intentions and outcome-based service specifications to enable providers to undertake effective operational planning aligned to national and local priorities.
- Convene and co-ordinate system-wide planning activities e.g. pathway redesign, neighbourhood health, fragile services, capital and estates.
- Work closely with region on planning activities where a cross-system or multi-ICB response is required.
- Co-ordinate system response to nationally determined NHS planning requirements, working with region and providers.

National:

- Set strategic direction and national priorities and standards for the NHS.
- Develop and continuously improve the national planning framework, including specific requirements for the nationally co-ordinated element of NHS planning.
- Support capability and capacity building across the system and promote sharing and adoption of best practice.
- Deliver centrally developed resources, such as analytical tools, data packs, modelling assumptions, and templates to reduce duplication and ensure consistency.
- Provide guidance and technical support to underpin planning and assurance processes
- Work closely with regions, ICBs and providers on the design and refinement of national planning products and processes.

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The integrated planning process

Planning is a continuous cycle that is linked to strategy, delivery and performance management. The most technically sound plan will fail if it does not command the support of the staff who must deliver it and the patients and public whose care it is designed to improve. A robust process ensures the plan is well-informed, broadly supported, and feasible to implement. This section sets out a two-phase process to support the development of credible, deliverable integrated plans.

The aim of the initial phase is to lay the foundations for success. This involves:

- setting up the integrated planning process and governance at organisation, place and system level
- building a robust evidence base including data-driven insights into population needs, service demand, workforce supply and capacity, and finances.

In the second phase, plans are fully developed, triangulated and assured through a multidisciplinary process, and finally signed off by boards. These phases are not rigid and the core activities across these phases may overlap and interact with each other. Table 2 sets out the core activities for ICBs, providers and place partners for each phase. Supporting resources will be shared on the Futures NHS Planning platform. We will continue to develop this into a library of planning best practice, including supporting models and tools, and encourage all organisations to contribute their own best-practice examples and experiences[1].

Phase one

The first step is to establish clear roles and responsibilities and multidisciplinary planning teams to drive and co-ordinate the activities set out in table 2. In phase one these should include:

- Population health needs assessment, identifying underserved communities and surfacing inequalities.
- Identifying service and pathway redesign opportunities, including where services are vulnerable to becoming unsustainable because of size, workforce shortages, infrastructure, or unmet demand.
- Demand and capacity analysis, including a bottom-up assessment to ensure demographic and technological changes are anticipated (demand), and productivity, workforce and estates factors are explicitly considered (capacity)

[1] Please get in touch at england.ops-planning@nhs.net

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- Identifying opportunities to improve productivity and efficiency (this should be a continuous process).
- Financial analysis to establish a baseline underlying position and cost drivers, including a clear understanding of unit costs.
- Reviewing and refreshing the organisation's clinical strategy to ensure it is up to date and aligned to the 10YHP.
- Reviewing the organisation's improvement capability.
- Reviewing strategic estates plans, opportunities for disposals and consolidation and where new additional or different estate is needed for transformation or performance improvement

Executives and boards should ensure that structures and processes are in place to support integrated planning e.g. through a programme board or steering group that meets regularly to drive the planning process forward. As noted in section 2, formal arrangements should also be in place to support effective planning with system partners, including the independent sector. This includes joint planning sessions with local authorities to align with their strategies at place, and structured collaboration with the VCSE sector, who often have deep community roots and provide vital services.

Phase two

The development of integrated plans should build on robust population health improvement and clinical strategies that reflect both local needs and national ambitions, including the three shifts set out in the 10YHP. Informed by the foundational activities and analysis undertaken during phase one, the integrated plan should bring together:

- **Service plans** that address key opportunities to redesign pathways to better meet local needs, improve access, quality, and productivity
- **Workforce plans** to deliver the right workforce with the right skills aligned to finance and activity plans. Over a five-year horizon, roles and required skills will evolve e.g. driven by digital transformation and new treatments. Plans will need reflect this as well as setting out the measures to attract staff and improve staff retention
- **Financial plans** that show how the organisation intends to live within its means and secure financial sustainability over the medium-term while delivering on operational and quality priorities
- **Quality improvement plans** to improve patient care, experience and outcomes
- **Digital plans** that build digital capability, leverage data for better decision-making, support improved population health, enable improved patient care and experience, and drive efficiency and integration

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- **Infrastructure and capital plans** that maximise the utilisation of existing assets and capital investment in the most effective way, to deliver objectives on transformation and performance improvement over the medium term

Organisations should also be considering how they mobilise their improvement capability to deliver these plans.

Triangulation

Triangulation is a critical part of the integrated planning process, ensuring that each element of the plan reinforces the others, making the plan internally consistent and realistic. As a minimum, this involves:

- a common data set and shared set of planning assumptions at the outset, so that everyone is planning on the same basis.
- holding regular reconciliation meetings, where - for example, finance, HR, and operational leads review draft numbers together to identify and resolve discrepancies.

Integrated planning tools or models that combine activity, workforce, and finance projections can help ensure consistency and provide transparency around how changes in one area of the plan affects others.

Triangulation is not only an internal NHS exercise, it also involves aligning NHS plans with those of local government and other partners. A truly integrated plan will consider the local authorities' plans for public health, social care, and broader community development.

Plan Assurance

Having an aligned, integrated plan is not enough – the plan must also be credible, deliverable and affordable. Credibility means the plan's assumptions and targets are evidence-based and convincing to stakeholders (including regulators and the public). Deliverability means that the plan can realistically be executed with the available resources and operating environment. Affordability means the plan's financial assumptions are sustainable and align with available funding and budgetary limits.

Executives and boards are expected to rigorously test the plan before finalising it using robust assurance processes. This includes formal challenge sessions during the plan's development, to critically test assumptions and proposals, and request revisions if needed. Scenario planning and sensitivity analysis should play a key role in supporting this process to:

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- provide a clear, quantitative measure of the plan's key financial and non-financial risks and focus attention on how these can be managed.
- systematically identify the most critical and uncertain assumptions and quantify the impact of this uncertainty.

Declaring a plan “deliverable” is not a one-off event – it requires ongoing oversight once implementation begins. Best practice involves setting up a robust delivery monitoring mechanism as part of the planning framework. Learning should be captured as part of this process to help inform continuous improvement across the planning and delivery cycle.

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Table 2: Core activities across the integrated planning cycle:

<table>
<tr><th></th><th>ICB</th><th>Provider[2]</th><th>Place partners</th></tr>
<tr><td rowspan="2">Phase one: Setting the foundations</td><td colspan="2">Perform a refresh of the clinical / organisational strategy as required to ensure they are updated to reflect changes in national policy (e.g. the 10YHP) or local context. Review organisational improvement capability.

Establish appropriate governance structures and agree responsibilities and ways of working to support the integrated planning process, including engagement with patients and local communities</td><td rowspan="2">Provide place-level input on population needs and local priorities including Joint Strategic Needs Assessment (JSNA)</td></tr>
<tr><td>Assess population needs, identifying underserved communities and surfacing inequalities, and share with providers

Review quality, performance and productivity of existing provision using data and input from stakeholders, people and communities

Develop initial forecasts and scenario modelling for demand and service pressures

Generate actionable insights to inform service and pathway design with providers

Create outline commissioning intentions for discussion with providers</td><td>Review quality, performance and productivity at service level as well as the organisation’s underlying capabilities (workforce, infrastructure, digital and technology)

Establish a robust financial baseline based on underlying position and drivers of costs

Identify key sources of unwarranted variation and improvement opportunities through benchmarking and best practice

Identify service and pathway redesign opportunities including reviewing fragile services

Undertake core demand and capacity analysis and develop initial forecasts and scenario modelling</td></tr>
</table>

[2] Individually and jointly across provider collaboratives

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	ICB	Provider[3]	Place partners
Phase two: Integrated planning	Develop an evidence-based five-year strategic commissioning plan to improve population health and access to consistently high –quality services	Develop a credible, integrated organisational five-year plan that demonstrates how national and local priorities will be delivered, including securing financial sustainability	Lead the co-design of integrated service models at place level Develop Neighbourhood Health Plan and supporting place-based delivery plans
	Bring together neighbourhood health plans into a population health improvement plan in discussion with people, communities and partners Iterate initial forecasting and scenario modelling for demand and service pressures Finalise commissioning plans to inform provider plan development Undertake QEIAs to support informed decision-making through the planning process Ensure improvement resources are aligned to the priority areas of the plan	Iterate core demand and capacity analysis and scenario modelling to reflect service redesign opportunities Develop clear service level plans that meet national and local priorities, including implementation plans best practice care pathways Triangulate and finalise finance, workforce, activity and quality plans Undertake QEIAs to support informed decision-making through the planning process Ensure improvement resources are in place to deliver plans	

[3] Individually and jointly across provider collaboratives

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The national planning architecture

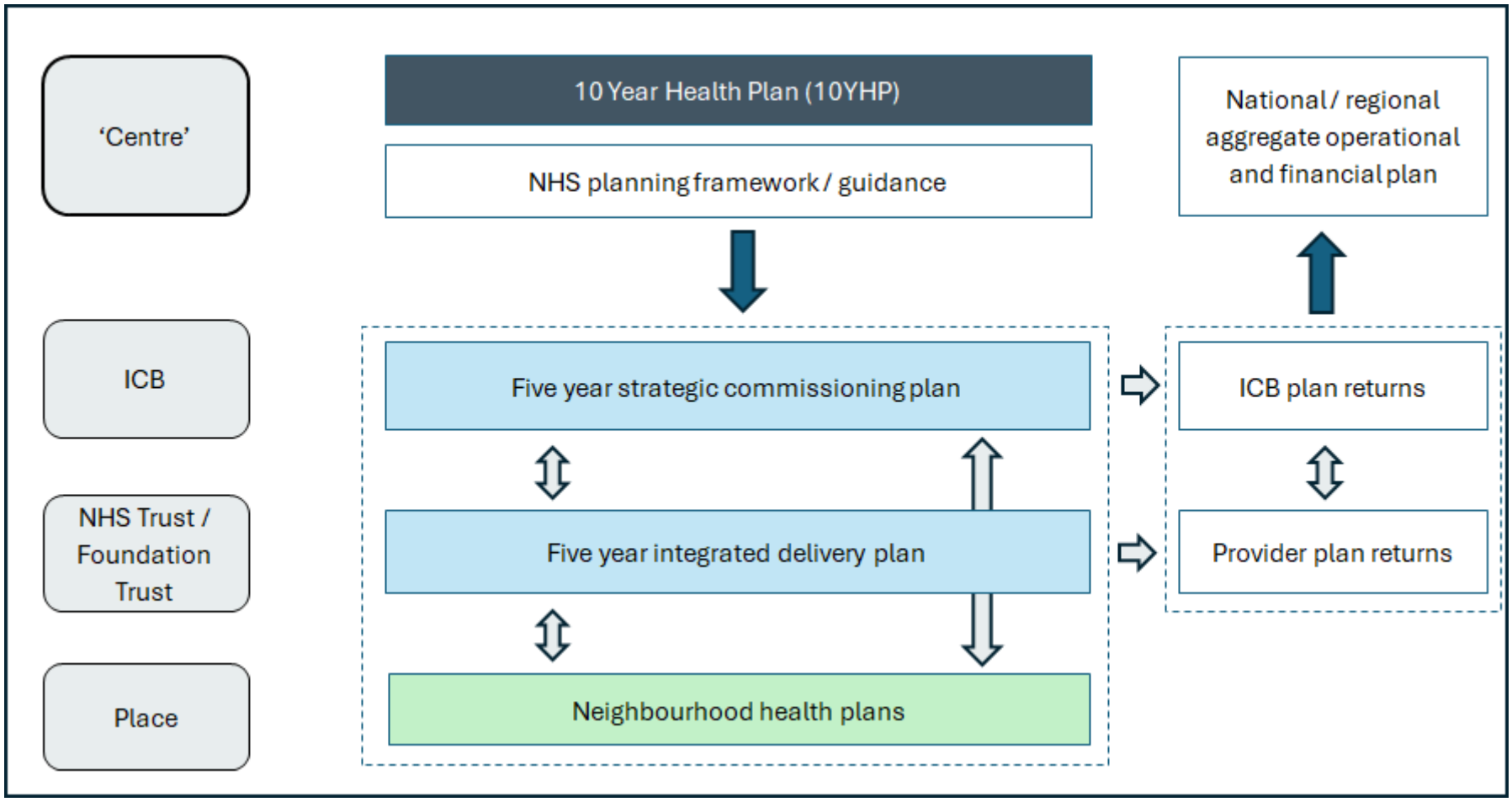
This framework has been developed as a guide for local leaders across England responsible for the development of the strategic and operational plans that will deliver on local priorities as well as our shared national ambitions for the NHS as set out in the 10YHP. These plans are the cornerstone of a wider national planning architecture designed to ensure that:

- plans are developed based on appropriate, accurate and timely information.
- plans are developed on a consistent basis to support aggregation, reporting, and oversight and accountability.
- planning activities at local, regional and national level align and support each other.

As set out in the 10YHP, five-year organisation plans together with neighbourhood health plans will be the core outputs of integrated local planning processes. They are described at a high level in Table 3. NHS England and DHSC will issue specific guidance to support their respective development. Given these changes, we will also work with government to review the requirement for ICBs and their partner trusts to prepare a five-year joint forward plan (JFP) and joint capital resource use plan (JCRUP).

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Relationship between key elements of the national planning architecture



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Table 3: Core planning outputs

Output	Description
Five-year strategic commissioning plans (ICBs)	Describes how, as a strategic commissioner, an ICB will improve population health and access to consistently high –quality services across its footprint. We will work with ICBs to develop specific guidance. As minimum, we expect that plans will: • set out the evidence base and overarching population health and commissioning strategy • bring together local neighbourhood health plans into a population health improvement plan (PHIP), including how health inequalities will be addressed • describe new care models and investment programmes that maximise value for patients and taxpayers aligned to 10YHP • demonstrate how the ICB will align funding and resources to meet population needs, maximise value, and deliver on key local and national priorities • describe how the core capabilities set out in ICB blueprint will be developed. ICBs will be expected to refresh these plans annually as part of establishing a rolling five-year planning horizon for the NHS.

Five-year integrated delivery plans (NHS Trusts and NHS Foundation Trusts)	Demonstrates how the organisation will deliver national and local priorities and secure financial sustainability. We will work with providers to develop specific guidance. As minimum, we expect that plans will:
	• set out the evidence base and organisation's strategic approach to:
	  ○ improving quality, productivity, and operational and financial performance
	  ○ meeting the health needs of the population it serves and how this approach contributes to delivering the overall objectives of the local health economy

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	• describe the actions that will support delivery of the trust's objectives, including key service development and transformation schemes and how these will impact quality and support operational and financial delivery • summarise how the underpinning capabilities, infrastructure and partnership arrangements required to deliver the plan will be developed e.g. workforce skills, digital capability, and estate. Providers will be expected to refresh these plans annually as part of establishing a rolling five-year planning horizon for the NHS.
Neighbourhood health plans	These will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund. The plan should set out how the NHS, local authority and other organisations, including social care providers and VCSE, will work together to design and deliver neighbourhood health services. DHSC will publish separate guidance to support their development.
National plan returns	We will engage with ICBs and providers on the specific requirements for the national plan returns. Five-year organisational plans will be expected to fully align with and support numerical returns. The existing set of annual finance, workforce, activity and performance templates will be redesigned and streamlined to better support integrated planning. There will be separate returns from ICBs and trusts rather than a single 'system return'. ICBs and providers will need to work together to ensure that these are fully aligned.

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Annex A: Development of plans for the five-year period from 2026/27 to 2030/31

We are issuing this framework to help inform the development of plans for the five-year period from 2026/27 to 2030/31. We will continue to work with you to develop specific requirements and ways of working.

Where not already in progress, ICBs and providers must now begin to lay the foundations for developing their five-year plans. This includes the critical work to secure financial sustainability over the medium term. The national planning timetable aligns with the phased approach set out in this framework:

- Phase one will run to the end of September. During this period, NHSE England and DHSC will work together to translate the 10YHP and spending review outcome into specific multi-year priorities and allocations.
- Phase two will launch at the end of September / early October with the publication of multi-year guidance and financial allocations. This will enable ICBs and providers to fully develop their medium-term plans and take them through board assurance and sign off processes in December.

During the initial planning phase, we are asking you to focus on:

- setting up your integrated planning process and establishing a multidisciplinary planning team to co-ordinate activity across functions.
- assessing your organisation's capability, capacity and preparedness against this framework. Key gaps, areas for concern and risks should be discussed at the earliest opportunity with your regional NHS England team, who will work with you to identify potential solutions and support.
- reviewing your clinical strategy against the direction set out in the 10YHP to identify and address any gaps .
- developing a transparent articulation of your underlying financial position
- continuing to develop your understanding of productivity and efficiency opportunities and how they will be delivered, building on the work done through the planning process for 2025/26. Build your Cost Improvement Plans (CIPs) by identifying areas of opportunity.
- developing, where not already in place, a shared view on service reconfiguration opportunities and plans, including approaches to address fragile services.
- assessing and improving the maturity of core demand and capacity planning within your organisation and across the wider system.
- working with NHS England to assess the impact of rebasing fixed payments.

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December plan returns will include firm financial, workforce and operational plans for the first year, which providers and ICBs will be held to account for delivering. Regional teams will lead on the review of these submissions and work with organisations to conclude the plan acceptance process during the first half of quarter four. A high-level timeline is shown below.

We will issue allocations based on the statutory ICB footprints for April 2026 and ask ICBs to prepare and submit plans on that basis. Where ICBs are entering into clustering arrangements ahead of a planned future merger they will need to work together to appropriately reflect these arrangements in their plans.

Specialised Services, Health and Justice, Vaccinations and Screening

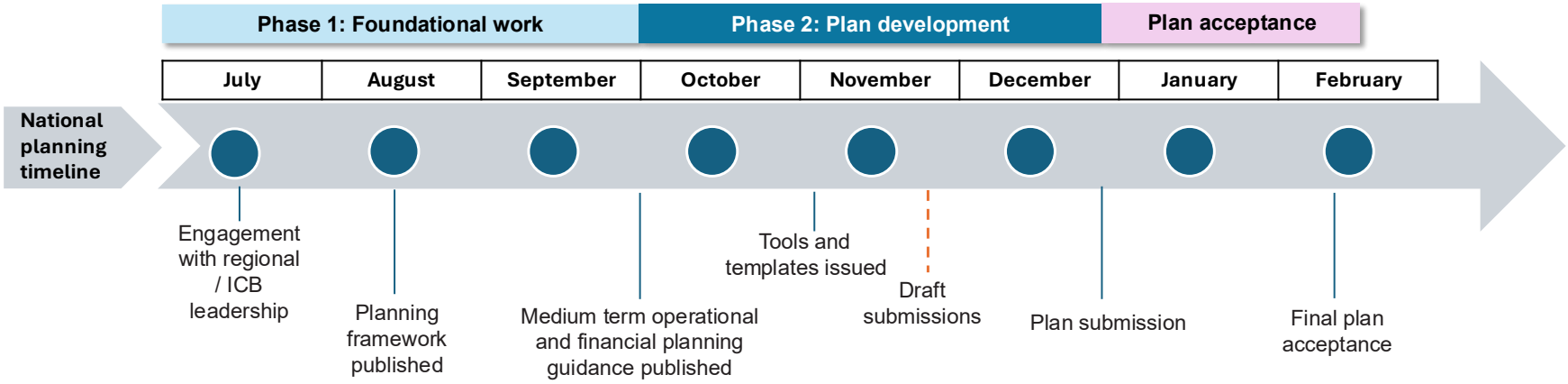
ICBs have already taken on delegated commissioning responsibility for certain specialised services and will also take on a greater leadership role from April 26 for the commissioning of screening services, vaccination services (building on existing partnership arrangements already in place with ICBs), and health and justice services. It is anticipated that full commissioning accountability for these services will transfer to ICBs from April 27.

ICBs will need to work in close partnership with their NHS England Regional Teams to prepare for these changes, including establishing a single (one per NHS Region) ‘Office for Pan-ICB Commissioning’ to ensure appropriate ‘at-scale’ commissioning of these services continues, and a concentration of expert commissioning capability maintained. The Offices will support all ICBs equally and collectively across a Region in discharging these new responsibilities and future accountabilities. Further details on the requirements and timetable for transition will follow.

It is therefore critical that ICBs, in partnership with their NHS England Regional Teams, ensure these services are fully factored into medium terms plans and that those plans begin to realise the benefits of whole pathway and population-based commissioning, including the opportunities that upstream interventions can have in reducing demand for specialised services.

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Indicative timetable for 2026/27 – across two phases



Regional activities	Develop medium-term strategic framework Engage with ICBs and providers to identify support needs		Risk-based planning support to ICBs and providers		Review of draft plans	Plan assurance and acceptance	
ICB activities	Set up process, governance and build a robust evidence base	Create outline commissioning intentions and discuss with providers	Integrated planning		Finalise plans & board sign-off	Respond to outcome of plan assurance	Prepare to implement plans
Provider activities	Set up process, governance and build a robust evidence	Complete foundational work	Integrated planning		Finalise plans & board sign-off		
Outputs		Underlying financial position Block contract reviews		Draft Planning returns	Five year plans National returns		

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Board of Directors' Meeting
5th September 2025

The Rotherham NHS Foundation Trust

Agenda item	P135/25
Report	**Endoscopic Retrograde Cholangio-Pancreatography (ERCP) Service at The Rotherham NHS FT: Update**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	P1: We will not embed quality care within the five year plan U4: We do not develop and maintain a positive culture
How does this paper support Trust Values	**Ambitious:** Demonstrates that the Trust strives to deliver the highest standards and quality of care possible. **Caring:** Demonstrates that the Trust strives to give outstanding, compassionate care. **Together:** Demonstrates that the Trust strives to ensure that quality improvement and the learning from incidents is achieved through a multidisciplinary approach.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	Following the board paper reporting on the deficiencies if the ERCP service and publication of the Royal College of Physicians Invited Service Review, Woodward and Painter Review an update is provided. Prior to the board meeting the Duty of Candour Process had been initiated for the 68 patients whose case was reviewed. 54 patients have been contacted as part of the initial phone calls. Unfortunately we have been unable to contact 14 although only 3 of these patients met the threshold for duty of candour. 23 patients have had a form of follow up as requested by themselves or the family. 60 cases have been closed and 8 remain open. The external governance review is expected shortly.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Update report submitted to Executive Team Meeting on 21st August and a follow up paper to ERCP in June public board.
Board powers to make this decision	No decisions are required.

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Who, What and When (what action is required, who is the lead and when should it be completed?)	The Medical Director will continue to keep the Board appraised of the position.
Recommendations	It is recommended that the Board note the report and the next steps.
Appendices	Not Applicable

Overview

The Board received a paper in June 2025 reporting on the deficiencies in the Endoscopic Retrograde Cholangio-Pancreatography (ERCP) service at The Rotherham NHS Foundation Trust between 2016-2021.

ERCPs make up less than 5% of endoscopies performed in the UK and carry well-recognised risks. ERCPs are undertaken to diagnose and treat problems in the liver, gallbladder, bile ducts, and pancreas. The procedure combines X-ray and endoscopy to look at the bile duct and the pancreatic duct and can also be used to remove gallstones or take tissue samples for analysis. Patients requiring an ERCP often have complex health conditions which can be considered life limiting such as frailty or an underlying malignant disease. The reported mortality rates after ERCP in the UK average 4.2% and the Trust's mortality rate was below this.

From 2016, the Trust's ERCP service was delivered by a single operator but following a cluster of adverse incidents and complications, the service was suspended in July 2021. Since then patients from Rotherham needing an ERCP have had this nearby with the support of our partners Sheffield Teaching Hospitals NHS FT.

The Trust commissioned the Royal College of Physicians (RCP) to undertake an external review which reported in January 2023. The RCP report found a range of failures of care including inadequate recording of informed consent, deficiencies in the ERCP report, poor radiological documentation, no documentation regarding prophylaxis to reduce risk of pancreatitis, concerns regarding stent choice, concerns regarding sedation, discharge processes and lack of responsiveness to deteriorating patients, lack of appropriate Multi-Disciplinary Team discussion and decision making, and deficiencies in case records. A number of recommendations were made which were accepted and have been implemented.

We identified 959 ERCP procedures undertaken from 2016 to 2021 and, as recommended by the RCP, the care of 68 patients who had died or suffered a complication within 30 days of the procedure were externally reviewed by independent experts. A similar pattern of care failures was identified. Overall the care of 58 patients was found to have had failures with 25 having suffered some degree of harm. It is important to note that ERCP has an inherent risk of harm and it isn't necessarily the case that a deficiency in care was the cause of harm.

The Board was informed of the intention to contact all 68 patients or their families on the 4th and 5th June to apologise, to explain what had happened and to outline what the external review has said about their individual care.

The external reports were published through the public board papers on the Trust website on the 6th June.

Patient Follow Up

68 patients were involved across the RCP, Woodward and Painter review.

Initial telephone contact was attempted on the 4-5th June with further follow up calls as necessary.

All phone calls were made by a clinician either senior nursing or medical staff. The phone calls were initial duty of candour phone calls with a duty of candour letter following.

54 patients were contacted during these phone calls which involved a brief explanation of the reasons for the call and a chance to confirm contact details. Each patient or relative then received a letter with a contact telephone number to arrange further follow up as required.

Of the 14 patients or relatives we were unable to contact there was a robust process of checking medical records and contacting GP surgeries in an attempt to find a correct telephone number.

Of the 14 patients we were unable to contact no further attempts were made to contact 11 as these patients had had no or low harm found in the review process. One patient who is deceased has no next of kin. Two patients were sent letters asking them to contact the Trust.

For patients with low or no harm no further contact has been made unless requested by the patient or family.

For patients with moderate harm or above who did not contact the telephone number on the letter a further follow up phone call was made. These phone calls took place the week beginning 14th July as they were delayed until after media coverage.

Follow up has taken place as follows;

9 follow up telephone calls requested and all have been completed.

11 patients or families have requested the reports which have been sent.

6 face to face meetings have been completed with no further meetings planned. .

2 subject access requests

A total of 23 patients have had follow up actions.

60 cases have been closed as follow up completed.

8 cases remain open;

3 further follow up action required

5 awaiting follow up

The follow up calls and meetings have generally been met positively by patients and relatives. The themes and feedback from the patients and families are consistent with the findings of the reports. In a small number of cases the feedback from the family or patients has led to consideration of the level of harm being upgraded from moderate to severe.

Concerned Public

2 patients contacted the patient experience team and these concerns were followed up. One patient was reassured with no further follow up required and one patient was a patient involved in the reviews who had already received a phone call and letter.

Staff Follow Up

Teams were visited ahead of the public board meeting and after to inform them of the release of the report and to offer support and an opportunity to address concerns. Staff involved in the RCP report and process were also informed.

An all staff email communication was sent ahead of anticipated media coverage.

Communications Update

The publication of the reports led to some media attention with no recent further coverage. The Communications team continue to provide support.

External Governance Review

Following the Trust's board meeting in July, further material was submitted to the external governance review and the team conducted a small number of additional interviews. The Trust expects to receive the completed review shortly, and we aim to report to the next board meeting.

ERCP Incident Coordination Group

The group has met on two further occasions since the publication of the report and is awaiting the external governance review.

Next Steps

The Trust will continue to support the affected patients and families involved in these reports. We appreciate this will be a difficult time for them and the Trust apologises unreservedly and will ensure they have the opportunity to understand the care they or their relative received.

The Board will receive an update once the external governance review is available.

Dr Jo Beahan
Medical Director
August 2025

Board of Directors' Meeting
5th September 2025

The Rotherham NHS Foundation Trust

Agenda item	P136/25
Report	**Yusuf Nazir (YN) Patient Safety Independent Investigation**
Executive Lead	Dr Jo Beahan Medical Director
Link with the BAF	**P1:**There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The Independent Patient Safety Investigation report into the sad death of Yusuf Nazir by Nurture was published on Thursday 31st July 2025. Yusuf was a 5 year old boy who sadly died on the 23rd November 2022. Yusuf attended the Urgent and Emergency Care Centre at TRFT on the 15th – 16th November 2022 and was discharged home with oral antibiotics. He was admitted to Sheffield Children's Hospital on the 18th November and died on the 23rd. **<u>Report Summary</u>** The report has found that Yusuf died of pneumonia and sepsis which led to respiratory failure and his death. No causative organism was found so it is impossible to say if earlier detection or intravenous antibiotics would have prevented his death. The report has found that the treatment at TRFT was in line with clinical guidelines and treatment in line with his presentation at the time. On the balance of probabilities the presentation was likely to be tonsillitis and appropriate consideration was given to the red flag symptoms which were not present. In response to the question ' Is there any clinical evidence to suggest that earlier admission to TRFT for IV antibiotics would possibly prevent death?' . The independent expert stated ' I do not believe it would have done' and has confirmed there was no recommendation for IV antibiotics. **<u>Recommendations</u>** The report has made a number of recommendations which are general, organisational, family and national.

	TRFT has one recommendation regarding parental concerns as follows; Introduce structured documentation prompts specifically designed to consistently capture and address parental concerns during clinical and nursing assessments. Implement by June 2026. There is a plan in place to implement this. The Trust will be reviewing the general recommendations alongside all recommendations in the Trust and will develop an action plan and will ensure these actions are embedded. A number of actions have already been completed following the previous report. **Next Steps** There will be a Coronial inquest in January 2026.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper has been discussed at Executive Team Meeting 21st August 2025.
Board powers to make this decision	No decision is required.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Executive Team will receive a paper in September in response to the recommendations in the report and the progress that has been made in embedding the recommendations. This will be monitored through Quality Committee.
Recommendations	It is recommended that the board considers the report and agrees next steps.
Appendices	The following are available in the Review Room: YN PSII Report & Appendices

The Independent Patient Safety Investigation report into the sad death of Yusuf Nazir by Nurture was published on Thursday 31st July 2025.

Yusuf was a 5 year old boy who sadly died on the 23rd November 2022.

Yusuf attended the Urgent and Emergency Care Centre at TRFT on the 15th – 16th November 2022 and was discharged home with oral antibiotics. He was admitted to Sheffield Children's Hospital on the 18th November and died on the 23rd.

Shared by Yusuf's family;

"The unimaginable loss of Yusuf has left all his family heartbroken with a feeling of emptiness that can never be filled. Yusuf's energy, mannerisms and infectious smile will forever be missed by everyone he came in contact with."

Report Summary

The report has found that Yusuf died of pneumonia and sepsis which led to respiratory failure and his death. No causative organism was found so it is impossible to say if earlier detection or intravenous antibiotics would have prevented his death.

The report's primary finding is that the parental concerns, particularly the mother's instinct that her child was unwell, were repeatedly not addressed across services. A reliance on clinical metrics over caregiver insight caused distress for the family. This led to a lack of shared decision-making and there was limited evidence of collaborative discussions with Yusuf's family around clinical decisions, leading to a sense of exclusion and reduced trust in care plans.

In response to the question 'I*s there any clinical evidence to suggest that earlier admission to TRFT for IV antibiotics would possibly prevent death?'* The independent expert stated 'I do not believe it would have done' and has confirmed there was no recommendation for IV antibiotics.

Recommendations

The report has made a number of recommendations which are general, organisational, family and national.

TRFT has one recommendation regarding parental concerns as follows;

Introduce structured documentation prompts specifically designed to consistently capture and address parental concerns during clinical and nursing assessments. Implement by June 2026. Audit patient records quarterly from June 2026 to confirm structured prompts are routinely completed and actioned effectively.

In the Urgent and Emergency Care System we use the Paediatric Observation Priority Score which uses a combination of physiological measurements, behavioural and risk factors to generate a score between 0-16 to support assessment and prioritisation of the care of acutely ill children in emergency and urgent care settings.
This includes 'gut feeling 'but this usually relates to staff perception.

To address parental concerns we will add a mandatory section alongside the POPS score which will ask:

Parent/Carer Concern (Ask your parent/carer: How is your child different from when I last saw them? You then decide if their response means: Worse, Same, Better)

If the answer Worse is selected this will trigger an alert *"Inform Nurse in Charge. Consider increased monitoring and Medical Review"*

This will be audited quarterly by June 2026 to confirm the prompt is completed and the action is effective.

The Paediatric ward will be moving to the National PEWS scoring system in September. This scoring includes parental concern and allows this to trigger escalation and a review.

The Trust has embedded Martha's rule in all in patient settings which allows relatives an opportunity to call if concerned and a team not currently caring for the patient will review.

The Trust will be a pilot site for the next roll out of Martha's rule and will be piloting this in the Urgent and Emergency Care setting.

General recommendations

Differential Diagnosis

Implement structured reflective practice within supervision to systematically consider differential diagnoses, explicitly addressing cognitive biases.

Develop audit criteria for medical records to verify inclusion of differential diagnosis by December 2025.

Identify whether the audit has positively impacted on the management of patients by considering how you can measure identification of the outliers, those who have not responded to initial treatment and therefore benefited from an alternative diagnosis.

Embedding Caregiver Concerns

Embed consultation skills addressing caregiver concerns within existing departmental education and simulation programmes focused on managing the acutely unwell child.

Ensure 100% of relevant local training programmes including simulations include clearly defined learning outcomes related to caregiver communication skills and are completed by December 2026.

Enhance clinicians' skills in managing caregiver concerns improving overall patient and caregiver experience in acute presentations. Integrate this objective within existing educational frameworks, avoiding additional burdens by leveraging current simulation and education resources.

Publication

The publication of the report received local and national media attention. The Trust briefed relevant stakeholders and published external and internal communications.

The Trust continues to offer support by the staff who have been affected by the report.

Next Steps

The death will now be the subject of a Coronial Investigation with a pre inquest hearing expected later this year and an anticipated inquest scheduled for January2026.

The Trust will consider all the recommendations made in the report including those for other organisations to ensure we optimise learning.

The Executive Team will receive a paper detailing the Trust response to the recommendations in September. The action plan will be monitored through Quality Committee.

The Trust continues to meet with the YN IPSI Governance Review Group.

Dr Jo Beahan
Medical Director
August 2025

Board of Directors
5th September 2025

Agenda item	P138/25						
Report	Skills Street update						
Executive Lead	Daniel Hartley – Director of People						
Link with the BAF	This item supports and enables all areas of the BAF						
Purpose	Decision		To Note	✓	For Approval		For Information	
Executive Summary (including reason for the report, background, key issues and risks)	As set out in the Trust Workforce Plan 2025-2028 Skills Street is a significant part our work as an Anchor institution, and a project that the Trust is proud to be part of. The Skills street initiative provides open in summer this year and is an immersive and innovative experience designed to wider career aspirations among children, young people and adults in the region. TRFT has collaborated with Rotherham Metropolitan Borough Council and Rotherham, Doncaster and South Humber NHS FT to create a Health and Care zone within Skills Street. The zone is one of 15 sector zones and Skills Street has attracted significant investment and engagement from and with leading employers across the South Yorkshire economy and beyond. It is the only facility of its type in the North of England and it is based in Rotherham near Gullivers Valley theme park. In the first two months of operation more than 1600 students have visited Skills Street, more than a quarter of whom are from Rotherham primary and secondary schools. It is and will play a key role in both inspiring the future and securing a pipeline of new recruits into health and social care. The attached presentation is designed to showcase this work and update the Board on progress made to date. It also sets out next steps and the Board is asked to support a visit to the facility in the near future.						
Recommendations	The Board of Directors are asked to; • Note the TRFT involvement in Skills Street as part of Anchor institution work • Support a visit for the Board to the facility to see it first hand						
Appendices	Skills Street presentation						



Immersive Health and Social Care Careers Zone

What is Skills Street?

- Skills Street is a collaborative Community Interest Company, co-founded by Gulliver's Valley Resorts and The Work-Wise Foundation. In total £1.6m has been invested through a range of partners including HM Government. It is the only facility of its kind in the North of England.
- It features 15 different interactive sector zones, each co-designed by brands and businesses, highlighting their industry roles, skills needs, and routes into employment, allowing young people to see different futures by experiencing different opportunities.
- The particular collaboration the Trust is part of is between Skills Street and TRFT, Rotherham Metropolitan Borough Council and Rotherham Doncaster and South Humber NHS FT to create a health and social care careers zone.



- TRFT has made a 3 year commitment, @ £15K per annum to inspire the future and attract people to careers in health and social care.
- Education and activities have been co-designed are delivered by Skills street education partners. As part of that investment Skills street is developing data and analytics on effectiveness.

What is in the Health & Social Care Zone?

- The curriculum has been designed by our education experts and teachers at the South Yorkshire Education Hub.
- The space has been kitted out with hospital and community equipment, an AI-based computer activity and uniforms for an immersive learning experience.



Skills on Show /Developed

Skill	Person-centred Care	Team working	Compassionate	Detail-focussed
What it means in health and social care	Thinking about what a patient or service user needs from you and their care / treatment at every step of the way	We go out of our way to help the whole team deliver it's aims	Taking time to understand others with empathy and how we can support them to be at their best	Ensuring safety and accuracy are of the highest priority in everything we do

Typical activities:

- include helping someone put a uniform on without them speaking or moving – teaches empathy for those with differing needs.
- Roleplaying patients in distress (Skills Street Eduplay staff support with this)
- Responding to an AI-avatar/computer system re: symptoms
- Building a simple anatomical model of a human body from parts
- Top-trumps style card game about the skills needed for different health & social care activities.

What does immersive learning look like?







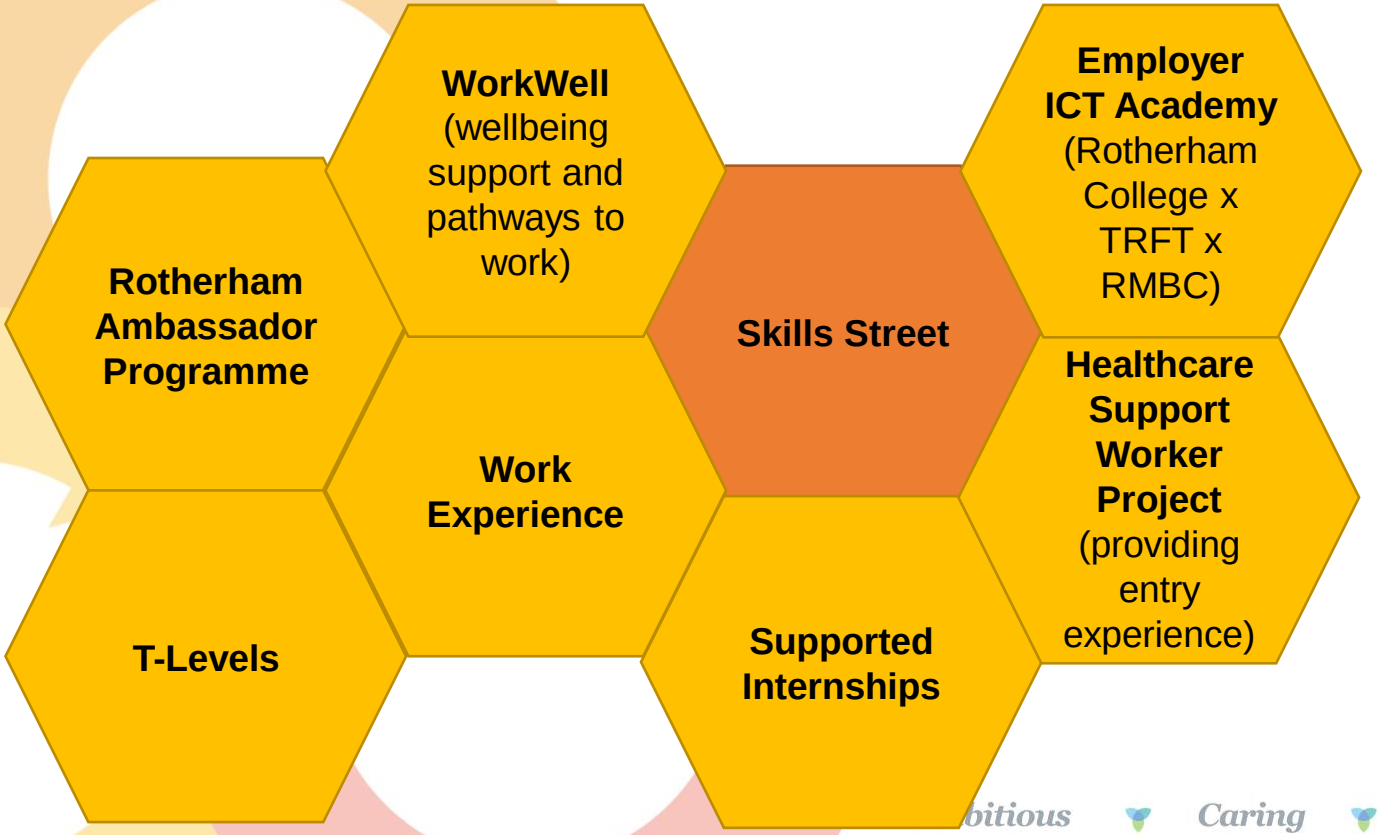




Attendances and next steps

- To date, since opening in July 2025, 1600 students have attended Skills Street, 445 of whom have been from Rotherham Primary and Secondary Schools.
- Furthest school visit to date has come from Pickering, North Yorkshire.
- The site continues to develop, including outdoor landscaping, the addition of a decommissioned ambulance from YAS and other employers joining the wider site.
- We will be working to gather feedback and consider any improvements we can make to the sector space in Q3 and working with Skills Street in Q3/Q4 on evaluation

Part of Trust role as an Anchor institution



bitious Caring Together

Board of Directors' Meeting
5th September 2025

Agenda item	P139/25i
Report	**Teaching Hospital Status**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	
How does this paper support Trust Values	This paper supports the Trust Value of 'Ambitious'
Purpose	**For decision ☒ For assurance ☐ For information ☐**
Executive Summary	Over the last few months the Trust has embarked on its ambition to become a recognised Teaching Trust and is also one of our key strategic objectives. This change to our name is to reflect our ongoing and significant teaching commitment across the organisation. Recognition of our work to educate our current and future workforce will increase our ability to train, recruit and retain the best staff to treat our patients going forward.
Due Diligence	The project surrounding Teaching Status has been subject to weekly updates at a dedicated Task & Finish Group as well as reporting through the Executive Team.
Board powers to make this decision	The Trust Board of Directors are required to have oversight and support the programme of work in order to achieve Teaching status
Who, What and When	Once presented, the Medical Director will proceed with the next steps and progress the recommendations. There will be regular reporting to the Board of Directors.
Recommendations	It is recommended that: 1. Board of Directors are asked to support the approach and suggested timeline for assessing readiness for Teaching Status. 2. The Board of Directors note the potential financial and non financial resourse impacts associated with obtaining Teaching Status with further clarity provided in January. 3. The Board of Directors to endorse the Showcase Document which is a fundamental publication in order to commence the engagement workstreams of the project. 4. The Board of Directors are asked to note that following completion of the engagement workstreams; a portfolio and final paper on Teaching Status will be presented to the Board of

	Directors in January 2026 seeking formal approval for the change which will subsequently be presented to Council of Governors.
Appendices	1. Teaching Status Showcase document.

1. Ambition for recognised Teaching Status

Over the last few months the Trust has embarked on its ambition to become a recognised Teaching Trust and is also one of our key strategic objectives. This change to our name is to reflect our ongoing and significant teaching commitment across the organisation. Recognition of our work to educate our current and future workforce will increase our ability to train, recruit and retain the best staff to treat our patients going forward.

As stated in the update to Board of Directors in July, there is no formal process / application form which needs to be completed to be able to change the name of the Trust and a Teaching Trust. To enable to change in name, both the Board of Directors and the Council of Governors need to agree to the change. This has been confirmed by the Interim Joint Director of Corporate Governance.

Therefore, this work and process if focused on providing the information to the Board of Directors and Council of Governors to enable these bodies to appropriately support the change. This is intended to be done through a portfolio based around a Showcase Document and several letters of support from partner organisations.

2. Work undertaken to date

There has been a significant amount of work undertaken to date, led by the Medical Director and team. This has primarily been through the creation of the Showcase Document. This is a critical part of the process, as it allows the Trust to demonstrate the work that is already in place within the Trust. The Showcase Document is key to inform the discussions that will take place as part of the engagement workstreams and will be a key part of the case presented to Board and Council of Governors when seeking formal approval for the change.

The communications team have sought advice on the naming conventions to ensure that this follows the rules and regulations surrounding NHS Brand Guidelines. The current suggestion to change the name of the Trust to '**Rotherham Teaching NHS Foundation Trust'** would be in-keeping with those guidelines.

A weekly task and finish group has been established, chaired by the Medical Director and Managing Director, and they have formulated a project plan consisting of four workstreams. Each workstream outlines a timeframe with an overall expectation that the Trust would become a recognised Teaching Trust by the 1st April 2026. This is later than originally planned but allows sufficient time for internal and external stakeholder engagement, to receive letters of support and undertake further work to identify some of the currently unknown changes that would need to be made as a result of this work.

3. Financial Impact

Whilst it is to be recognised that there will inevitably be cost implications to becoming a Teaching Trust; the approach we are taken will allow this to be managed in a structured, cost-effective way. Therefore, at this stage, it is not expected that by supporting this change that significant additional financial costs are incurred. This would be confirmed in the paper presented to Board of Directors in January. Details of this approach is set out below.

As part of our engagement with neighbouring Trust they shared with us their experience of updating branding, signage etc as part of the natural series of updates over a period of time. This is likely to be our recommended approach, with minimal 'physical' changes on the 1st April, but items replaced 'as required'. For example, ID badges. Under this approach ID badges would be updated only when naturally issued or replaced (i.e. new starter or expired) rather than re issuing 5000+ badges in one step. This should limit additional financial costs.

Of the required changes we would want to make on the 1st April, it is likely that the main entrance sign to the hospital site will incur the most cost, with an estimated cost of circa £8500.

The ambition to update and modernisation of the education facilities will continue irrespective of this process and would be undertaken in line with the usual process surrounding capital bids. Whilst it is understandable that the overall ambition is to provide our educational offering in a state of the art building/facilities, this has to be done in a sensible, measured, financially sustainable way. Investment in our teaching facilities is a key priority, but it should continue to be prioritised against the other requirements within the Trust such as medical equipment, IT infrastructure and other estates developments.

Whilst the environment and the estate of our training facilities can be challenging, we have to recognise that we already deliver a high quality of education and training at the Trust and therefore any development is not expected to be a pre request for this change.

4. Non-Financial Costs

There will be non-financial costs associated with this change in terms of time and effort. While this not fully known currently, examples of this would include the updating of a significant number of digital templates (i.e. letter templates, BI reports etc). Work will be undertaken to get a fuller understanding of this requirement over the coming months.

As with the financial costs, a pragmatic approach is recommended with only critical / required changes updated on day 1 and remaining changes being updated over a period to time to reduce (or potentially eliminate) the need for additional financial resources.

5. Timeline

The Task and Finish Group has formulated a roadmap which highlights key workstreams and outlines the fundamental stages that the organisation must navigate in order to achieve its primary goal of being recognised as a Teaching Trust by April 2026.Below is an outline of the key milestones and time frames which are proposed

Within this timeline is a range of engagement both internally and externally. A full list of external partners / organisations we are proposing to engage with are listed in the project plan.

This external engagement has been split into two groups of stakeholders.

Group 1: The first is those where we are planning to engage and inform partners of our ambition to move to a Teaching Trust. This will include organisations such as Rotherham Council and Sheffield Children's Hospital.

Group 2: The second group is those where we are planning to engage and seek explicit support for this change, for example the Universities which we work with and key NHS organisations such as NHS England. We plan to receive this support through the collection of 'letters of support' from these organisations.

For the group 2, the timeline splits this engagement into two parts, an initial engagement section where we sound out and seek verbal support (using our Showcase Document to support) and then a second section where we receive formal support. This has been shown in this way to recognise that these organisations may need time to take this support through their internal governance processes.

There continues to be some risk within this timeline, in particular regarding the letters of support which is dependent on external bodies being able to return as expected. This has been mitigated through the two-stage approach and the wide window provided, however, there could still be delays that we are unable to control.

Council of Governors Initial Engagement	3rd September 2025
Board of Directors: Update & Timeline	5th September 2025
Engagement with organisations where we want explicit support (Group 1) – initial engagement sessions	8th September – 30th October 2025
Engagement (Group 2) • Internal and External Stakeholders • Public	8th September 2025 – 30th November 2025
Update to Board of Directors	7th November 2025
Receipt of Stakeholder Support Letters (Group 1)	30th October 2025 – 30th December 2025
Final Approval – Board of Directors	16th January 2026

Final Approval – Council of Governors	TBC (January 2026)
Seek change of Establishment Order (estimated 8 week timeframe)	End of January 2026
Recognised as a Teaching Trust	**1st April 2026**
Post approval changes • Signage/Estate • IT/Coding • Branding/Communications	From formal approval onwards

6. Recommendations

It is recommended that:

1. Board of Directors are asked to support the approach and suggested timeline for assessing readiness for Teaching Status.

2. The Board of Directors note the potential financial impact associated with obtaining Teaching Status with further clarity provided in January.

3. The Board of Directors to endorse the Showcase Document which is a fundamental publication in order to commence the engagement workstreams of the project.

4. The Board of Directors are asked to note that following completion of the engagement workstreams; a portfolio and final paper on Teaching Status will be presented to the Board of Directors in January 2026 seeking formal approval for the change which will subsequently be presented to Council of Governors.

Dr Jo Beahan
Medical Director
September 2025





The Rotherham NHS Foundation Trust

Teaching Status 2025

Ambitious Caring Together

NHS
The Rotherham
NHS Foundation Trust

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A message from Dr Mike Richmond, Chair



When I started my role in Rotherham in January 2024, I was struck by the sheer amount of determination and ambition our teams have to constantly improve the services we provide to the people of Rotherham. We have harnessed this ambition to further our strategic ambitions so that we are striving for excellence in everything we do.

The Trust has long-established partnerships with local and regional organisations in the health and care sectors, as well as with education providers and universities across South Yorkshire and beyond, which have helped to develop the skills and expertise of our current and future NHS workforce.

As an anchor institution and a major employer in Rotherham, we have a responsibility to not only help our local community access the very best healthcare services, but also to inspire the future workforce and provide local people with the opportunity to thrive in their careers. Adding teaching to our name makes our ongoing commitment to teaching, training and education clear to our partners, and our current and future workforce.

The Board of Directors are proud to submit our application to become a teaching Trust, and we have been hugely encouraged by the enthusiasm and support our colleagues and local stakeholders have provided in our bid.





A message from Dr Richard Jenkins, Chief Executive

We are proud of our commitment to teaching, education and development, and we provide over and above what would be ordinarily expected of us. This showcase document provides an insight into our commitment to teaching and why we are keen to be recognised as a teaching Trust.

Our commitment extends across all departments and colleagues across the Trust, ensuring we support as many opportunities as possible to develop our current and future workforce, which ultimately has a positive impact on patient care. Underpinning this are our values – Ambitious, Caring, Together.

We have excellent relationships with universities and education providers across South Yorkshire and further afield.

Over the past few years, we have had successes in improving our recruitment and retention, ensuring we're able to provide high quality and sustainable services for the local community. Achieving teaching status will build on this work, helping us to attract highly skilled professionals to care for our patients, and to further develop and expand the teaching and education we provide.

Since our strategy was launched in 2022, we have made great strides towards meeting, and exceeding, the ambitions we set out to achieve. We are positive that the recognition teaching status would give us will fuel our ambitions further, making us a leader for education across Yorkshire and beyond, improving patient care and colleague experience and setting the bar others aim to reach.

Medical students have stated Rotherham provides the best education and placement support of the Trusts in South Yorkshire – an accolade we are extremely proud of.

Our Trust





The Rotherham NHS Foundation Trust is a combined acute and community Trust which provides services from a number of sites across Rotherham, including:

- Rotherham Hospital
- Rotherham Community Health Centre
- BreathingSpace
- Park Rehabilitation Centre
- Kimberworth Place

We also provide some dental services in Doncaster and Barnsley, as well as having some smaller hubs at GP practices across the borough.

We are a major employer in Rotherham, employing over 5,000 staff from the town and the wider South Yorkshire region.

Education, professional development and training are fundamental to continually developing, attracting and retaining our workforce. We invest in opportunities for all staff groups, ranging from T-Levels and apprenticeships through to degrees. We have a dedicated education centre with hands-on learning and simulation suites, lecture theatre and library and knowledge service. This brochure showcases how we have embedded a culture of teaching and learning throughout the Trust.

Activity highlights for 2024/25

- Serve a local population of approx. 271,000
- 90 newly registered nurses recruited in September 2024 – the highest in our history
- Xxx student nursing placements
- Xxx Foundation year 1 and 2 doctors
- 5,032 staff members
- Xxxx babies born
- Xxx medical student placements
- Xxxxxx seen in the Urgent Emergency Care Centre (UEC)
- 3,237 patients recruited into research studies
- 47 open research studies
- Xxxxxx outpatient appointments
- Xxx staff on apprenticeships

AWAITING CONTENT

Our strategic objectives



Research and Development

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





Our strategic plan

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

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

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



Recent successes

Research participation growth: The Research and Development team have grown the number of TRFT participants recruited to research trials from under 300 in 2015/16 to over 3200 in 2024/25

Research performance:

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

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

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

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



Colleague perspectives



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

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



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

Dr Arun Alfred, Consultant Haematologist, Principal Investigator

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

Ben Cooper, Senior Physiotherapist, Meteor2 Trial physiotherapist







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Patient feedback

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

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



Mr Draviaraj, Principal Investigator Racer2 Trial



For the last three years, I have taken part in the Radar UK-MRA Myeloma XV trial at Rotherham Hospital. During this time, the care and treatment I have received has been excellent. The radar nurses are very approachable, friendly, and supportive and have helped me through treatments. Nothing is too much trouble for them and cannot praise them enough.

Mrs C Davies

Innovation

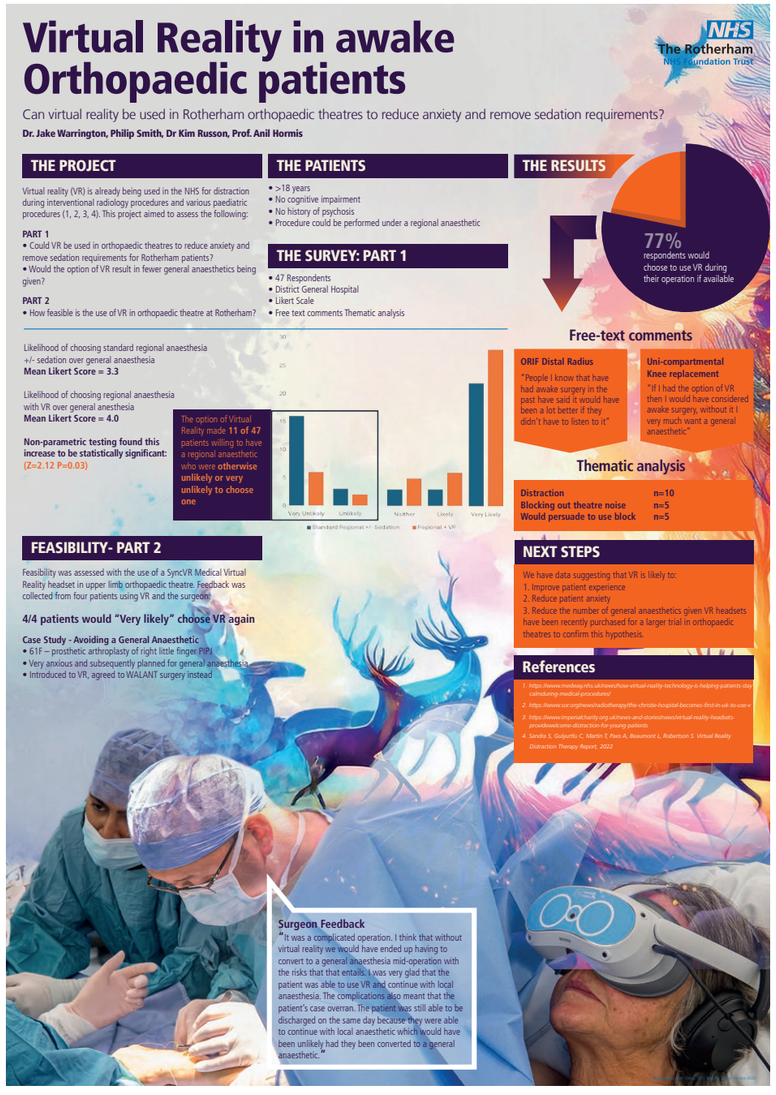
Professor Anil Hormis and Dr Kim Russon trialled the use of virtual reality (VR) glasses during awake surgical procedures to improve patient experiences and manage anxiety, whilst reducing the need for sedation. Patients and staff provided positive feedback. The potential benefits include quicker recovery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

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

Oral Presentation: WRAIG: Wrightington International Regional Anaesthesia Congress 2024

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

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







The Medical Education Department is proud to support the Trust's application for teaching status. We offer a dynamic, inclusive and high-quality education programme for undergraduate, foundation and postgraduate learners. Our team is dedicated to ensuring the Trust is an outstanding place to learn, teach and develop. Our ethos is rooted in creating an environment where learners feel valued, supported and equipped to thrive, and where teaching is a core component of everyday clinical practice.



Medical education

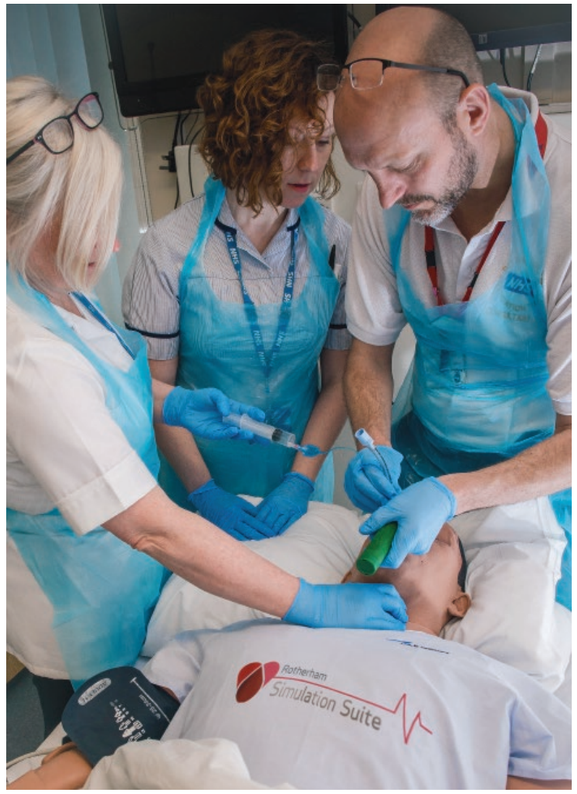
Undergraduate medical education

Each year, the Trust welcomes more than 300 medical students across all core specialties. We are proud to maintain an excellent relationship with the University of Sheffield Medical School, as evidenced by consistently strong feedback received from student evaluations. The Medical Undergraduate Team is praised year on year for their dedication, pastoral care and innovative approach to learning. Quotes from students include:

"The Med Ed team at RDGH were exceptional! Excellent induction and organisation," and "The best formal teaching I have received on placement so far! Brilliant organisation and delivery."

Our undergraduate programme is supported by a full-time team that includes a Consultant Clinical Educator, a Clinical Teaching Fellow and a Pharmacist Educator, as well as over 30 part-time funded clinical educators.
Students benefit from a range of innovative educational methods, such as:

- simulated ward round teaching
- remote facilitated clinical encounters (developed during COVID-19)
- a self-rostering system for Emergency Medicine
- a flipped classroom model for out-of-hours teaching



A key recent innovation is the ROSE (Rotherham Online Scheduler for Education) system, developed in-house with the Trust's IT team. ROSE enables students to book into a wide range of educational activities across the Trust and is aligned with the University of Sheffield's Longitudinal Integrated Clinical Placement (LICP) framework. The system has potential for broader application beyond medical student scheduling and is currently being modified to support postgraduate internal medical training in the Trust.

The simulation programme is wide-ranging and tailored for all levels of students. Sessions include core clinical skills as well as high-fidelity simulation. Students have access to a well-equipped simulation suite and a dedicated timetable of simulation opportunities. We also provide comprehensive skills refreshers and support for OSCE preparations, mock exams and bespoke sessions, such as prescribing assessments and case-based discussions.

We take great pride in our inclusive ethos and our strong track record in supporting students with additional academic or physical needs. All administrative faculty are mental health first aid-trained. Our team operates an open-door policy and is based adjacent to the student study areas, fostering accessibility and support.

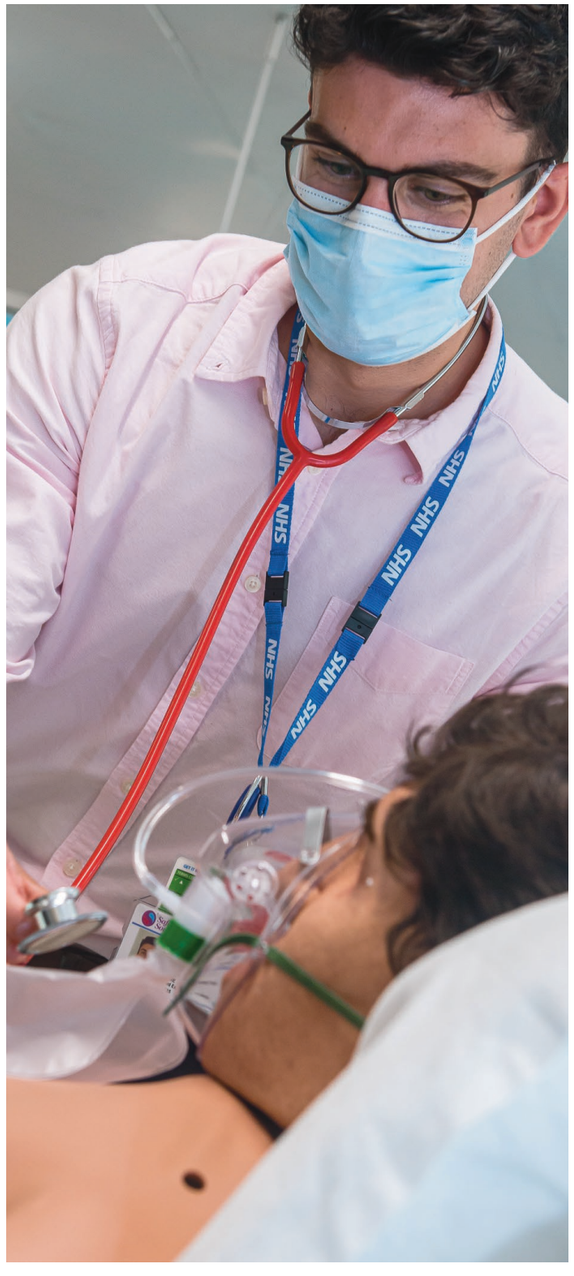
Our facilities include a dedicated undergraduate suite with a kitchen, dining area, lounge and study space. Innovative developments such as the integration of primary care experience into women's and child health placements (utilising the collaborative learning in practice (CLIP) model) further enhance the learning experience.

Students are encouraged to undertake research projects and present at national conferences. Notably, students from the sexual health department have consistently had work accepted at national conferences and even secured national undergraduate essay prizes.

Foundation programme

We support 48 Foundation Year doctors across both Foundation Year 1 (FY1) and Foundation Year 2 (FY2) programmes, spanning acute Trust placements, General Practice and Psychiatry. The Foundation Programme is led by a dedicated Training Programme Director and supported by a full-time Postgraduate Co-ordinator. Weekly structured teaching sessions draw on faculty from across the Trust and cover a range of topics, from specialty-specific updates to core clinical teaching.

Survey data from May 2025 revealed that 70% of Foundation doctors rated their placements as either 'excellent' or 'very good', with the remaining 30% rating them as 'good'. This detailed feedback is now directly shaping improvements to the programme for August 2025 and beyond.



Postgraduate medical education

Postgraduate education is firmly embedded in the culture of the organisation. Trainees from foundation to higher specialty training are supported by a robust educational framework, aligned with UK General Medical Council (GMC) and NHS England (NHSE) standards.

Our faculty includes national and regional education leaders, including:

- Training Programme Directors across several specialties
- Three Trainers of the Year in Orthopaedics
- National chair of the AO Hand and Wrist course
- Breast surgery team invited to teach on national courses, for example, the ABS courses (Association of Breast Surgery)
- Sexual Health Consultants invited to teach on national courses and conferences eg. BASHH HIV Masterclass.
- Anesthetics Consultants regularly invited to teach on national and international conferences and courses and selected to author chapters in highly prestigious text books including Smith & Aitkenhead Textbook of Anaesthesia (previous edition was awarded First Prize at the BMJ Medical Book Awards).

The weekly postgraduate teaching timetable is structured to ensure consistency and depth. Teaching includes Monday Grand Rounds, Tuesday Respiratory and lunchtime lectures, Wednesday Cardiology and Healthcare of Older People, Thursday FY1 teaching, and Friday sessions in Internal Medicine and Surgery.
Our education centre hosts a variety of internal and external educational events, including:

- Simulation training for midwives
- The regional Critical Care Transfer course
- Advanced Trauma Life support and a Royal College of Surgeons Basic Surgical Skills course. Notably, we are the only institution offering these courses in the whole of South Yorkshire.

We also run courses replacing NHSE-funded courses lost in recent years such as Advanced Procedural Skills and communication for Internal Medicine Resident Doctors
In addition, ad-hoc teaching and bespoke sessions are arranged to meet individual needs, including procedural refreshers (such as central venous pressure line insertion, catheterisation, arterial blood gas (ABG) sampling and analysis, etc.), simulation of procedures (such as chest drain insertion, lumbar puncture), and ad-hoc bespoke clinical skills training to support international medical graduates entering the NHS locally.



Simulation and clinical skills

The simulation programme is comprehensive and continues to evolve. Simulation is delivered both in situ in departments and within dedicated spaces.
Key programmes include:

- Cross-Specialty Multidisciplinary Paediatric Emergency Training (CRUMPET)
- Interprofessional non-technical clinical and assessment skills in emergencies (INCASE)
- Return to Acute Care Training (ReACT)
- Physiotherapy simulation
- Simulated scenarios support midwives (Practical Obstetric Multiprofessional Training (PROMPT), and maternity Mandatory and Statutory Training (MAST])
- Medical students and Physician Associate simulation

Objective Structured Clinical Examination (OSCE) mock exams are a major part of our calendar, with University of Sheffield LICP1 and LICP3 students participating in full-day mock OSCEs. Physician Associate OSCEs are also supported. Skills refreshers are delivered throughout placements, covering everything from injections to complex invasive procedures. Simulation rooms are well-equipped and faculty-led, creating an immersive and safe environment for experiential learning.





Teaching fellows

The Trust employs both a Clinical Teaching Fellow (CTF) and a Future Leader (FL), each appointed on a 12-month basis. The Clinical Teaching Fellow has oversight of over 300 medical students and delivers a variety of teaching formats, from one-on-one bedside teaching to larger case-based sessions. A variety of educational styles are employed, including "gamification" of learning and the Clinical Teaching Fellows are encouraged to undertake educational research to both support their teaching with published evidence and add to it.

These roles provide rich opportunities for leadership, quality improvement , education and research. For example, Clinical Teaching Fellows have developed bespoke teaching for the Prescribing Safety Assessment (PSA) and the Medical Licensing Assessment (MLA) exams and are integral to the development of educational materials, peer observation of teaching and educational research.

Clinical Teaching Fellows and Future Leaders contribute to postgraduate teaching, run revision OSCEs and support with Foundation programme delivery. Their portfolios evolve year-on-year, adding to a growing institutional education resource bank.

Educational leadership and faculty development

Medical education is steered by a strengthened leadership team comprising an Associate Medicine Director, Deputy Director and two Assistant Directors, one of whom has a specific portfolio for faculty development. The Medical Education Committee and Advancing Healthcare Education and Development (AHEAD) Rotherham meetings provide strategic oversight, educator communication, (including colleagues in primary care), faculty updates and foster a vibrant faculty community.

Regular educational supervisor courses ensure on-boarding and continued professional development for faculty. New appraisal processes aligned with the Association of Medical Educators (AoME) standards will allow better governance and targeted faculty development.

We also support external leadership training, including the 'Dare to Lead' programme for senior education faculty, which will commence in 2026.





Innovation and strategic development

The Trust leads the region in educational innovation. Our Women's Health programme was commended at the British Medical Journal (BMJ) 2021 Awards and offers the only regional courses in South Yorkshire for both intrauterine device placement and implant insertion).

The Department of Paediatrics runs the STEPP (Specialist Training and Education Programme for Paediatrics). STEPP is a regional teaching programme, specifically designed to meet the training needs of Level 1 Paediatric trainees. Our training day is attended by all Yorkshire ST1 Paediatric trainees and feedback is consistently exemplary. We have proudly hosted sessions at Rotherham for over 10 years.

We are currently developing new roles in surgical education, anaesthetic simulation, and communication. A Non-Operative Technical skills (NOTS) course and a South Yorkshire Teaching Fellows Academy are also in progress. There is also opportunity for medical learners to gain expertise in community care, and in the future, community respiratory care. BreathingSpace is the only purpose-built community respiratory facility in the UK; our pulmonary rehabilitation service is second-to-none. There is a seven-day exacerbation service, community clinics and case management. Given the direction of the NHS 10-year plan, focusing on training in the community is crucial.

Sixth form work experience

Rotherham runs the only sixth-form medical work experience for medicine programme in South Yorkshire. Delivered three times a year, each cohort includes 15 students who take part in an immersive five-day programme. Activities include ward visits, clinical skills workshops (such as catheterisation, ABGs, injections, orthopaedic fracture fixation), interactive sessions in ethics, suturing, laparoscopy, and hand hygiene, simulation, opportunity to observe in theatre and lectures from a range of professionals, including medical students, Specialty and Associate Specialist (SAS) doctors, palliative care leads, psychiatrists and library staff. This unique course helps students make a more considered decision about whether to apply to medical school.

"I have learnt about the whole journey towards the career and then life as a doctor. I have learnt about all the advantages and disadvantages."



Library and Knowledge Services

Our first-class library provides tailored literature search training and knowledge mobilisation services across all clinical departments, with a special emphasis on critical care, paediatrics, trauma and orthopaedics. From autumn 2025, the library will also offer specialised training options for medical students and foundation doctors, including research assistance and information literacy sessions to support better patient care.

We are the only library in the North of England with an NHS England-endorsed CPD resource collection, updating the skills of medical librarians.

Multiprofessional and national contributions

The Trust hosts the Practitioner's e-Portfolio (PeP) national e-portfolio platform for Advanced Practitioners, Physicians Associates and non-training grade doctors, supporting over 1,000 users. PeP is based on a well-validated e-portfolio platform and is gaining high penetration across all nations of the UK with over 20 Trusts now using the system as well as several general practices. It was conceived and developed by our Medical Education department to assist in the development and supervision of practitioners to ensure patient and professional safety is in line with national guidance when no other system was available to do this.

We also host and run nationally recognised training courses, including ATLS and BSS, and will soon offer the NOTS course.

Survey and quality assurance

We actively participate in the GMC national training survey (NTS) and NHSE National Education and Training Survey (NETS). Feedback informs continuous improvement in our programmes and provides quality and governance data back to NHSE workforce, training and education as well as regulatory bodies such as the GMC. Where it is required, we undertake local surveys and focus groups with resident doctors to look at details of postgraduate training. Resident doctors are also invited to attend monthly meetings with the Director of Medical Education to ensure that any issues are swiftly addressed. The local May 2025 Foundation survey showed strong ratings and provided actionable insights for future development.



Future plans: new education centre

We are working towards developing a state-of-the-art education centre, designed to meet the educational demands of the next 25 years. It is envisioned this will include expanded simulation areas (including cadaveric), augmented reality and virtual reality capabilities, flexible teaching rooms, and dedicated space for high-stakes exams and preparation for exams at all levels from undergraduate to exiting from postgraduate training.



Resuscitation service



Comprehensive life support training

Our resuscitation service is responsible for delivering life support training to staff at all levels across the Trust. Our portfolio includes both basic, immediate (ILS/PILS) and advanced life support courses for those working in adult, paediatric, and newborn specialities.

As an accredited centre for both the Resuscitation Council UK and the Advanced Life Support Group (ALSG), our service acts as a "one stop shop" for all advanced resuscitation training.

Advanced Life Support (ALS) courses

- 2-day ALS course: This comprehensive face-to-face program includes hybrid e-learning, mentoring, coaching and clinical skills. It is ideal for clinicians beginning their journey in advanced resuscitation.
- 1-day E-ALS course: Our most popular format, this course allows for several weeks of online pre-learning, followed by an intensive day of hands-on skill development and practical application.
- ALS Recertification (short course): Aimed at experienced ALS providers, this course focuses on revalidating current skills through challenging scenarios, peer reviews, and focused skills teaching.
- Each year, we facilitate an average of 15 ALS courses. This attracts learners from across the UK and internationally. Our faculty trains around 400 ALS providers annually, equipping doctors, nurses, and allied health professionals with essential lifesaving skills.





Newborn Life Support (NLS)

As a busy maternity hub, we recognise the importance of newborn resuscitation skills. The NLS (Newborn Life Support) course is an essential, highly accredited one-day program for clinical staff involved in childbirth. It remains extremely popular and attracts participants from across the country. We provide up to eight courses per year with 192 places available.

European Paediatric Advanced Life Support (EPALS)

Beyond adult life support, we offer the EPALS (European Paediatric Advanced Life Support) course, accredited by the RCUK. This two-day face-to-face program follows the ALS model and is tailored for paediatric nurses and doctors in paediatric, anaesthetic, or emergency medicine training. We run four EPALS courses annually, offering 96 places with full attendance at every session.



Generic Instructor Course (GIC)

The GIC is designed for candidates who have shown instructor potential on RCUK/ALSG provider courses, it is a highly regarded educational course, it teaches candidate how to teach on the provider course. There are a limited number of GIC centres in the UK, we are the only one that offers all the course backgrounds in South Yorkshire. We run three of these each year utilising an international faculty attracting candidates from all around the country and European union.



Ward based in situ sim/ bespoke training

We offer a wide range of bespoke teaching to clinical areas allowing them to put into practise in their own environments the skills they have been taught. This can be specialised training for obstetric emergencies, difficult access areas like toilets and showers where cardiac arrests can happen, deteriorating patient training, specialised areas like off-site remote CT, debriefing and ReSPECT training to name but a few.

The service continues to expand its portfolio catering for all educational and practical needs within the resuscitation sphere, this allows us to improve patient safety, deliver excellent resuscitation skills to patients in cardiac arrest or acutely deteriorating making the Resuscitation Service the choice for the learner to be educated with us.



Nurses, midwives and allied health professionals



Student nurses and midwives

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

- Sheffield Hallam University
- University of Sheffield

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

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

University of Sheffield

Sheffield Hallam University

Practice Assessors and Practice Supervisors

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

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

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



Student AHPs

We support training for 9 of the Allied Health Professionals that TRFT employs, working with 4 primary Universities, and accepting student placements on elective rotation from many more across the UK.

Our education team has an AHP Practice Learning Facilitator who is an ODP. He works closely with the AHP departments and in particular those responsible for student placements to ensure that everything goes smoothly for our AHP students whilst they are on placement.



Internationally educated nurses

Internationally educated nurses (IENs) play a vital role in our Trust and we have over 150 in our nursing workforce. These nurses have brought diverse skills and perspectives adding to our wealth of experience and cultural understanding. The education team have supported our IENs with their Nursing and Midwifery Council (NMC) registration process

This involves a two-part process: a computer-based test (CBT) and a practical objective structured clinical examination (OSCE). The process also includes an initial eligibility and qualification application, and a final registration application demonstrating English language proficiency, health, and character requirements.

All IENs undertake preceptorship once on the NMC register.



Refugee support, training, orientation, recruitment and education nurses (ReSTORE)

ReSTORE is a structured programme for refugee nurses living in South Yorkshire delivered by the South Yorkshire Primary Care Workforce and Training Hub. The Trust has successfully employed three nurses referred by ReSTORE, initially as healthcare support workers while they build up confidence with clinical skills.

OSCE preparation has been provided by the education and development team with all three nurses having passed their NMC OSCE.

The ReSTORE nurses will undertake preceptorship once on the NMC register.

Preceptorship academy

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

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

In 2024, the Trust launched its Preceptorship Academy, which includes:

- Structured support: newly registered professionals receive guidance and development from experienced practitioners (preceptors).
- Focus on confidence and competence: preceptorship helps build confidence and develop competence in the new role.
- Transition to autonomy: facilitating the transition from student to an autonomous practitioner.
- Quality Improvement: QI training for newly registered practitioners is built into our preceptorship programme, focusing on developing skills and knowledge in quality improvement methodologies and their practical application in clinical practice. This training can empower newly registered professionals to contribute to improvements in patient care and working conditions.

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





Preceptor role

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

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

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

Early career midwives

The preceptorship programme in midwifery is designed to ensure our early career midwives gain all the experience, exposure, clinical skills, knowledge and support they require to complete their preceptorship and gain the Band 6 uplift within 12-18 months.

Our programme gives early career midwives a rotation working on Labour Ward, Wharncliffe Ward (Antenatal/ Postnatal), Greenoaks (Outpatient antenatal), and as a part of the Ivy Team (Maternity Triage and Antenatal Day Ward) settings within the hospital setting, and also working in the community midwifery teams.

Early career midwives are supported with supernumerary time at the start of their experience in each new working area, working alongside buddy midwives, an allocated named Preceptor for support and regular review meetings to embed learning and give pastoral support. Early career midwives are also supported with the study time required to increase and gain their clinical skills in perineal suturing, epidural management, fetal surveillance assessment, Newborn and infant screening, safe bedside blood administration and IV access training.



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Specialist midwifery roles

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

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

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





Early careers nurses

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

We can provide a broad range of different specialties for nurses to gain experience in, including:

Community nursing
Medical care nursing
Emergency care nursing
Surgical nursing
Theatre nursing
Critical care nursing
Children's nursing
Gynaecology and sexual health nursing





Leadership - Ward and department managers

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

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

Clinical Nurse Specialists



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

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

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

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

Cancer clinical nurse specialist development

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

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

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



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

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



Advanced Practice

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

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

We have AHPs in a number of different extended/enhanced, advanced and consultant practitioners; and a number of AHPs have gone through the multiprofessional advanced practice route to become Advanced Clinical Practitioners (ACPs).



Clinical academic career

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

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



Nurse clinical leadership development

The Trust has commissioned various leadership development opportunities through Continued Professional Development (CPD) funding.

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

We have also commissioned a programme for more senior leaders through the Florence Nightingale Foundation (FNF). This is aimed at nurses in Band 8a level who wish to stretch their leadership and Qi knowledge further. 40 nurses have been through the FNF leadership development programme.





Continued Professional Development (CPD)

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

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

CPD is a statutory requirement for our registered staff; and for medical and nursing staff supports revalidation with the General Medical Council (GMC) or Nursing and Midwifery Council (NMC).

CPD funding for nurses, midwives and AHPs

NHS England currently provides funding for all registered nurses, nursing associates, midwives, and AHPs (Allied Health Professionals) with a financial allowance to support their Continuing Professional Development. This funding allows for development in areas like clinical skills, career advancement, and is a requirement of maintaining professional registration.

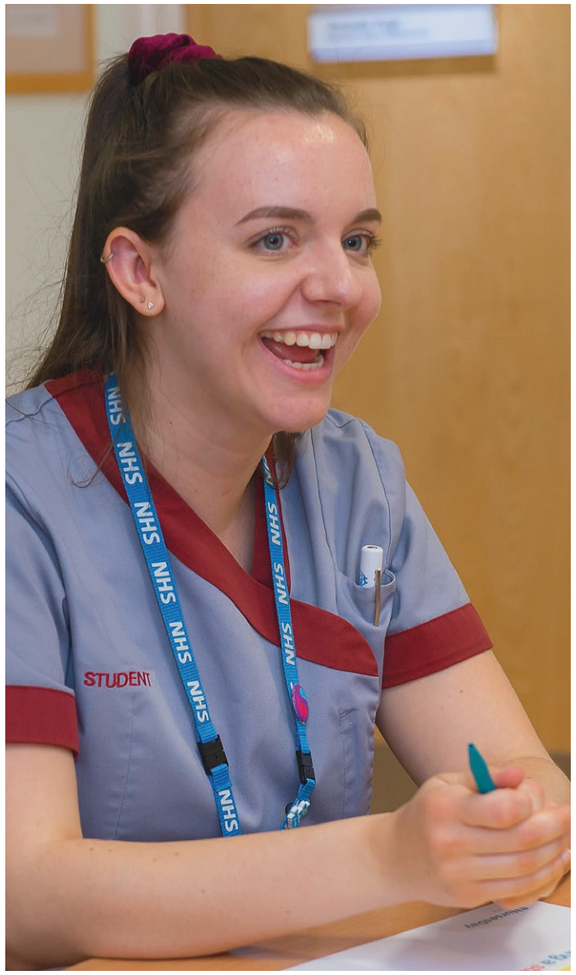
The funding provides a £1,000 allowance per individual over three years, or £333 per year. This is available to registered nurses, nursing associates, midwives, and other allied health professionals working for the Trust.

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

Role specific training

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

The following courses are now on offer:



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

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

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

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

Healthcare Support Worker/ Care Support Worker Academy

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

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

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



People experience and development



Inclusion and widening participation

Creating opportunities for the next generation of healthcare and support staff

We recognise our role as one of the largest employers in Rotherham; growing our future workforce from local talent is a priority to ensure that the district continues to develop and thrive. Whether is our support for work experience or dedicated programmes for disabled people and NEET (Not in Education, Employment, or Training) young people, we recognise the value of employability skills and practical experience as a route to both employment and improved health outcomes.

Work experience

In 2024, we focussed on growing our infrastructure for departments who wished to be involved in hosting work experience placements. Half way through 2025, we have already hosted 25 placements and this is increasing each month! Our focus is high quality placements, which allow people to explore careers and gain valuable insights and experience into working in the NHS.

Employment is for everyone

Employment for Everyone is an innovative South Yorkshire-based programme designed to support people with autism and learning disabilities to gain meaningful employment experience. Working in close partnership with colleagues from Rotherham Metropolitan Borough Council and other Place-based partners, we are supporting people with autism and disabilities to engage with employers in the region and undertake supported placements or internship, some of which will be with us. A key part to this is co-production with the people this programme aims to benefit; Speak Up are a local advocacy group for people with autism and learning disabilities who are supporting the programme and actively involved in all aspects of it.

Work well

South Yorkshire Mayoral Combined Authority (SYMCA) and South Yorkshire Housing Association (SYHA) have launched the Work Well programme to help people with disabilities into employment as well as support those who are in work to stay and thrive. The programme involves providing employment skills to those seeking employment, as well as provide proactive support for those already in work but struggling with illness, disabilities, stress or other conditions that mean they may be at risk of taking time off. TRFT is a proud supporter of this programme, actively engaging with disabled groups and applicants wishing to work for the Trust, as well as our current workforce to ensure that they access the support they need to stay in work.

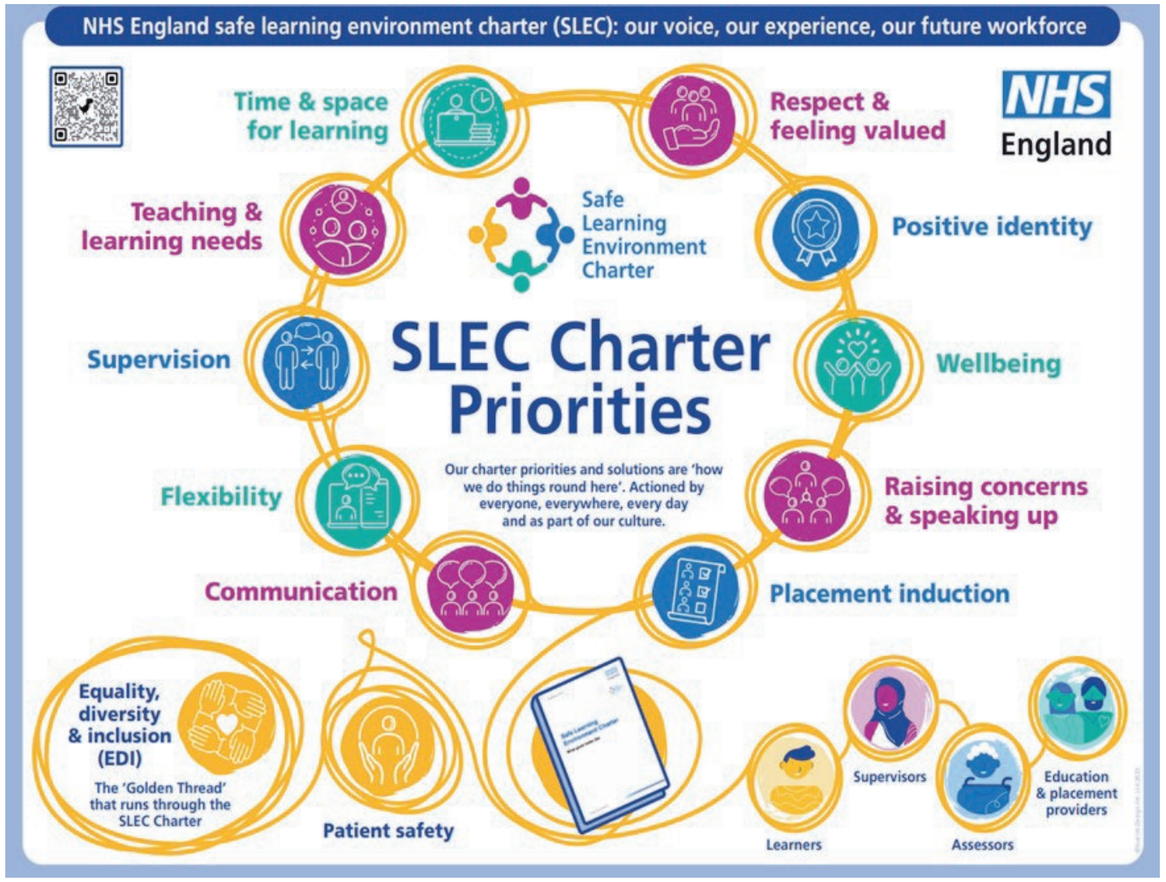
Employment is for Everyone



NHS Safe Learning Environment Charter (SLEC)

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

Our student handbook outlines the principles of SLEC and how we have implemented these safe learning cultures within the Trust.



Organisational development

Supporting teams to be more than a sum of their parts – developing high performing, inclusive, safe and patient-centred cultures

The People Experience and Development team also focusses on improving the quality of working life for our staff. Whether this is the wellbeing activities and support we run (gym classes, heated swimming, an employee assistance line) or supporting team development, improving the staff experience is key to improving patient experience of care. Using the National Staff Survey (NSS) as a baseline, the People Experience and Development Team support managers and team to develop through consultative, bespoke design, facilitated interventions, service process mapping, individual coaching, and psychometrics. Our local and regional approach to organisational development is led by a Do OD methodology and underpinned by Myron's Maxims as adopted by NHS Horizons.



Training centred on key aspects of the staff experience

- Appraisals and crucial conversations – a key focus on active listening, feedback, challenge, compassion, wellbeing, menopause, psychological safety and performance. This development is aimed predominately on how to have a quality appraisal conversation, but also supports with every workplace conversation.

- Interview skills to support colleagues with confidence as well as competence.

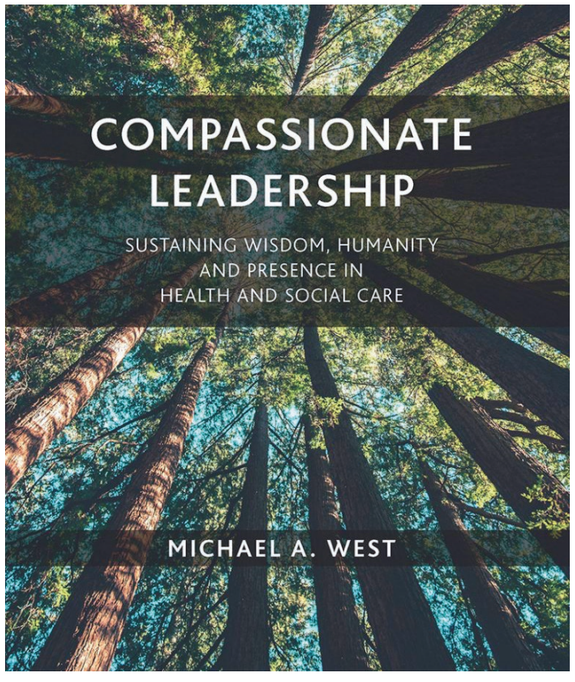
- Recruitment and selection support for every recruiting manager to gain knowledge and skills for every step of the process.



The Heart, Head and Hands of Leadership
Compassionate, Curious, Collaborative

Leadership and management

Good leadership and impactful management are key to the success of all of our departments and teams



We support existing and aspiring leaders in a number of ways from targeted programmes like the Florence Nightingale Leadership Programme for nurses, through to taster sessions and bespoke leadership interventions, based on team needs. The People Experience and Development team lead on content which is curated through the year, drawing on the NHS People Expectation of Line Managers framework, 'Our Leadership Way', 'The Healthcare Leadership Model' and 'Compassionate Leadership" by Michael West.

The team support individuals to access programmes through the NHS Leadership Academy, National Coaching & Mentoring Hub and a number of facilitated learning tools such as 360 Feedback and PRINT Insights. The NHS Leadership Academy Learning Hub provides additional support, resources and training such as authentic leadership, motivation, emotional intelligence, courageous conversations and systems leadership.

NHS Graduate Trainee Management Scheme (GMTS) – nurturing future leaders

The Trust, recognising the need to support and develop future leaders hosts Graduate Management Trainee Scheme (GMTS) trainees in collaboration with Barnsley Hospital NHS Foundation Trust. Since re-engaging with the scheme in 2023 the Trust has fully committed to providing the trainees with the best possible experience, supporting their professional, educational and personal development. The value given to this programme is reflective of the Trust's wider commitment to developing its teams. The programme Executive Lead is the Trust's Managing Director with the Deputy Director Strategy and Delivery as the delivery lead with several senior staff directly involved in supporting the trainees across the four disciplines.

The Trust has also supported the scheme and trainees outside of the organisation, providing targeted development to trainees across the region. The Trust's commitment and engagement with the GMTS has been recognised by the scheme itself:

"The Rotherham NHS Foundation Trust has been a consistently outstanding partner to the Graduate Management Training Scheme (GMTS). Their engagement goes far beyond the minimum expectations of a host organisation — it is clear that the Trust values the development of future NHS leaders and is genuinely invested in nurturing talent.

"The support provided to their hosted trainees is exemplary. Trainees at Rotherham speak highly of the quality of placements, the level of care and consideration in line management, and the Trust's commitment to providing stretching, meaningful learning opportunities. What sets Rotherham apart is not just their dedication to their own trainees, but their willingness to support the wider GMTS network.

"From participating in regional and national development sessions to offering career development support to trainees beyond their own placements, Rotherham demonstrates what excellent partnership looks like in practice." **GMTS Senior Leader**







Apprenticeships and T-levels

Apprentices and T-Levels are an important part of our education pipeline, supporting those who wish to begin their career in the NHS to get their foot in the door, as well as upskill, grow and support our existing staff. We have long been a champion of both early career pathways and lifelong learning. Working in partnership with our local colleges, universities and other specialist providers, we have supported local residents and existing staff to access high quality apprenticeships, and some of our apprentices are even award winners! Since 2022-23, we have increased our apprentice starts by 70%. As of the end of 2024-25, we had 161 apprentices enrolled:

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

To date, we have supported over 300 apprentices, having utilised the levy as part of our workforce planning, to support the reduction of gaps in our workforce. Via our dedicated Apprenticeships Manager, we work in partnership with managers and teams to ensure a high quality and impactful experience for apprentices, which has helped us to recruit and retain traditionally hard to fill roles such as Physiotherapists, Occupational Therapists, Advanced Clinical Practitioners and Radiographers.

The apprenticeship levy has given existing staff the opportunity to progress into these roles too, ensuring effective succession planning for better continuity of patient experience of care. We are also early adopters of some of the newer apprenticeship opportunities in Business Admin, Pharmacy and Healthcare Science, solidifying our commitment to the long-term national workforce plan.



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

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

For healthcare T-level students, support is offered by the education and development team. Placements include a structured induction in the fundamentals of care and wide variety of learning opportunities. Recently, our first healthcare T-level student was successful in gaining paid employment with us as a Care Support Worker.



Schools engagement

Capture hearts and minds so that young people make informed career choices

The Trust has a long history of working across organisational boundaries to deliver meaningful a meaningful careers education offer for the people of Rotherham and the surrounding areas. Our careers education staff have links with all 16 secondary schools in the borough, and in 2024-25 had contact with over 2,500 pupils across Rotherham. We have a team of 35 health and social care careers ambassadors, drawn from across the local authority, private care providers and the NHS; these ambassadors are trained to teach students and members of the public about the careers they can access in Rotherham.

The Trust is enhancing its careers program to deliver effective learning and tangible results. In collaboration with the Wickersley Partnership Trust, we target specific student groups, using pupil destination data to gauge the impact of its interventions. Classroom sessions will leverage technology to provide live patient care experiences remotely, complementing departmental open days and the long-standing 'So You Want to be a Doctor' program. Video career guides will include pre- and post-learning questionnaires to measure impact. We aim to utilise its Teaching Status to deliver quality careers education, widen participation, and create employment opportunities for all Rotherham residents.





An immersive space for young people to feel inspired about careers in health and social care

What happens when the local NHS trusts, local authority and Gulliver's Kingdom Rotherham get together? Skills Street is born! The only facility of its kind in the north of England, Skills Street offers young people the opportunities to explore careers in an immersive space. Skills Street hosts a variety of employers across the public and private sector. We have invested in the health and social care zone alongside Rotherham Metropolitan Borough Council and Rotherham, Doncaster and South Humber NHS Trust. The curriculum has been designed by our education experts and teachers at the South Yorkshire Education Hub. Built using Levelling-Up monies, this facility will allow pupils from 90 primary schools in Rotherham and across the region to see what careers are on offer in the sector. To date, since opening in July 2025, 1600 students have attended Skills Street, 445 of whom have been from Rotherham primary and secondary schools– these are booked by the school and delivered to classes of students in the same configuration in which they attend school, which means that students are from a wide background reflective of the local community, with the aim of raising aspirations for all students, demonstrating to them that there are roles that they could do that they had never thought about.

Quality improvement

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



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

Awards, recognition and achievements

From January 2024 to July 2025

Award wins

Royal College of Physicians – Developing Workforce Award – July 2025
Learner Student of the Year Award – South Yorkshire Teaching Partnership Awards – October 2024
AHP Innovation and Improvement Award – Chief Allied Health Professions Officer Awards – October 2024
Place-based Partnership and Integrated Care Award – HSJ Awards – November 2024
Royal College of Midwives Student Midwife of the Year – October 2024
Degree Apprentice of the Year – South Yorkshire Apprenticeship Awards 2025
Go Further Award – 2024 Sheffield College Apprenticeship Celebration Awards

Award shortlistings and commendations

Pharmacy shortlisted for two categories for the 2025 HSJ Digital Awards (Improving medicines management and pharmacy through digital, and Digital clinical safety award)
Shortlisted for three 2025 HSJ Patient Safety Awards – Harnessing a human factors approach to improve patient safety, Best use of integrated care and partnership working in patient safety, and Virtual or remote care initiative of the year.
Health and Public Service Apprentice of the Year – South Yorkshire Apprenticeship Awards 2025
Higher Apprentice of the Year – South Yorkshire Apprenticeship Awards 2025
Health, Care, Dental and Pharmacy Apprentice of the Year – Sheffield College Apprenticeship Awards 2025

Achievements and recognition

Significant improvement in the 2023 CQC inpatient survey (published August 2024)
NHS staff survey results show a trend of continual improvements – Trust named the second most improved in the country following the 2023 survey
Improvements in the CQC Urgent and Emergency Care survey 2024
Positively scored in the CQC Children and Young People's survey 2024 (published 2025), ranking 10th out of 54 Trusts using Picker
International Women's Day attendance at 10 Downing Street – March 2025
First Healthcare T-Level students welcomed to the Trust – April 2025
Awarded the Silver Award from the Defence Employer Recognition Scheme
Asthma + Lung UK trustee says BreathingSpace is an "example of NHS led excellence"
In 2024, the Trust earned the **Gold Award for health and safety performance** for the 11th consecutive year from the Royal Society for the Prevention of Accidents (RoSPA)
Shortlisted for three 2024 Nursing Times Awards – Care of older people, Infection prevention and control, and Learning disabilities nursing
National coverage as a result of a quality improvement initiative promoting decaffeinated tea and coffee
In May 2024, a group of student nurses set up a project to tackle **loneliness among recently discharged patients**
In April 2024, the Trust became the first in South Yorkshire to invest in a **robotic orthopaedic surgical assistant** to support total knee replacement surgeries
The Trust's Urgent and Emergency Care Centre was featured in a documentary series – **A&E After Dark** – broadcast in January 2024

Reading Status





Board of Directors' Meeting
5th September 2025

The Rotherham NHS Foundation Trust

Agenda item	P139/25ii
Report	**Annual Report 2024/25 : Research & Development**
Executive Lead	Dr Joanne Beahan, Medical Director
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	This report demonstrates an ambitious department, offering opportunities for patients to be part of research, working with colleagues across the Trust to achieve this.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	This report is provided to assure the Board that the activity of the Research & Development Department in the Trust continues to deliver clinical research and ensures the activity is compliant with required guidance and regulations. The Annual Report outlines our key success metrics since April 2024.
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	The paper has been updated from the 2023/24 report to reflect the changes and approved by the R&D Director on the 4th July 2025. It will have been presented to the Clinical Effectiveness Committee on 15th July 2025 and to Quality Committee on the 23rd July 2025.
Powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	
Recommendations	It is recommended that the Board note the report.
Appendices	Research & Development Annual Report 2024/25

Rachel Walker
Lead Research Nurse/Research & Development Manager
July 2025

24/25

Annual Report

RESEARCH & DEVELOPMENT (R&D)

The Rotherham NHS Foundation Trust

Prepared by :

Professor Anil Hormis
Rachel Walker

http://www.rftclinicalresearch.co.uk

Executive Summary

Professor Anil Hormis

DIRECTOR OF R&D



The Government's 10 Year Health Plan for England has just been launched, setting a new course for the NHS and providing a detailed roadmap for how services will respond to emerging healthcare challenges.

Crucially, the plan includes dedicated sections on Research and Innovation, reaffirming the central role of research in shaping the future of healthcare.

It outlines a vision for embedding research into everyday practice, expanding access through digital tools like the NHS App and streamlining clinical trial processes to accelerate innovation.

Our mission is to foster innovation, support clinical excellence, and collaborate across disciplines to generate evidence that improves patient outcomes and informs best practice.

Our strategic plan for the coming years is to continue to build on our strengths by :

- **Integrating Research into clinical pathways**
- **Develop a diverse Research Portfolio**
- **Promote Research Engagement**
- **Build Research Capacity**
- **Improve Collaboration and Partnership**

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

Key Achievements in 2024/25

47 open studies

12% INCREASE FROM 2023/24

3237 patients recruited

145% INCREASE FROM 2023/24

Anaesthesia, Perioperative Medicine and Pain Management portfolio

HIGHEST RECRUITER IN YORKSHIRE & THE HUMBER
2ND CONSECUTIVE YEAR

Critcal Care Research

SECOND HIGHEST RECRUITER IN YORKSHIRE & THE HUMBER

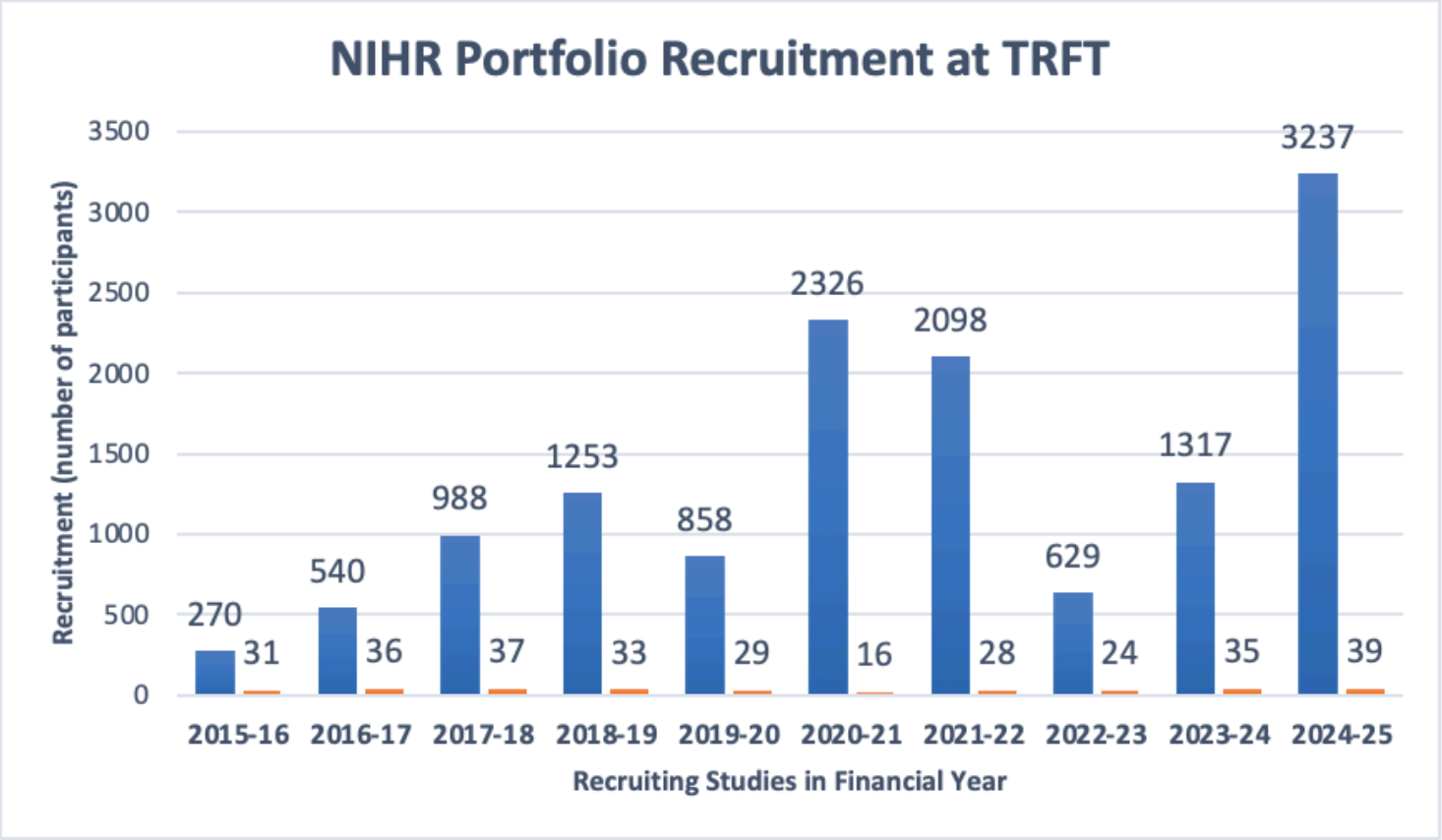
Reproductive Health & Childbirth Research

THIRD HIGHEST RECRUITER IN YORKSHIRE & THE HUMBER

Research Performance

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

This is an 1100% increase since2015/16.



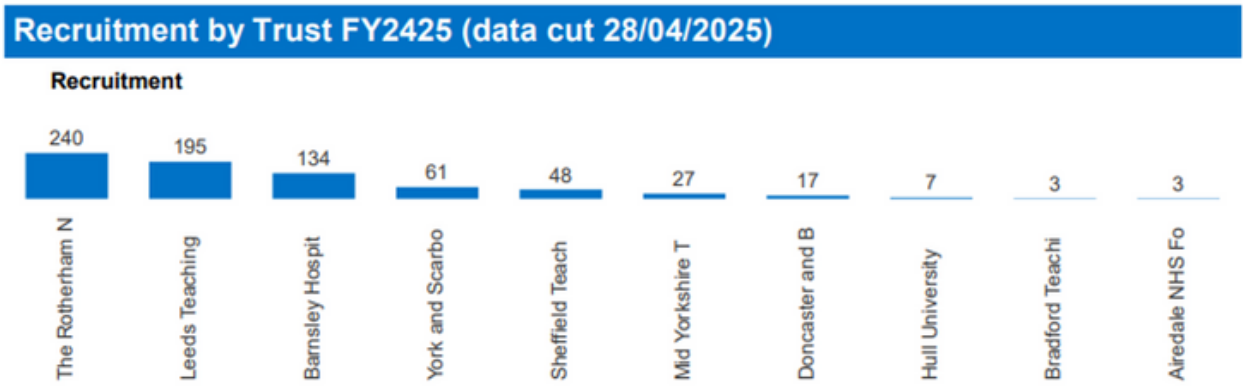
Anaesthesia & Critcal Care Research Porfolio

We recruit to all the major Anaesthesia & Critical Care trials and are approached to run a number of pilot studies due to our reputation in delivering to these trials. We have outperformed our local Teaching Hospitals in these studies.

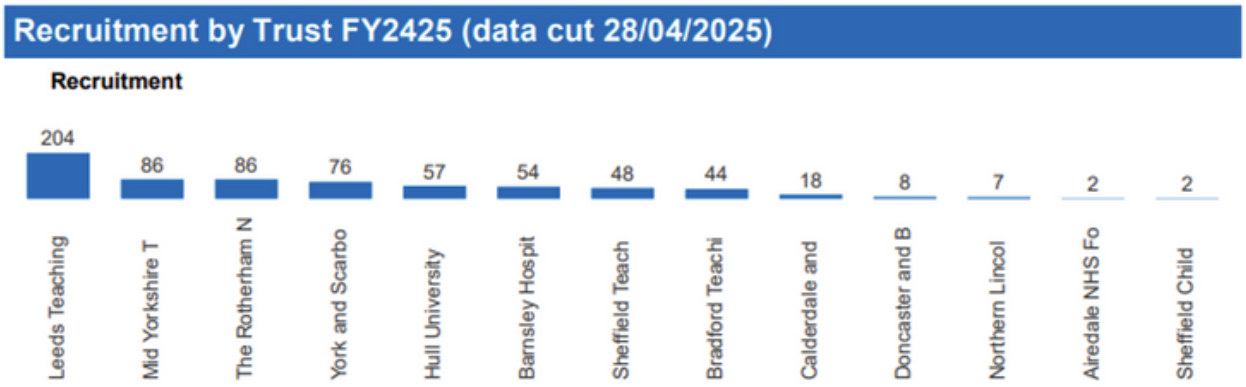
For the second consecutive year, TRFT was the highest recruiter to the Anaesthesia, Perioperative Medicine and Pain Management (APOMP) portfolio in Yorkshire and Humber, with 33% of all the LCRN recruitment.

For Critical Care research participation, TRFT ranked joint second out of all the acute trusts in Yorkshire & the Humber.

APOMP

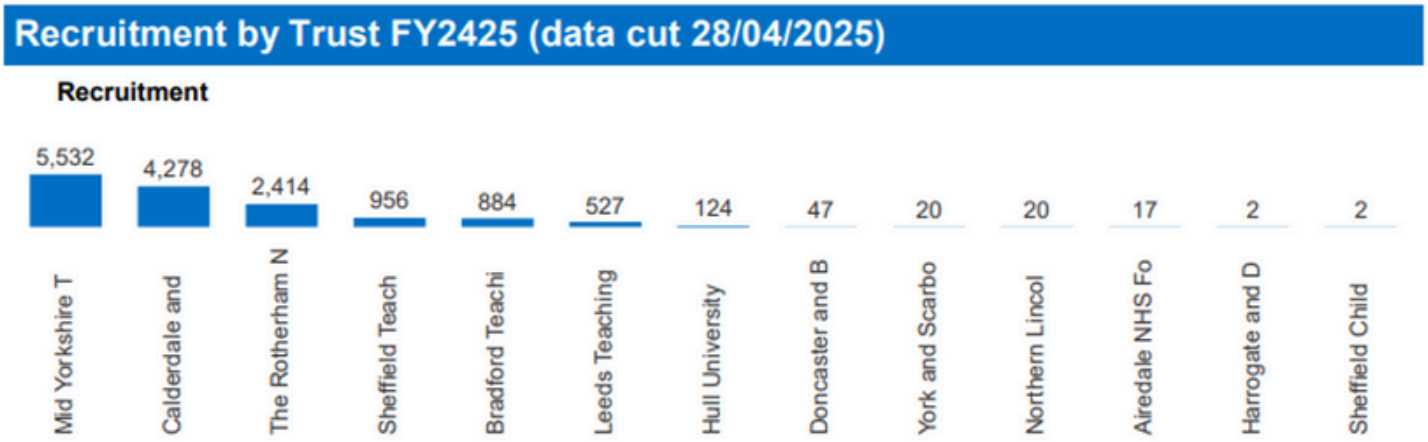


Critical Care



Reproductive Health & Childbirth Research

In the Reproductive Health and Childbrith Research Portfolio , TRFT were the tird highest recruiters of all acute NHS Trusts in Yorkshire & The Humber.



OBS UK
Obstetric Bleeding Study UK

Patient Research Experience Survey (PRES)

TRFT target	43
Surveys sent	85
Surveys received	50

Participants who responded were involved in the following studies:

Particpant comments

"I was taking part in research hoping it will benefit others"

"The staff involved were friendly, informative and curious – if you had any questions they answered truthfully"

"If my experiences help other people get the right treatment then that's good"

"The team kept me well informed and provided confidence in respect of my treatment. The staff were a credit to the service!"

"The research nurse was very professional, friendly and patient with me"

"The research team have always been clear with the information"

"The staff involved were friendly and informative and always helpful, nothing was too much trouble"

"The sense I was helping others"

"I found all the information I received before and after my surgery very useful"

Particpant comments

"A chance to contribute to future improved procedures and the possibility to benefit from the most up to date methods of treatment"

"Easy to take part plus extra follow up scan gave further reassurance"

"The fact that I can contribute in some small way in helping advance medical treatment and care"

"Not too intrusive, questionnaires not too frequent"

"From the start everything was fully explained and the option to stay or withdraw was offered on several occasions"

"The research nurse was very friendly and gave me all the information I needed"

"Everything was a good experience and it was a pleasure to help the study"

Local Investigator initiated Research

We have had success in our ambition to support Investigator Initiated research (small local unfunded projects), developing research capacity and culture by sponsoring research studies.

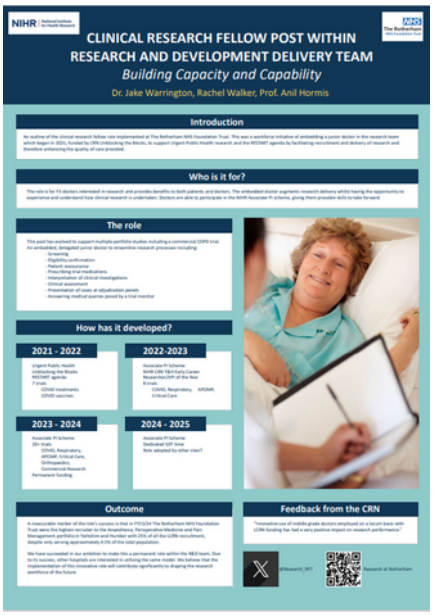
In 2024/25, we sponsored these studies:

- Does ward round simulation improve final year medical students' confidence in the basic skills required to perform a ward round? (25-02-01)
- What are Non-Consultant Doctor's Attitudes to Teaching Medical Students in an Informal Setting? (24-04-02)
- Carpal Tunnel Study (22-10-04)

Celebration : 10 years of the Clinical Research Network

TRFT was selected for a poster presentation, highlighting the innovative Clinical Research Fellow post, at the CRN Celebration Event.

This post was established in 2020 and is a fulle time 12 month post based in the Research Department.



Innovation

2024/25



Professor Anil Hormis and Dr Kim Russon led a project which trialled the use of virtual reality (VR) glasses during awake surgical procedures, in order to improve patient experiences and manage anxiety, whilst reducing the need for sedation.

Patients and staff provided positive feedback. The potential benefits include quicker recovery for patients and earlier discharge, increased use of regional rather than general anaesthesia, cost benefits in improving theatre efficiency and increasing the throughput of theatre lists.

R&D have now purchased a headset to facilitate further research.

Innovation

2024/25

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

- **Oral Presentation**: Wrightington International Regional Anaesthesia (WRAIG) Congress 2024
- **First Prize for Presentation** : Wrightington International Regional Anaesthesia (WRAIG) Congress 2024
- **Poster:** British Society of Orthopaedic Anaesthetists (BSOA) ASM 2024





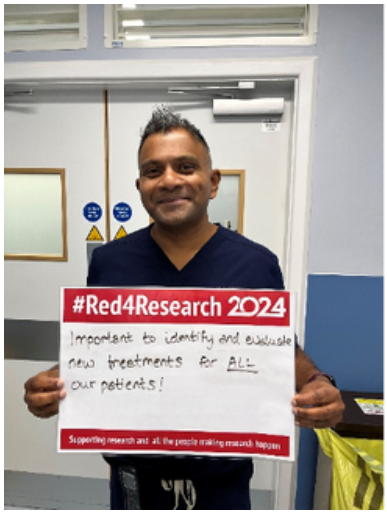


PROUD News: https://issuu.com/therotherhamnhsft/docs/proud_news_4_oct_2_

Red4Research
Raising Research Awareness

2024/25 has seen us increasing research awareness across the trust.

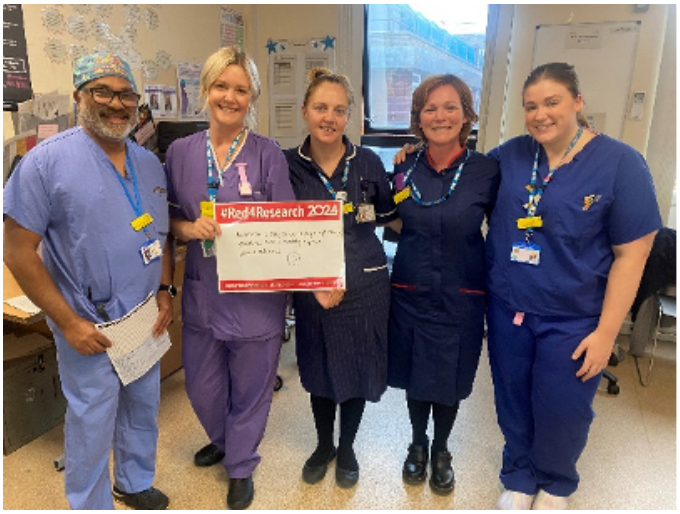
In September we participated in the national Red4Research campaign, bringing together all those participating, supporting and undertaking research, engaging with departments to share how pivotal research is in advancing medical knowledge and improving outcomes for patients.











Financial Summary

2024/25

TRFT R&D is funded externally as a Partner Organisation in the NIHR Yorkshire & Humber Clinical Research Network (Y&H CRN) and via commercial and non-commercial income generated through research activity.

NIHR Funding

2024/25 Financial Allocation to Partner The Rotherham NHS Foundation Trust PARTNER DELIVERY	
Partner Organisation Delivery (1st April 2024 - 30th September 2024)	£249 401
Partner Organisation Delivery (1st October 2024 - 31st March 2025)	£251 086
TOTAL	**£500 487**

Financial Summary

2024/25

DH Research Capability Funding (RCF)

Recruitment based RCF	25,000
TOTAL	**£25,000**

Research Activity Income

Non-commercial	£59 094
Commercial	£10 464
Excess Treatment Costs (ETC)	£6332
Deferred Income 2023/2024	£57 102
TOTAL	**£132 992**

Financial Summary

2024/25

Following agreement in 2016/17 on the commercial income distribution model at TRFT, commercial income was distributed appropriately to clinical departments, pharmacy and central trusts funds to cover the activity undertaken.

Non-commercial (non-NHS) income of £76 843 is carried forward to support activity in 2025/26.

Looking forward into 2025

Over the next year, we plan to undertake the following :

- Promote the role of Reserch Champions in the Trust
- Contribute to the TRFT bid for Teaching Hospital status
- Continue with the Clinical Research Fellow role (F3)



Publications

2024/25

PDelayed Mucosal Antiviral Responses Despite Robust Peripheral Inflammation in Fatal COVID-19. J Infect Dis 2024 Jul

Epidemiology, ventilation management and outcomes of COVID-19 ARDS patients versus patients with ARDS due to pneumonia in the Pre-COVID era. Rest Res 2024 Aug

Cognitive and psychiatric symptom trajectories 2-3 years after hospital admission for COVID-19: a longitudinal, prospective cohort study in the UK. Lancet Psychiatry 2024 Sept

Stratified analyses refine association between TLR7 rare variants and severe COVID-19. HGC Adv 2024 Oct

Critical care unit bed availability and postoperative outcomes: a multinational cohort study. Anaesthesia 2024 Nov

Long term health outcomes in people with diabetes 12 months after hospitalisation with COVID-19 in the UK: a prospective cohort study. EClinical Medicine 2024 Dec

Cohort Profile: Post-Hospitalisation COVID-19 (PHOSP-COVID) study. Int J Epidemiol 2024 Feb

Incidence of diabetes mellitus following hospitalisation for COVID-19 in the United Kingdom: A prospective observational study. Diabetes Obes Metal 2025 Feb

The effects of ultra-selective beta1-antagonism on the metabolic and cytokine profile in septic shock patients receiving noradrenaline: a sub-investigation from the STRESS-L Randomised Study. Intensive Care Med Exp 2025 Jan

Higher dose corticosteroids in hospitalised COVID-19 patients requiring ventilatory support (RECOVERY): a randomised, controlled, open-label, platform trial . ClinicalMedicine 2025 Feb

Molnupiravir or nirmatrelvir-ritonavir plus usual care versus usual care alone in patients admitted to hospital with COVID-19 (RECOVERY): a randomised, controlled, open-label, platform trial. Lancet Infect Dis 2025 May

Conservative Oxygen Therapy in Mechanically Ventilated Critically Ill Adult Patients: The UK-ROX Randomized Clinical Trial. JAMA 2025 Jun12

The COVIDTrach prospective cohort study on outcomes in 1982 tracheostomised COVID-19 patients during the first and second UK pandemic waves : Sci Rep. 2025 Jul 2;15(1):

Maternal views on RSV vaccination during the first season of implementation in England and Scotland. Lancet Infect Dis March 2025

Bivalent Prefusion F Vaccination in Pregnancy and Respiratory Syncytial Virus Hospitalisation in Infants: Results of a Prospective, Multi-Centre, Test-Negative Study. The Lancet Child & Adolescent Health 2025



RESEARCH @ ROTHERHAM HOSPITAL

THE R&D DEPARTMENT COVER A WIDE RANGE OF SPECIALITIES INCLUDING:

- ANAESTHESIA
- CRITICAL CARE
- ORTHOPAEDICS
- RHEUMATOLOGY
- RESPIRATORY
- HAEMATOLOGY
- CARDIOLOGY
- GASTROENTEROLOGY

FOR MORE INFORMATION ON HOW TO GET INVOLVED: **01709 426066**

NHS
The Rotherham
NHS Foundation Trust

Research & Developmemt Office
Roome DLE91
Level D
Post Graduate Medical Education Centre

01709 426066

Email : rgh-tr.researchanddevelopment@nhs.net

Public Board of Directors' Meeting

The Rotherham NHS Foundation Trust

Agenda item	P140/25
Report	**Bed Reconfiguration – Medical Bed Base at The Rotherham NHS Foundation Trust**
Executive Lead	Sally Kilgariff, Chief Operating Officer
Link with the BAF	D5: There is a risk we will not deliver safe and excellent performance because of insufficient resource (financial and human resource) leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.
How does this paper support Trust Values	Ambitious: Ensuring the Trust is delivering high quality services Caring: Ensuring patients are seen within the appropriate time frames Together: Working collaboratively with partners to achieve standards
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This business case seeks to address the current and ongoing issues in relation to escalation capacity across the medical bed base, where this is located and how in reality these beds are utilised. It will ensure a new escalation strategy ensuring that our admission areas are protected whilst also creating funded flexible ward capacity which is able to respond at times of peak pressure and then de-escalated when the pressure subsides. This business case seeks to address the current demand and how we will mitigate that demand within our existing footprint and will seek to clarify how the existing bed base will be readjusted within the existing footprint. Our outturn position in 2024/25 to run our existing ward bed base, inclusive of additional winter capacity up to 317 beds was £20,962,542. Current run rate for 2025/26 suggests that we are likely to outturn a similar figure if no action is taken. As such, this business case will ask for £1,784,794 of recurrent funding, a decrease on run rate, for a flexible escalation style model, increasing our bed base to 317 at times of peak pressure from Sunday to Wednesday and then correspondingly flex down to 287 at times of reduced pressure. This will ensure that the medical bed base is right-sized and adequately resourced all year round by increasing the number of medical wards from 11 to 12 and building in the corresponding flex capacity. This case will present 4 options, either do nothing, establish a new ward area creating 3 areas with unfunded escalation capacity, establish a new ward with built in flex capacity from Sunday to Wednesday, or to ensure fully funded escalation capacity all year round. These options are costed within the case and in appendix 1.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This business case has been discussed and recommended for approval by the Executive Team on 17 July 2025 and subsequently by the Finance and Performance Committee on 23 July 2025. Tight controls will be maintained regarding the usage of escalation capacity which will be outlined in a Standard Operating Procedure alongside strict roster controls with overall decision making held in hours by Chief Operating Officer or Gold Director on call out of hours.
Board powers to make this decision	This Business case requires Board approval due to the requested amount of recurrent budget uplift within the case.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Executive lead will remain Sally Kilgariff, Chief Operating Officer and will be actioned by Paul Stewart, General Manager for Care Group One, it is expected that this will be implemented from September 2025. Roster templates will be amended from October due to lead in times with rotas and revised reporting of the Trust be bed numbers from October in line with this and the start of Quarter 3.
Recommendations	It is recommended that the Board approve Option 3.
Appendices	Appendix 1: Ward costs for A3 Appendix 2: SAPIT data

The Rotherham NHS Foundation Trust

FULL BUSINESS CASE

Business Case Title:	Bed Reconfiguration – Medical Bed Base at The Rotherham NHS Foundation Trust
Business Case ID:	2506001
Executive Sponsor:	Sally Kilgariff, Chief Operating Officer
Service:	Care Group One (UECC and Medicine)
Care Group / Corporate:	Care Group One (UECC and Medicine)
Business Case Owner:	Paul Stewart, General Manager, Care Group One
Delivery and Benefits Owner:	Paul Stewart, General Manager Care Group One and Senior Leadership Team

Date: 16/07/2025

Version: 6

Control Page

THIS PAGE MUST BE COMPLETED IN FULL BEFORE SUBMISSION

DOCUMENT CONTROL

Version	Date	Summary of changes / Detail	Author
1	02/06/2025		Paul Stewart
2	04/06/2025	Minor changes to content	Paul Stewart
3	10/06/2026	Minor changes to content	Paul Stewart
4	07/07/2026	Addition of enhanced information - bed modelling data	Paul Stewart
5	14/07/2025	Inclusion of 2025/26 activity and changes to running order	Paul Stewart

APPROVAL CONTROL

SERVICE LEADERSHIP	Name	Support		
		Yes	No	N/A
Care Group Director / Corporate Lead	Ruhail Mir	☒	☐	☐
General Manager / Service Lead	Paul Stewart	☒	☐	☐
Head of Nursing / Service or equivalent	Gail Smith	☒	☐	☐
STAKEHOLDER REVIEW				
Finance	Nicola Colley	☒	☐	☐
Human Resources		☐	☐	☐
Estates		☐	☐	☐
Procurement		☐	☐	☐
IT / Digital / Information		☐	☐	☐
<add other names as necessary>		☐	☐	☐

GROUP SUPPORT				
Group	**Date Presented**	**Yes**	**No**	**N/A**
Digital Transformation Committee		☐	☐	☒
Capital Monitoring Group		☐	☐	☒
Elective Recovery Group		☐	☐	☒
Acute Care Transformation Steering Group		☐	☐	☐
Quality Governance and Assurance		☐	☐	☐

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1. THE ASK

This business case seeks to address the current and ongoing issues in relation to escalation capacity across the medical bed base, where this is located and how in reality these beds are utilised. It will ensure a new escalation strategy across the Trust ensuring that our admission areas are protected whilst also creating funded flexible ward capacity which is able to respond at times of peak pressure and then is de-escalated when the pressure subsides. This business case seeks to address the current demand and how we will mitigate that demand within our existing footprint and will seek to clarify how the existing bed base will be readjusted within the existing footprint.

This business case will ask for £1,784,794 of recurrent funding of a flex style model which will increase our bed base to 317 at times of peak pressure from Sunday to Wednesday and then correspondingly flex down to 287 at times of reduced pressure. This will ensure that the medical bed base is right-sized and adequately resourced all year round by increasing the number of medical wards from 11 to 12 wards and building in the corresponding flex capacity. It is important to note that the outturn from last year was £20,962,542 to run our existing ward bed base which was inclusive of additional winter capacity up to 317 beds, current run rate for 2025/26 suggests that we are likely to outturn a similar amount as to 2024/25 if no action is taken, however the proposed model is expected to make run rate reductions.

Whilst ensuring that this reconfiguration is able to keep up with ever increasing demand, and allow us to ensure we move closer to ensuring the right patient, seen by the right specialty clinician at the right place and time this will also allow us to benefit from established ward teams working in their own areas with a clear escalation plan which removes uncertainty, places downward pressure on sickness absence and drives down the associated costs of bank and agency staffing and will ultimately ensure patient safety through reduction in patient safety incidents, complaints, concerns and PALs enquires and improve patient experience.

2. CONTEXT IN WHICH THE DECISION IS MADE

The Medical bed reconfiguration is a significant priority for the Trust and as such featured as a key element of the Acute Care Transformation programme under the Patient Flow workstream throughout 2024/25. This is key in our ability to ultimately deliver the Trust commitment to achieve 78% against the 4 hour target, to deliver timely care for our patients in the most appropriate setting with the most appropriate clinical team and delivering a seamless approach to patient care in hospital and at home.

In the Trust's recently launched Organisational Priorities for 2025/26, the Bed Reconfiguration work is a central tenet to those priorities in that this will address each of the four quadrants and in particular will touch on each of the follow priorities:

- Quality of Care – 1: Deliver high quality safe, caring and effective care that is good with some exemplar areas
- Access to Care – 1: Deliver the three core national access standards; 68% RTT, 80% FDS, 75% 62-Day Cancer and 78% 4hrs by March 2026

- People and Culture – 2: Deliver improved attendance by reducing the sickness absence rate by 1% and achieve a healthy retention rate in the range of 8-9.5% across the year
- Financial Sustainability – 1: Deliver our financial plan for 2025/26, reducing our cost base and delivering a balanced financial position.

Additionally, as part of the Multi Year Financial Plan document under *KLOE3: Operational Productivity*, there is an ambition for the Trust to reduce capacity by 28 beds with a stated £1.8 million financial opportunity, however this has been RAG rated as red given the significant challenges in extrapolating such a saving given the significant non-elective demands on the organisation at this point in time.

In line with these ambitions the overall aim of the medical bed reconfiguration is to ensure that we achieve the right patient, seen by the right specialty clinician at the right place and time. It is also incumbent on us to be able to respond to peaks in demand which have largely been sustained leading to the reality of opened G&A beds at 317 beds which is significantly in excess of the 293 funded G&A capacity (total recurrent budget for 293 beds is £18,687,840). As a response to this, and through winter funding, Ward B4 was set up as a winter ward and is currently open until the end of July and so we would need a decision on this from July 2025.

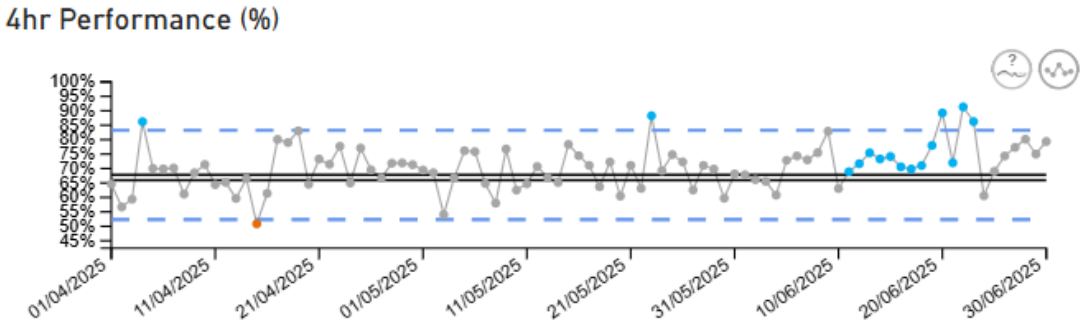
In order to address the need for additional bed capacity during winter, approval was given to utilise winter funding to ensure the 27 beds on B4 remained open, with a corresponding nursing establishment to ensure consistent nursing leadership and ownership during this time. However medical cover was derived from the Acute Medical team which has inevitably created additional strain on their workforce throughout this time. Our intention is, through the reconfiguration that the responsibility for B4 will transfer to a different medical team and therefore releasing medical resource towards SDEC.

It is also important to note that alongside this, the recommendations arising from the Safer Care Nursing Tool review for an increased nursing establishments have been presented to the Trust Board Directors and as such this has been factored into the business case for consideration.

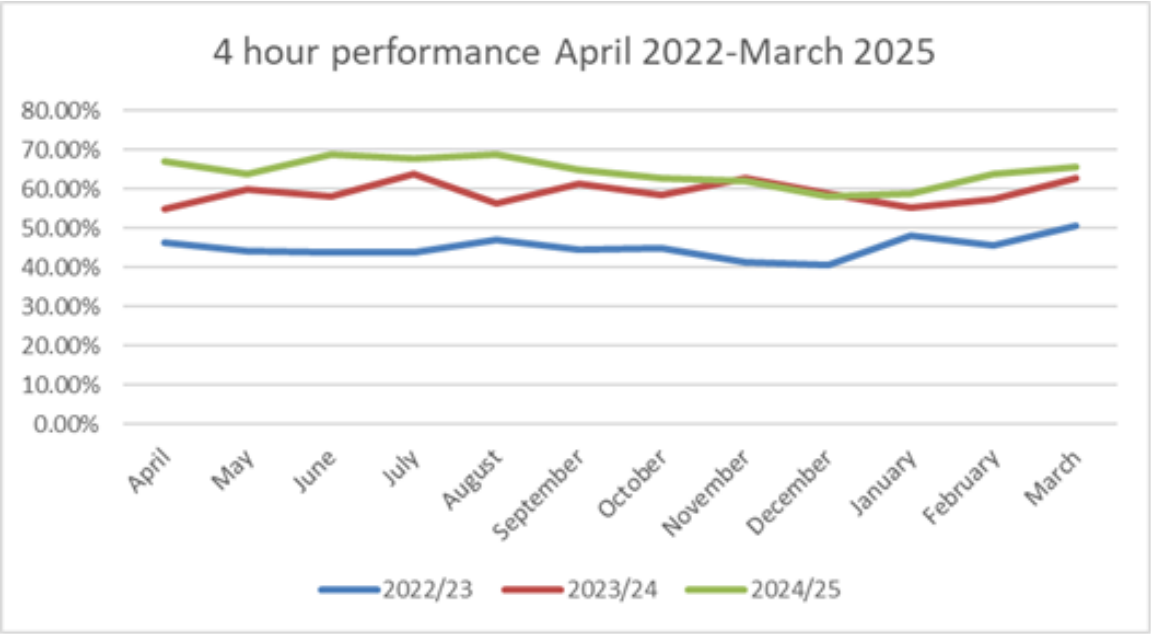
3. WHAT IS THE CASE FOR CHANGE

3.1. Current Service Arrangements

One of the key targets for the Trust is to achieve 78% 4 hour performance, this is effectively a national barometer for how effective we are at moving patients through the organisation from the front door through to discharge and whether we are ensuring the right patient is seen by the right specialty clinician at the right place and time. If we are able to make gains from a patient flow perspective on the ward areas with the aim of reducing length of stay and getting patients to where they need to be more quickly this should correspond to more available bed capacity and better flow out of UECC into the organisation. Our current 4 hour performance is consistently improving, with our performance in June at 73.46% and our first quarter performance at 70.26%. The current 4 hour performance is shown below (April-24 to current):



Set across the last 3 years, our performance has improved year on year as shown below:



Despite an acute decline in Winter 2024-25, particularly October to December, we have seen an improving trajectory which continues to improve.

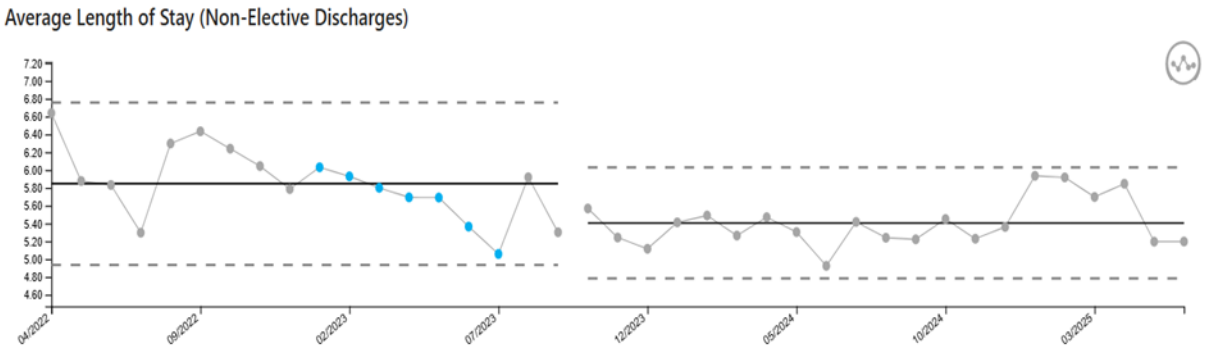
Currently, the Medical bed base is budgeted for 293 beds (officially 290 but 3 additional beds recognised as funded with no corresponding increase on funding required) which are split across 11 ward areas, with a total budget of £18,687,840 these are shown below:

	Current Position (Pay only)	
	No Of Beds	Annual Budget*
A1	33	1,798,804
A2	24	1,565,570
A3 - respiratory	33	1,845,768
A4	33	1,814,463
A5	33	1,728,623
A7	12	959,069
Stroke	27	1,935,009
B5 - Respiratory	24	1,728,623
CCU	8	1,037,542
RAT (B2)*	10	
AMU B3	29	2,695,738
SSU (was B4 to be on B2)	27	1,578,631
Total Direct ward Costs	**293**	**18,687,840**
Other Net Costs		
Medical/Domestics etc. (see additional ward costs table)		
Total		**18,687,840**

**RAT beds are only funded from 08:00-00:00 7 days per week.*

To accommodate the reconfiguration work we have already moved Short Stay Unit down the AMU footprint to Ward B2 (previous SDEC inpatient area), however our intention is to move the current B5 ward which currently hosts medically optimised patients for discharge into the vacated B4 footprint. This would then allow us to move Respiratory from its current location on A3 to B5 which will then vacate Ward A3. Our intention then is then to ensure HCOP wards are all co-located together and will allow us to benefit from the economies of scale which will be created by ensuring the medical teams are able to benefit from close proximity of the wards.

We are also currently running a significant Quality Improvement project to ensure significant improvements in Patient Flow and Discharge, the intention of this project is to improve patient care through reduced length of stay, quicker access to treatment (right patient, right bed, first time), empowering all staff to make changes in their areas, reduce delays and improvements in Key Performance Indicators, this is also supporting the gains we have seen in overall Trust bed occupancy levels.

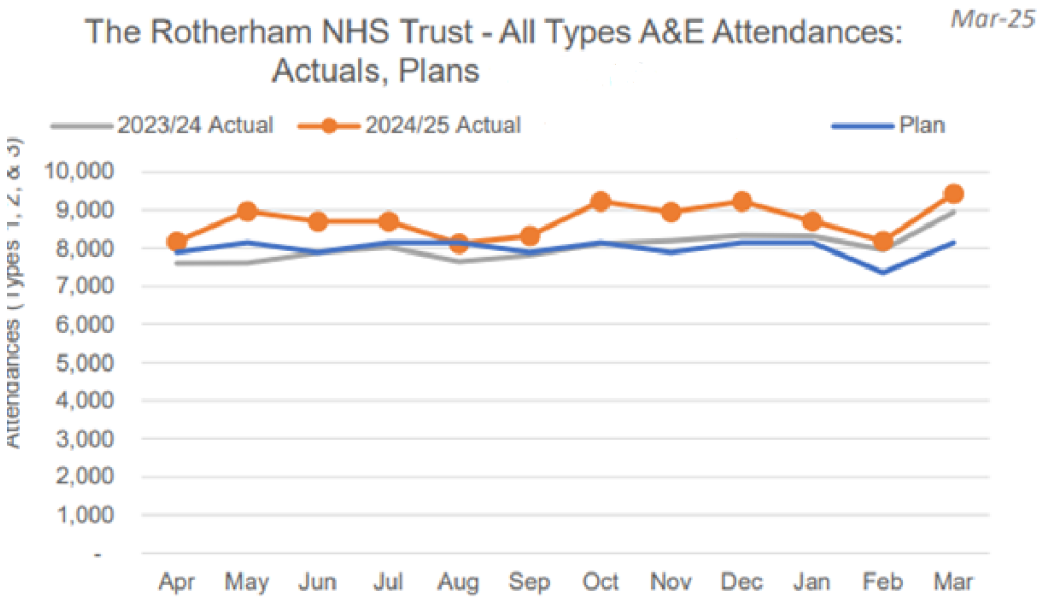


The chart above shows that there are gains being made from a length of stay perspective over the last 3 years, however there is further work to do and as such, we hope that through delivery of a right sized medical bed base alongside this continued quality improvement work, we hope to make further gains from a length of stay perspective ultimately to deliver a case in the future to close beds in line with the Trust's ambitions through the Multi Year Financial Plan.

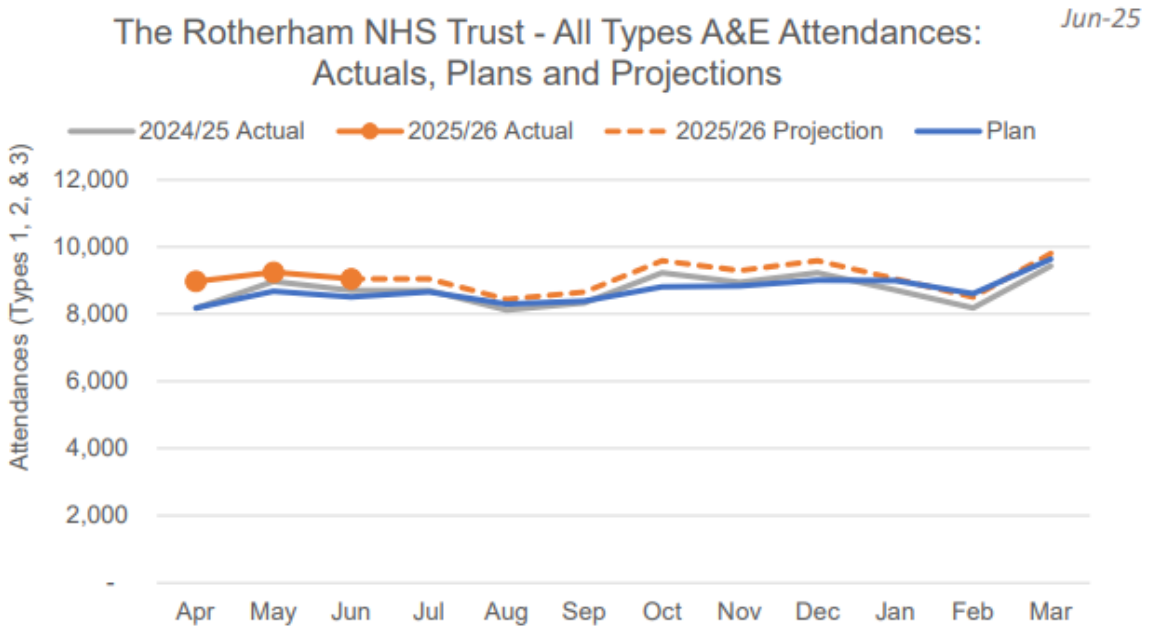
3.2. The Issues, Concerns or Opportunities

3.2.1. Non-Elective Demand

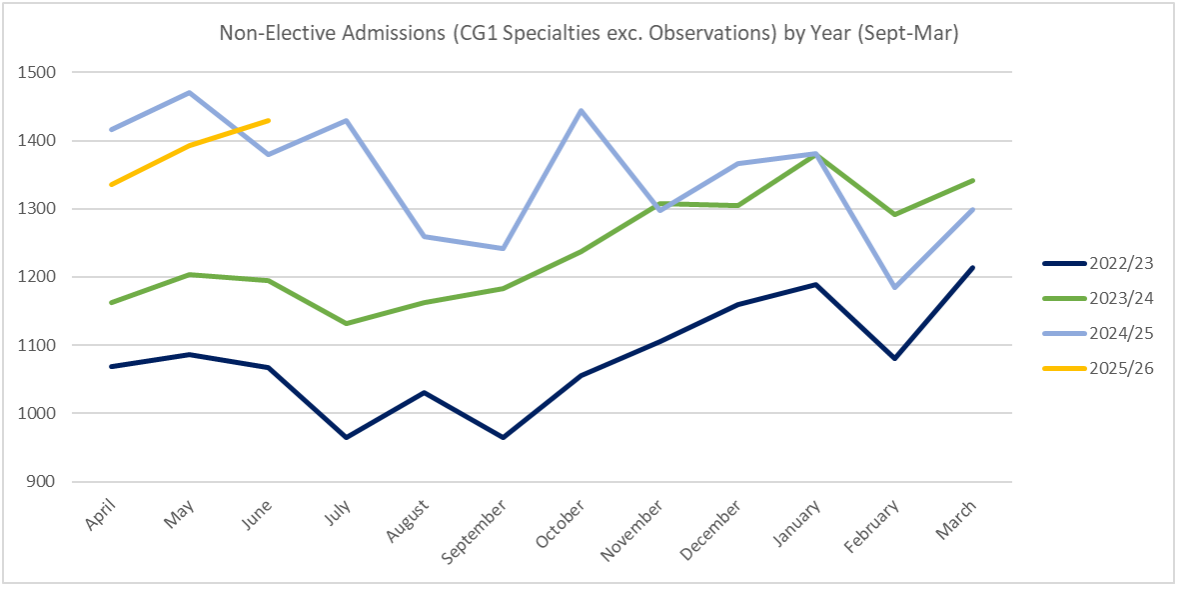
We have seen a significant uplift in the level of urgent care activity at the Trust with attendances across the year up 8.6% from 2023/24 (an increase of 8292), as such this has created corresponding pressure on escalation beds and contributed to winter beds remaining open for an extended period earlier in the year and frequent inpatient escalation on Ward B6.



The graph below shows the current position for 2025/26:



In line with increased attendances, we are also seeing a corresponding year on year increase in non-elective admissions, in 2023/24 we saw an average increase of 13%, followed by an average of 8% increase in 2024/25 and currently an average of 3% increase year to date in 2025/26, as shown below:



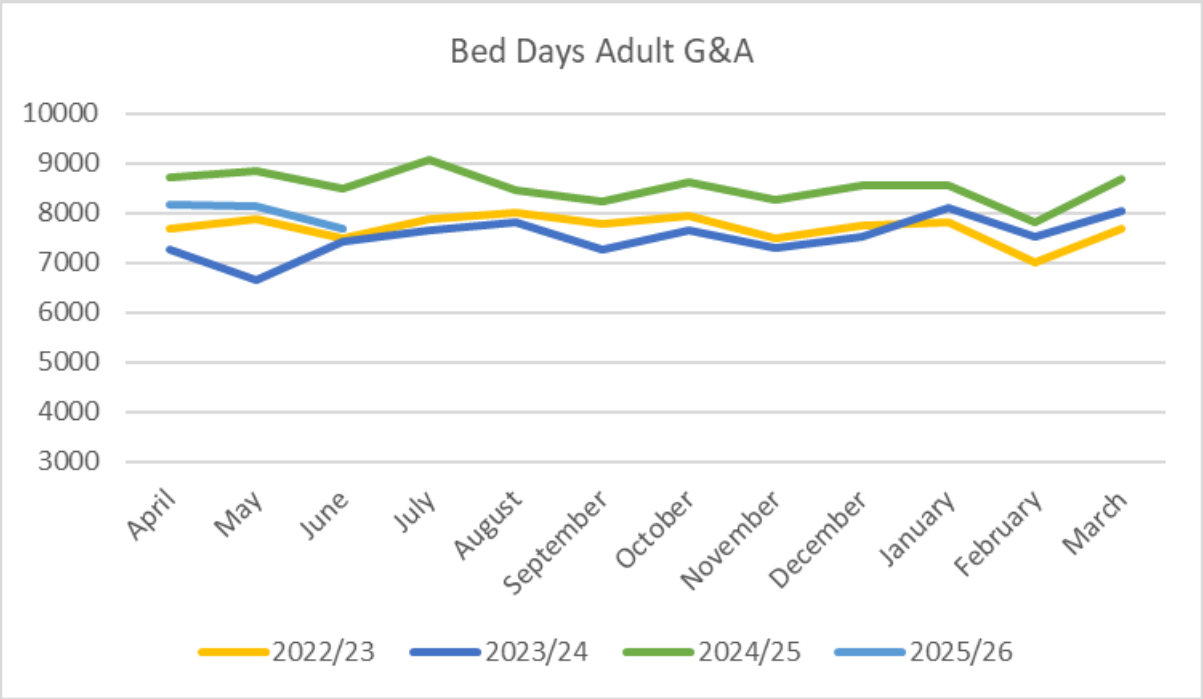
POD (groups)	Activity Plan	Activity Actual	Activity Var	Activity % to Plan	Price Plan	Price Actual	Price Var	Income % to Plan
AE	95,652	122,253	26,601	127.8%	£19,345,227	£24,175,551	£4,830,324	125.0%
NEL	17,866	16,447	-1,419	92.1%	£46,221,204	£52,029,564	£5,808,359	112.6%
NELNE	263	209	-54	79.4%	£1,661,175	£1,392,063	-£269,112	83.8%
NELNEXBD	63	273	210	430.7%	£19,276	£82,474	£63,198	427.9%
NELST	4,398	3,046	-1,352	69.3%	£4,030,318	£2,834,409	-£1,195,909	70.3%
NELXBD	5,032	5,159	127	102.5%	£1,605,945	£1,654,035	£48,090	103.0%
Total	**123,274**	**147,387**	**24,113**	**119.6%**	**£72,883,145**	**£82,168,095**	**£9,284,950**	**112.7%**

It is evident, and as shown from the tables above, whilst NEL activity was down in 2024/25 against plan the level of complexity has increased, driving increased income against plan. The tables above demonstrate, that if the attributed tariff per HRG was applied, all non-elective activity for Care Group 1 was up in 2024/25 by £9.284 million. This trend appears to be continuing into 2025/26 as shown below with the year to date estimate position showing an increase in activity and shows that NEL is already 463 above plan.

Month 3 year to date position shown below:

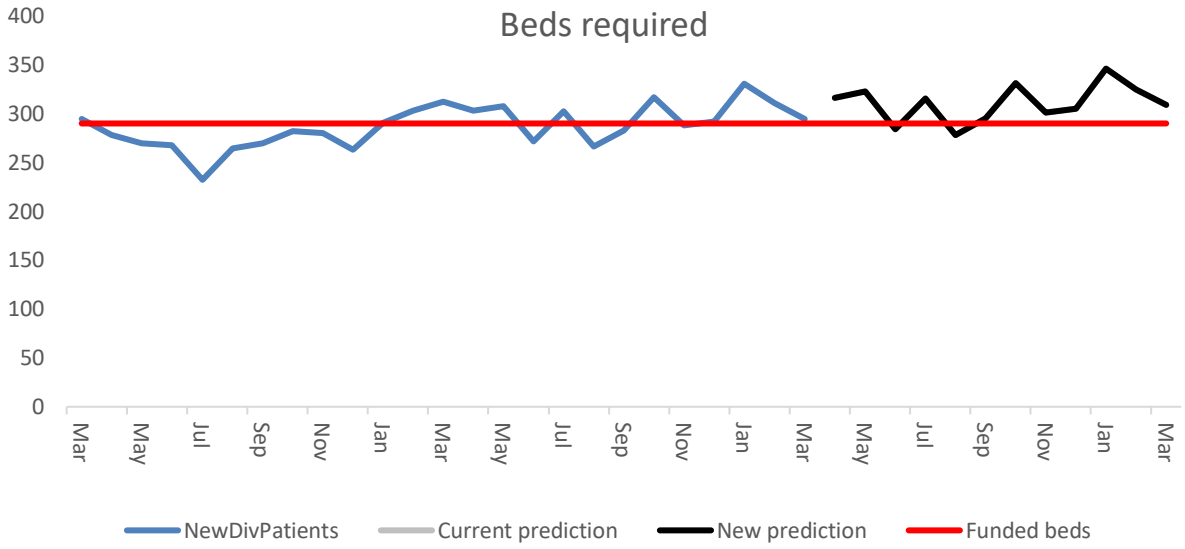
Row Labels	Sum of Activity Plan	Sum of Activity Actual	Sum of Activity Variance
Excess Bed Days	1,569	1,409	-160
Non-Electives	4,053	4,515	463
UECC	33,389	34,448	1,059
Grand Total	39,010	40,372	1,361

This level of complexity is also reflected in overall bed days, as shown below:



Based on ECIST bed modelling, the current bed modelling data, suggests that we will need an average of 310 beds and up to 346 bed (at times of peak demand) as shown below, however this is prior to any assumptions including Medical SDEC, pathway work and

stronger links with community including virtual ward which will be discussed further in Section 3.2.4.



N.B. Data shown above is derived directly from the ECIST (Emergency Care Improvement Support Team) Bed Modelling Tool. Note "NewDivPatients" = average monthly beds occupied

3.2.2. Existing Escalation Capacity

We have been consistently running with additional escalation beds opened due to the aforementioned increase in demand with the organisation regularly running on 9 additional beds (Ward B5) and additional capacity on B4 (recognised through winter funding) and usage of B6 as an inpatient area at times. Despite positive reductions in agency usage, this increased pressure contributes to significant associated spend through bank and agency usage and risks increased prevalence of concerns and complaints. Furthermore, it is impacting on the existing teams through stretching resource further to meet demand which has a negative effect on sickness absence levels, which for Care Group One have been running significantly higher than the Trust target of 4.8% with average sickness at 7.72% across the period April 2024 to April 2025.

To combat staff moves and create stability the aforementioned winter funding of B4 has mitigated these concerns significantly with consistent nursing leadership and seconded staff to cover the unit.

3.2.3. Increased Running Costs

As previously mentioned in section 3.2.2 the actual reality of running the bed base in excess of the 293 funded capacity was £20,483,407 in 2024/25, this increased bed base including B4 as a winter ward totals 317 beds. These costs are shown below:

	Current Position (Pay only)		2024-25 M12 Position	
	No Of Beds	Annual Budget*	Beds	Outturn
A1	33	1,798,804	33	1,895,484
A2	24	1,565,570	24	1,924,289
A3 - respiratory	33	1,845,768	33	2,036,005
A4	33	1,814,463	33	1,964,058
A5	33	1,728,623	33	1,849,767
A7	12	959,069	12	999,321
Stroke	27	1,935,009	27	2,105,998
B4 - Vacant	0		27	167,713
B5 - Respiratory	24	1,728,623	33	1,743,927
CCU	8	1,037,542	8	1,064,098
RAT (B2)*	10		0	0
AMU B3	29	2,695,738	26	3,426,188
SSU (was B4 to be on B2)	27	1,578,631	28	1,785,695
Total Direct ward Costs	**293**	**18,687,840**	**317**	**20,962,542**
Other Net Costs				
Medical/Domestics etc. (see additional ward costs table)				
Total		**18,687,840**		**20,962,542**

These costs include additional bank and agency spend across all areas and should be noted that the costs on B4 are only representative of 4 months (since winter funding pilot) and that the associated costs including bank and agency costs may not map directly to B4 with staffing moved around across ward areas on a daily basis to ensure adequate safe staffing levels across wards.

3.2.4. Admission Avoidance Strategies (including Medical SDEC)

Whilst this business case has very much focussed on the current position, we do expect to see significant gains in the relocation of SDEC to its new location much closer to the front door with protection from inpatient bedding, the revised model of working will allow and facilitate quicker turnaround with dedicated senior decision making capacity which should in turn decrease the number of onward admissions to the Acute Medical Unit. There is also work ongoing with integrating community teams and SDECs much more intrinsically with the intention of creating an interface whereby patients can be assessed and managed out in the community without the need for attendance to hospital through strengthened virtual ward opportunities.

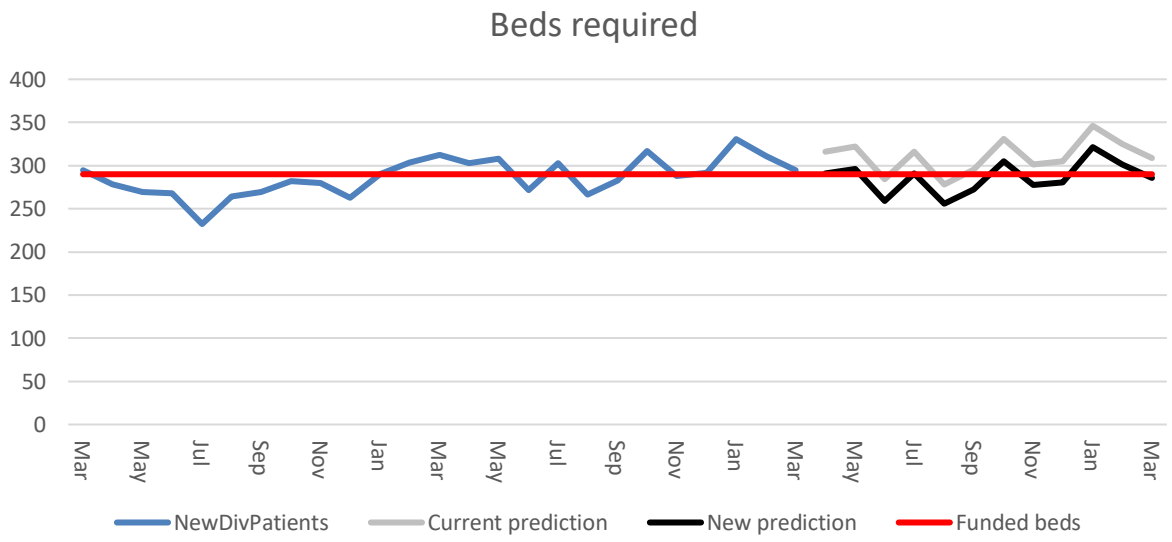
It should be stated that at the time this business case is being written that the Medical SDEC has only just been relocated (opening on 02 July 2025) and so assumptions have been included in this case based on review of national information (SAMEDAY Strategy, 2024 and SDEC Service Specification, 2024).

Applying these assumptions to our current data, throughout the year last year, we had 4351 discharges from AMU of patients whom had a 0-2 day LOS, this presents a significant opportunity. If we were to reduce admissions from this cohort by 30% through these combined admission avoidance measures (an average of just 3.5 patients per day), we would reduce the overall number of bed days down, however we would then expect to see

average LOS increase as a result of only admitting the most acutely unwell/complex patients. The calculations from these strategies are as follows:

	Admissions	Bed Days	LOS
All Admissions (June 2024-May 2025)	31804	209906	6.6
0-2 Days LOS	4351	6526	
Admissions excluding 0-2 days	27453	203380	7.4
Reduction of 30% on LOS in 0-2 Days Cohort	3046	4568	
Net Difference	-1305	-1958	
New Admissions	30498.7	207948	6.8
Net Reduction in Beddays	-1305	-1958	

When we put this information into the National ECIST bed modelling tool, this shows we require 287 beds on average with peak number of beds required at 321, this is set against a previous average without any of these changes of 310 with a peak of 346 (on average 25 less beds at peak and 23 on average), this information aligns with the most recent SAPIT data which agrees with this assumption that we require on average 287 beds given the latest data. This effectively underlines the deliverability of the proposed model of 12 wards with built in establishments to enable wards to comfortably flex up to 317 and down to 287 at times of peak demand and reduced demand respectively.



N.B. Data shown above is derived directly from the ECIST (Emergency Care Improvement Support Team) Bed Modelling Tool. Note "NewDivPatients" = average monthly beds occupied

The model above shows the revised plan with the assumptions included, this is also demonstrated in the table below:

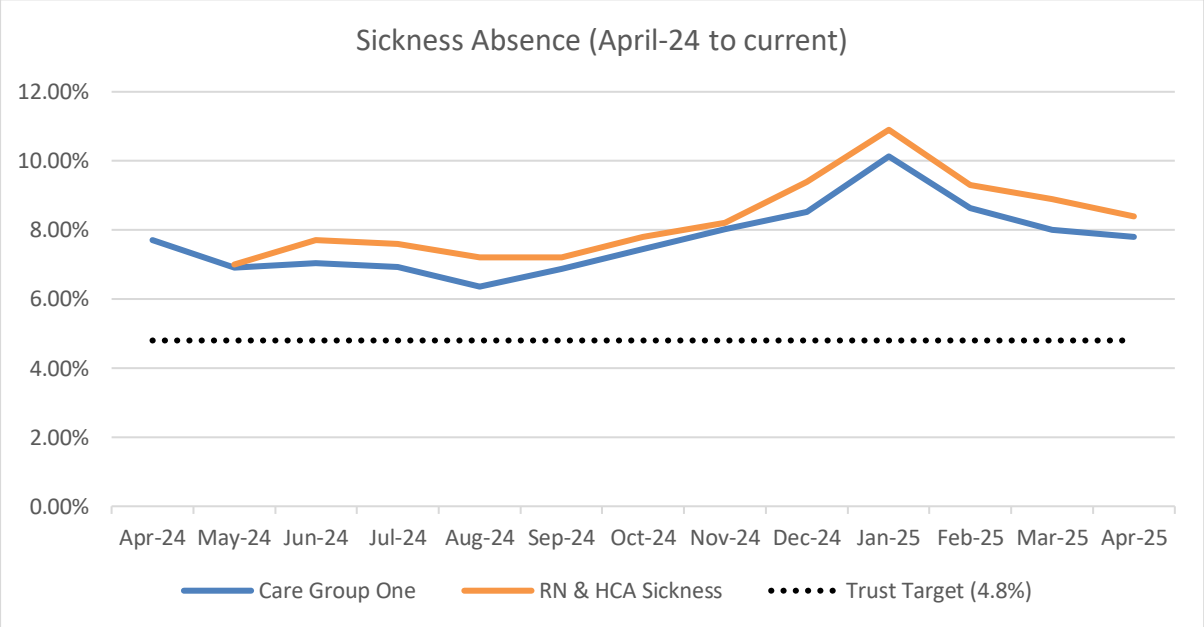
Bed Modelling	Minimum beds required	Peak beds required	Average beds required
Initial modelling	278	346	310
Modelling including revisions	255	321	287

3.2.4.1. Going further to 2026/27 and beyond

As previously stated, the model this business case has articulated is for the current state and existing demand, however looking towards the future in line with the quality improvement work ongoing across ward areas and further developments including expansion of virtual hospital, Medical SDEC and the ambitions within the NHS 10 Fit for the Future 10 year plan including expansion of community care and focus on prevention, the success of these schemes will point towards a future state whereby we will be able to consider reducing the bed base further in line with the commitments set out in the Multi Year Financial Plan. Within the plans we have provided, the future state may include the same principles to remove beds on the remaining 33 bedded wards (A5 and B5) to further drive down bed capacity and realise the ambitions of the Trust multi-year financial plan. If, for instance we were able to shut 10 beds on each of those wards permanently, this would release approximately £466,000 through reduction in establishments on those areas.

3.2.5. Sickness Absence

As above, Care Group One have been experiencing consistently higher sickness rates than the Trust target throughout 2024/25 and into 2025/26, whilst multi-factorial it is highly likely that unfunded escalation capacity and resultant staff moves (redeployments) have a direct impact on sickness absence.



For every percentage point we bring sickness absence down we could save approximately £374,000 from a nursing and HCA bank and agency perspective, in total if we brought this down to the Trust target this would save approximately £1,196,000 based on our current spend on bank and agency.

As a guide, this cost equates to 12 nursing shifts (11.5 hours) per week and 11 HCA shifts (11.5 hours) per week, 3 per day across RNs and HCAs. If, for example, we saved 1 lost RN shift and 1 lost HCA shift per day due to sickness this would equate to approximately £622 per day or approximately £227k per year.

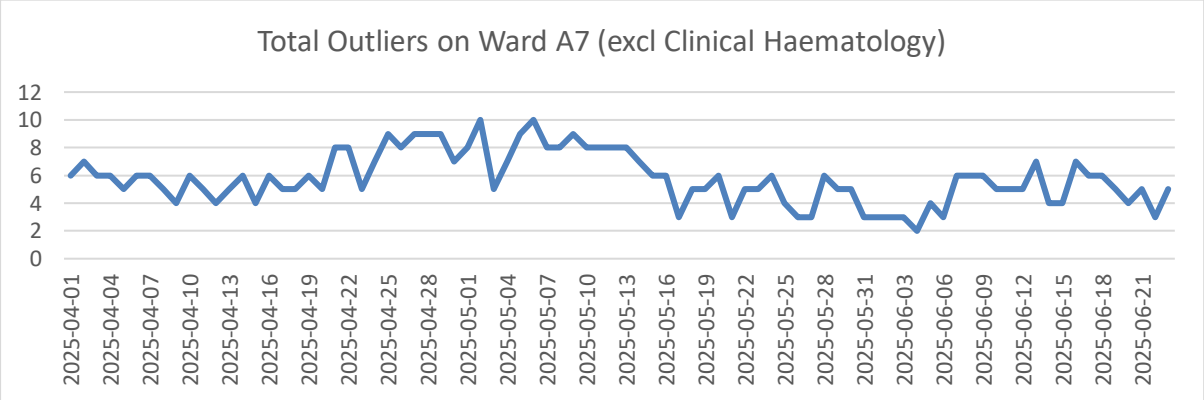
3.2.6. Right sizing and Co-locating Specialties

Through a revision of the current composition of our beds we are seeking to address both location and right sizing of our specialties, however we are now proposing to segment this into 2 elements, the first being to ensure the specialties are in the right location and secondly to address the expansion of specialty bed bases as a separate and distinct element. Through this reconfiguration we will initially aim to co-locate HCOP wards together and to locate Respiratory closer to Critical Care and Radiology by moving the ward down to B5. It is important to note however that pending the outcome of the wider bed modelling work Trust-wide, this may contribute to a variation of this plan in the future.

3.2.7. Outliers + Specialty Outliers

Largely the previous bed reconfiguration work has ensured that the Medical Bed base has not encroached onto Surgical / B11 beds with the move of B5 to Medicine. However, this is not entirely consistent and fluctuates according to demand, however the number of outliers has reduced significantly from its previous average of 33 to an average of 6 since October 2023 (however this does not account for outliers on B6 which are additional patients to Medicine).

We should however state that within the bed base at any one time, we have a cohort of General Medical patients who occupy beds on the Haematology Ward, these would be considered to be specialty outliers. The Haematology Partnership work with Barnsley Hospital NHS Foundation Trust has an ultimate objective to have a single inpatient facility dedicated to Haematology patients only and as such we would need to bear in mind that this would impact on capacity on the G&A bed base.



The average run rate of patients on the Haematology Ward is 5.7 patients which potentially would need to be moved back into the G&A bed base when the new ward goes live. However, given the assumptions made in section 3.2.3 we would expect to be able to cope with these additional patients in the existing footprint.

3.2.8. Non-invasive ventilation provision at TRFT

Currently our non-invasive ventilation provision is hosted in Critical Care. Most trusts deploy what is known as a Respiratory Support Unit to enable dedicated respiratory specialist care in a facility with a suitably trained multi-disciplinary team to enable early intervention, closer

monitoring and better planning with the overall aim of reducing complications, length of stay and mortality rates and also ensuring reduction of unnecessary admissions to critical care. Rotherham had an area designated as a Respiratory Support Unit which was located on Ward A3, however due to staffing challenges and multiple serious incidents in the initial implementation, it was decided to close the RSU at that time, with the provision moved correspondingly to Critical Care. However NICE and BTS guidelines recommend specialised care for acute exacerbations of chronic lung disease and other respiratory emergencies and so to bring ourselves in line with these standards will improve overall the quality of care we are providing to the population of Rotherham. There is a bespoke piece of work currently ongoing to address this, however any outcomes of that will likely require investment and estates work to accommodate adequately.

3.3. What are Others Doing?

Non-elective demand across the country has not been consistent, with South Yorkshire having seen particularly high levels of demand which have not been seen elsewhere, this business case aims to ensure that there is a clear plan for The Rotherham NHS Foundation Trust which addresses the level of demand we have seen and a plan to ensure the Trust is right sized for the level of demand we are experiencing.

4. WHAT ARE THE AIMS OF THE BUSINESS CASE

#	Aim	Benefit Type • Financial • Productivity • Quality • Operational
1	Ensure a reduction in bed days	Operational
2	Improve patient experience	Quality
3	Ensure a reduction in staff moves, sickness absence and turnover	Operational
4	Ensure a relative reduction in patient safety incidents, complaints, concerns and PALS enquiries	Quality
5	Reduce bank and agency spend on nursing staffing	Financial
6	Reduce patient ward moves for non-clinical reasons	Operational / Quality

5. WHAT ARE THE OPTIONS TO DELIVER THE AIMS

OPTION 1: Do Nothing - Continue with existing capacity as it is currently configured	
Description of the Option:	Continue with existing capacity as it is currently configured (11 wards and 293 beds)
Delivery of Aims	As has previously been articulated this will not address the aims due to the utilisation of unfunded escalation capacity and lack of establishment to meet demand
Risk / Issues	This does not take into account the need to address right sizing and locating specialties in their ideal locations alongside the significant risks

	around continuation of usage of escalation capacity and the associated unplanned costs and quality of care issues that this option presents including further pressure on staffing resource and sickness absence levels.
Financial Impact	Whilst there is no budgetary impact through this option, the total financial risk for operating within our current unfunded escalation capacity generated an outturn position of £20,962,542
Deliverability	As has already been articulated in the business case, this carries significant risk through unfunded escalation capacity being utilised
Impact outside the service	This may impact on number of outliers into the surgical bed base as a result of unfunded escalation capacity, increased B&A staffing, higher length of stay

OPTION 2: Funded G&A beds with unfunded escalation capacity – increase of £1,543,764 against current budget	
Description of the Option:	This option would mean that no surge capacity in excess of the agreed 290 currently funded beds would be commissioned recurrently. However, within this requirement we would seek to move specialties into their ideal location, address shortfalls in specialty capacity and in doing so open a new ward area through dropping 3 x 33 bedded wards to 23 beds (and thus creating 4 bedded bays) ultimately consolidating these into a new ward area
Delivery of Aims	This option would ensure that we will run on 12 ward areas as opposed to 11, with funded capacity reduced on 3 x 33 bedded areas to 23 and creating a new ward with the corresponding drop in capacity on other ward areas. The unfunded escalation capacity would sit on A1, A3 and A4 with each ward dropping from 33 to 23 beds.
Risk / Issues	Whilst this addresses the need to right size and ideally locate specialties, this does not ultimately take into account the need to ensure the organisation is able to respond to peaks in demand outside of our existing escalation capacity (now located on B4) and address the ongoing need for funded escalation capacity outside of our existing funded bed base.
Financial Impact	The overall budgetary cost of this model is £20,231,604 (exclusive of pay awards) which presents an increase of £1,599,340 against current budget however is a reduction against the outturn position of 2024/25 of -£730,938. This is inclusive of Safer Care Nursing Tool recommendations which were provided to the Board of Directors in July 2025.
Deliverability	This option would ensure we have staffing establishments on each ward area (for their revised bed numbers) and so may have a positive impact on length of stay, patient experience, reducing staff moves, reducing relative number of patient complaints and concerns, however with the number of beds we are consistently running on this would present a risk around bank and agency costs and sickness absence with areas not set up for the full demand on beds.
Impact outside the service	As with option 1, This may impact on number of outliers into the surgical bed base

OPTION 3: Create a new ward area with funded surge capacity available Sunday to Wednesday – increase of £1,784,794 million against current budget	
Description of the Option:	This option would present an ability to flex up from 287 to 317 at times of peak demand (Sunday-Wednesday). This option would establish teams appropriately to cope with this increased demand with the expectation that beds are shut down on the remaining days of the week. Alongside our existing funded bed capacity the total full year effect cost for this model is £20,286,322.
Delivery of Aims	This option ensures that we establish a new ward to take us to 12 wards and create a corresponding partially funded flex capacity within the system, this will likely have a positive impact on length of stay, reduced staff moves, reduced sickness absence, reduced bank and agency spend, corresponding reduction in complaints and overall improved patient safety and experience
Risk / Issues	This option would ensure there is consistent planned and funded establishments on every ward area, would likely positively contribute to a reduction in LOS, a decrease in concerns, complaints and would give us greater ability to respond to peaks in demand but in line with when the increased demand presents. This does present the second most costly option for the organisation, however this is below the current costs of running 317 beds. It is also important to note the risk that acuity and activity may not stay static and as such may mean wards have escalation beds outside of these times
Financial Impact	The overall budgetary cost of this model is £20,472,634 (exclusive of pay awards) which presents an increase of £1,784,794 against current budget however is a reduction against the outturn position of 2024/25 of -£489,908. This is inclusive of Safer Care Nursing Tool recommendations which were provided to the Board of Directors in July 2025.
Deliverability	This option would ensure that wards are fully established for 317 beds at times of peak demand
Impact outside the service	There may be at times of peak pressure the need to outlie onto other areas which may impact on the CG2 and CG3 bed base.

OPTION 4: Create a new ward area with funded escalation capacity all year round – increase of £2,203,558 million against current budget	
Description of the Option:	This option would see no reduction in capacity on any ward and would in effect open B4 up to its full capacity all year round. This would overall increase funded bed numbers to 317. Alongside our existing funded bed capacity the total full year effect cost for this model is £20,572,675.
Delivery of Aims	This options ensures that we establish a new ward to take us to 12 wards and create a corresponding fully funded flex capacity within the system, this will likely have a positive impact on length of stay, reduced staff moves, reduced sickness absence, reduced bank and agency spend, corresponding reduction in complaints and overall improved patient safety and experience

Risk / Issues	This option would ensure there is consistent planned and funded establishments on every ward area, would likely positively contribute to a reduction in LOS, a decrease in concerns, complaints and would significantly uplift our capacity from their current levels at 290 to 317 beds. This does present the most costly option for the organisation, however this is not outwith the current costs of running 317 beds.
Financial Impact	The overall budgetary cost of this model is £20,891,398 (exclusive of pay awards) which presents an increase of £2,203,558 against current budget however is a reduction against the outturn position of 2024/25 of -£71,144. This is inclusive of Safer Care Nursing Tool recommendations which were provided to the Board of Directors in July 2025.
Deliverability	This option would ensure that wards are fully established for 317 beds at all times and would enable teams to be empowered to request de-escalation of their beds and would effectively incentivise them to do so
Impact outside the service	There may be at times of peak pressure the need to outlie onto other areas which may impact on the CG2 and CG3 bed base.

N.B. The associated costs for each option are based on 2024/25 pay rates and will be subject to change based on the 3.6% pay award due to take effect in August 2025.

6. DETAILS OF THE PREFERRED OPTION

We are requesting support for **Option 3: Create a new ward area with funded surge capacity available Sunday to Wednesday**, this will ensure an appropriately sized medical bed base with the funded capacity to be able to flex up and down based on peaks in demand, the costings for this model are shown below.

6.1. Managing the New Surge Capacity (including winter 2025/26)

In terms of how this will be transacted on a daily and weekly basis, tight operational controls will be implemented which will be articulated through the establishment of a robust standard operating procedure. The Care Group will retain overall responsibility for internal processes to ensure continued focus on usage of the flexible escalation capacity and plans to de-escalate, alongside this Ward Managers for the escalation wards will be responsible for oversight of their position each day. There will be clear and robust discussions at each site meeting both in and out of hours as to the position relating to the escalation capacity where plans will be sought regarding de-escalation of these beds. In addition, each Tuesday there is a Long Length of Stay meeting which addresses plans to action the longest staying patients on each ward area, each ward manager on the escalation wards will be asked to provide an update on their escalation bed position and plans to de-escalate by the afternoon of the following day to ensure beds return to their established position for Thursday to Saturday or indeed any risks to de-escalation. These will be co-ordinated by the Clinical Manager for Site and Patient Flow with escalation through to the Chief Operating Officer or Deputy in hours for utilisation of the beds outside of the designated escalation times and out of hours will be escalated through from Silver to Gold on Call.

Rostering arrangements to support Option 3 will be put in place so as to ensure the appropriate shifts are available during this time period from Sunday through to Tuesday with

the remaining days reduced down to correspond to the flexible model. Monthly roster reviews are already in place with all ward managers and will continue with a prospective review put in place to ensure we are appropriately managing these arrangements.

With reference to section 3.2.4, the bed modelling tool suggests that at times of peak pressure, we will need 321 beds, this is marginally in excess of the 317 maximum capacity across medical wards. Our intention is that, as per previous winters at times of peak pressure, alongside the actions in the winter plan, during this period there will be flexible reduction in elective activity to be able to effectively manage the level of non-elective demand generally across the organisation.

In addition to daily transaction, giving due consideration to the winter plan for this year, adopting 23 bedded wards will allow for better patient distancing and support with the reduction of closed beds for infection control reasons as a result of reduced risk of cross-infection throughout the winter period when traditionally we have seen significant numbers of closed beds.

	Option 3	
	10 beds closed on 3 wards Wed-Sun am* **	
	No of Beds	**Proposed Budget**
A1	23-33	1,661,716
A2	24	1,565,570
A3 - New Ward	23-33	1,677,375
A4	23-33	1,677,375
A5	33	1,728,623
A7	12	959,069
Stroke	27	1,935,009
B4 - Medical Optimised	27	1,538,270
B5 - Respiratory	33	1,814,463
CCU	8	1,037,542
RAT (B2)*	0	0
AMU B3	26	2,695,738
SSU (was B4 to be on B2)	28	1,578,631
Total Direct ward Costs	**287-317**	**19,869,381**
Other Net Costs		
Medical/Domestics etc. (see additional ward costs table)		**284,530**
Total		**20,153,912**
Difference to current budgets incl winter		**1,466,072**
SCNT - Approved paper July 2025 (see appendix)		**318,722**
Total excluding 2025-26 pay awards		**1,784,794**
Estimated cost Including pay awards @ 3.6%		**1,849,046**

N.B. Please note that on some occasions ward costs can differ slightly. This will largely depend on the composition of qualified staffing and some wards have also having Registered Nurse Associates. These roles are paid at a Band 4, but are part of the qualified rotas. Another reason is that the Care Group used to work to a model of 2 deputy ward managers plus 1 clinical ward sister

per shift. Following a review it was deemed that 1 band 6 per shift was more appropriate, so the care group has been reducing the numbers down as colleagues have left their roles, replacing them with Band 5s.

All options (1, 2, 3 and 4) are shown below:

	Option 1				Option 2		Option 3		Option 4	
	Current Position (Pay only)		2024-25 M12 Position		Baseline escalation beds not funded		10 beds closed on 3 wards Wed-Sun am***		Proposed baseline all beds funded**	
	No Of Beds	Annual Budget*	Beds	Outturn****	No of Beds	Proposed Budget	No of Beds	Proposed Budget	No of Beds	Proposed Budget
A1	33	1,798,804	33	1,895,484	24	1,578,873	23-33	1,661,716	33	1,798,804
A2	24	1,565,570	24	1,924,289	24	1,565,570	24	1,565,570	24	1,565,570
A3 - respiratory	33	1,845,768	33	2,036,005						
A3 - New Ward				0	24	1,594,532	23-33	1,677,375	33	1,814,463
A4	33	1,814,463	33	1,964,058	24	1,594,532	23-33	1,677,375	33	1,814,463
A5	33	1,728,623	33	1,849,767	33	1,728,623	33	1,728,623	33	1,728,623
A7	12	959,069	12	999,321	12	959,069	12	959,069	12	959,069
Stroke	27	1,935,009	27	2,105,998	27	1,935,009	27	1,935,009	27	1,935,009
B4 - Vacant	0		27	167,713				0		
B4 - Medical Optimised			0	0	27	1,538,270	27	1,538,270	27	1,538,270
B5 - Respiratory	24	1,728,623	33	1,743,927	33	1,814,463	33	1,814,463	33	1,814,463
CCU	8	1,037,542	8	1,064,098	8	1,037,542	8	1,037,542	8	1,037,542
RAT (B2)*	10		0	0	0		0	0	0	
AMU B3	29	2,695,738	26	3,426,188	26	2,695,738	26	2,695,738	26	2,695,738
SSU (was B4 to be on B2)	27	1,578,631	28	1,785,695	28	1,578,631	28	1,578,631	28	1,578,631
Total Direct ward Costs	**293**	**18,687,840**	**317**	**20,962,542**	**290**	**19,620,852**	**287-317**	**19,869,381**	**317**	**20,280,645**
Other Net Costs										
Medical/Domestics etc. (see additional ward costs table)						**292,030**		**284,530**		**292,030**
Total		**18,687,840**		**20,962,542**		**19,912,882**		**20,153,912**		**20,572,676**
Difference to current budgets incl winter						**1,225,042**		**1,466,072**		**1,884,836**
SCNT - Recommendation to ETM and Board July 2025 (see appendix) 6.09 wte						**318,722**		**318,722**		**318,722**
Total excluding 2025-26 pay awards						**1,543,764**		**1,784,794**		**2,203,558**
Estimated cost Including pay awards @ 3.6%						**1,599,340**		**1,849,046**		**2,282,886**

Notes

1. * Annual budget includes £251,000 support for winter pressures for nursing costs
2. ** There will be some minor difference to this due to Band 2 to Band 3 exercise. Ward B4 has £29,014 taken out as the discharge Coordinator will be funded from corporate budgets
3. *** 1 Long shift reduced to recognise reduced number of beds, reduction of 1 RN and HCA, A1, A3 A4
4. ****To enable comparison 2024-25 outturn has been uplifts to incorporate the changes in employers national insurance
5. £206,000 was claimed from winter reserves for Medical costs, part of which covered the Medical Cover for Ward B4
6. Option 3 would likely require funding to full capacity during the winter months, November to March and into the next fincial year, April and May. Allowing for a slight premium for bank costs, this would require £174,485 additional funding for direct ward nursing costs (£34,900 per month)
7. Average sickness rates included in 24-25 outturn was around 8%, which is 4% above funded baselines. Current overspends in some wards will not be eradicated due to substantiating establishments, though its expected it will aid reduction

We should note that B4 was opened as part of winter funding in order to ensure the Trust was able to meet the increase in demand. B4 has therefore been opened until the end of July 2025 with associated draw down of additional winter funding to act as a bridge until a decision is made as to whether to keep these beds open or otherwise by the end of July 2025, as a result funding has been allocated from the 2025/26 winter reserves to support this.

	Yes	No	N/A
Minimum information included?	☒	☐	☐

6.2. Management Arrangements

As per existing arrangements, the new ward will be set up with a new ward manager and clinical sister model and will sit under the responsibility of the Matron and Service Manager with reporting arrangements through to the General Manager and Head of Nursing for delivery.

6.3. Impact Assessments

For the preferred option the following impact assessments should be considered and completed where relevant and attached as an appendix. If not relevant, an explanation should be provided.

Impact Assessment	Applicable?	Comments
Equality	Yes	
Quality	Yes	This will positively impact on quality of care delivered to patients, full impact assessment will be completed on decision

7. HOW WILL THE PREFERRED OPTION BE IMPLEMENTED AND REVIEWED

7.1. Implementation Arrangements

Once agreement is reached with the bed reconfiguration, we will immediately look to commence moving ward areas to the ideal location, this will mean Respiratory moving to Ward B5, Ward B5 moving to Ward B4 and Ward A3 being established as a new HCOP ward which will then ensure HCOP wards are co-located and that Respiratory is in an optimised location in terms of its proximity to critical care and radiology.

Task / Milestone	Delivered By	Date
Brief teams on decision	CG1 SLT	July 2025
Ward moves to be implemented	CG1 SLT	End-August 2025
Nursing Recruitment to take place	Matron team	Immediately
Review of business case aims	CG1 SLT	Monthly through business and

		governance mechanisms
Formal review of business case aims	General Manager / Head of Nursing	February 2026

7.2. Risks

Outline the main risks with the proposed approach and how these will be mitigated.

Risk Detail	Impact / Effect	C	L	S	Mitigation	Owner
No reduction in overall bed days	No future de-escalation of ward capacity	4	3	12	Quality Improvement Patient Flow work	CG1 and Corporate
Failure to reduce Bank and Agency Spend by 10% on sickness as reason	Risk to financial break even plan	4	3	12	-Weekly NHSP meeting -Monthly roster review meetings	CG1
Failure of ability to reduce sickness absence	Impacts on all aims of business case and also creates issues monitoring sickness absence	4	3	12	-Close monitoring of Long Term Absence cases -Health and wellbeing work -"We said we did" plan -Less redeployments within Care Group	CG1
Risk of higher turnover rate	Reduced level of experience on ward areas and risk of increased bank and agency spend	4	3	12	As above	CG1

C=Consequence, L=Likelihood, S=Score

8. HOW WILL THE BENEFITS BE MEASURED AND DELIVERED

Aim	Benefit	Owner	Baseline	Target	Date
Ensure a reduction in bed days	Identifiable decrease in bed days	General Manager / Head of Nursing	Sustained reduction below 5.42	4.9 days (0.5 days reduction in mean LOS)	April 2026
Improve Patient Experience	Improved scores through CQC inpatient survey Improved Friends and Family response rate and positive score	General Manager / Head of Nursing		10% increase in response rate and improvement in scores on previous years	October 2025
Ensure a reduction in staff moves, sickness absence and turnover	Tangible reduction in both staff moves and reduced sickness absence Improved response rate and scores from staff survey	General Manager / Head of Nursing	7.8%	6.0%*	October 2025
Ensure a relative reduction in patient safety incidents, complaints, concerns and PALS enquiries	Tangible decrease in patient complaints and concerns from ward based areas Reduction in incidents resulting in harm to patients	General Manager/Head of Nursing		10% reduction	Monitored monthly through Governance processes
Reduce Bank and Agency Spend on Nursing Staffing	Tangible decrease in Bank and Agency spend utilised to cover sickness	General Manager/Head of Nursing	£1.196 million	50% reduction (approximately £598,000)*	Ongoing however will manifest in overall outturn position

Reduce patient ward moves for non-clinical reasons	Tangible decrease in the number of times patients are moved during their inpatient stay	General Manager/Head of Nursing		metric to be created	Ongoing measured on a monthly basis through governance

**these elements are linked and discussed further in section 3.2.5*

9. HOW WILL THE PREFERRED OPTION BE FUNDED

The costs for all options are detailed in Section 6, costs for Ward A3 are shown in Appendix 1.

9.1. Current State

All costs have been identified in the business case and are included in section 6 or Appendix 1.

9.1.1. Recent Budget Changes

There have been no recent budgetary changes, however through winter reserves the Care Group has drawn down £ 180,859 which is inclusive of direct nursing and HCA costs for Ward B4 for April and May, further funding has been ring fenced for June. For December to March additional funds from the winter reserves was capped to the amount approved in the winter plan, which was £186,175. The difference to actual costs was within the Care Groups run rate, estimated around an additional £314,000 excluding medical cover.

9.2. Funding Requirements

All costs have been identified in the business case and are repeated in section 6 with full ward costs in Appendix 1. In order to implement Option 3, we will require investment of £1,784,794 recurrently this will ensure the establishment of beds to take the overall bed base up to 317 beds from Sunday to Wednesday each week with the expectation that this capacity will de-escalate on Wednesday through to Saturday. It should be noted that this includes all ward costs including associated medical cover.

9.2.1. Summary Position

As has previously been articulated that this business case is requesting an increase in funding for increased capacity to support the level of non-elective demand. It is worth noting that if we attracted PbR (Payment by Results) income, the Care Group would have attracted £4.454 million in income. The total effect of the Non-elective demand through the entirety of the care group including AE and SDEC would have seen income rise further to £9.284 million overall.

It is also worth noting as has been highlighted in the business case, if we brought nursing and HCA sickness down in line with Trust target of 4.8% overall, we could have saved £1,196,000 based on calculations from this financial year, however in terms of the overall ask of the business case and outturn, this is a cost avoidance measure and does not bring down the overall ask of the business case.

Finance staff assuring Figures: Nicola Colley, Group Finance Manager

9.2.2. Revenue Costs

Revenue costs are detailed throughout the business case and detailed in Section 6 and Appendix 1.

9.2.3. Capital Costs

We are not expecting any associated capital costs, however any work will likely be limited to refreshing ward areas as opposed to significant capital costs including i.e. complete ward refurbishment schemes.

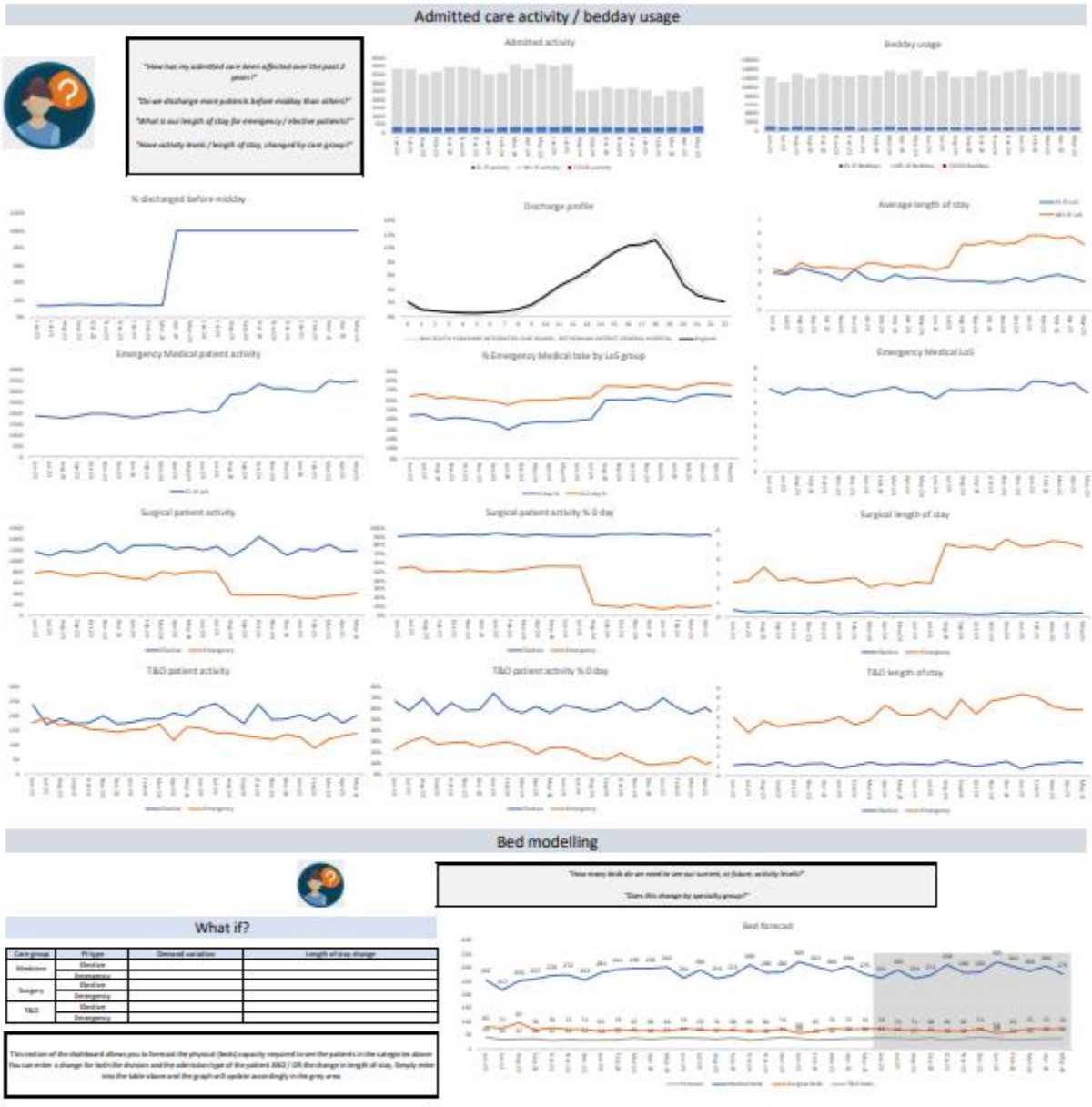
9.2.4. Key Financial Assumptions

These are detailed in Appendix 1.

Appendix 1: Ward Costs for A3 (New Ward in configuration in accordance with option 3)

	Total Costs		Contributions		Net Total		Comment
Direct Ward Costs	wte	£'s	wte	£'s	wte	£'s	
Band 7	1.00	62,707			1.00	62,707	
Band 6	5.26	315,316			5.26	315,316	3 wards to reduce by 3 short shifts and 3 LD
Band 5	13.12	644,874			13.12	644,874	(1.69 wte+ 2.6 wte each ward)
Band 3	10.52	409,112			10.52	409,112	
Band 2	7.86	295,411			7.86	295,411	
Ward Clerk	1.00	29,014			1.00	29,014	
Discharge Co-ordinator	1.00	29,014			1.00	0	£29,014 to be funded from Corporate budgets
Housekeeper	1.00	29,014			1.00	29,014	
Total Direct Costs of the ward	**40.76**	**1,814,463**	**0.00**	**0**	**40.76**	**1,785,449**	
Other costs							
Domestic Cover	1.69	55,567			1.69	55,567	
Consultant	1.00	147,000	-1.00	-147,000	0.00	0	Within HCOP Budget
Registrar	1.00	96,356			1.00	96,356	
Foundation Level 2	3.00	222,320	-2.00	-145,307	1.00	77,013	Within HCOP Budget
Foundation Level 1	1.00	56,857	-1.00	-56,857	0.00	0	Within HCOP Budget
Non Pay costs (transfer of overspend from other areas)		63,095			0.00	63,095	
Total Other Costs	**7.69**	**641,194**	**-4.00**	**-349,164**	**3.69**	**292,030**	
Total costs	**48.45**	**2,455,657**	**-4.00**	**-349,164**	**44.45**	**2,077,479**	

Appendix 2: SAPIT Data (Q3 2025)



Board of Directors Meeting
5 September 2025

Agenda item	P141/25
Report	**Green Plan 2025 - 2028**
Executive Lead	Scott Dickinson, Director of Estates and Facilities
Link with the BAF	This paper links to all BAF risks
How does this paper support Trust Values	The Green plan demonstrates the Trust commitment to achieving net zero targets. The plan details the Trust approach and actions towards reducing emissions, as outlined in the 2021/22 NHS Standard Contract and a requirement by NHS England. The contents of the report have bearing on all three Trust values.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Rotherham NHS Foundation Trust's Green Plan sets out how the Trust will address the Net Zero challenge for the NHS to reduce the environmental impact arising from carbon emissions with a view to achieving 80% net zero by 2032 and to be totally emissions free on site by 2040. Our Green Plan is in response to the global climate change emergency. If the matter is not addressed, the consequences of poorer air quality and environmental stress may significantly impact on the wellbeing of our population and result in an increase in diseases such as cardiac issues, respiratory disease and cancer, which may affect us all and our future generations. Our Green Plan intends to meet the current NHS commitments towards environmental sustainability, by: • Achieving at least an 80% reduction in emissions from on-site sources by 2032. • Achieving a further 2% reduction in general waste, based on 2025's levels. • Reducing patient service mileage by 25% based on 2020 by 2032, by delivering care closer to home and in the community settings. • Continue to work towards the cessation of all single use plastics • The Trust has seen over the last two years an increase in water consumption which is currently being investigated, as a result the 10% reduction in water usage has not been achieved. The Trust is committed to driving the Green Plan forward and is fully supported by the Executive Team. Wider organisation engagement will be through senior leaders and sustainability champions.

Due Diligence	The Green Plan has been submitted to June 2025 ETM and July 2025 Finance & Performance Committee as well as board members for comments or objections via email in July 2025. Comments received and incorporated into the document as requested.
Board powers to make this decision	For decision
Who, What and When	The Green Plan is required to be approved by Board and published on the Trust website in line with NHS England requirements.
Recommendations	It is recommended that the Green Plan is approved.
Appendices	

The Rotherham
NHS Foundation Trust



The Rotherham NHS Foundation Trust

Green Plan 2025 - 2028

Executive Summary

The Rotherham NHS Foundation Trust's Green Plan sets out how the Trust will address the Net Zero challenge for the NHS to reduce the environmental impact arising from carbon emissions with a view to achieving 80% net zero by 2032 and to be totally emissions free on site by 2040.

Our Green Plan is in response to the global climate change emergency. If the matter is not addressed, the consequences of poorer air quality and environmental stress may significantly impact on the wellbeing of our population and result in an increase in diseases such as cardiac issues, respiratory disease and cancer, which may affect us all and our future generations.

Our Estates Strategy 2022 – 2027 is wholly aligned to the Green Plan, ensuring that over the next few years we will continue to invest in further carbon reduction targets in the areas of Built Environment and Infrastructure; Estates and Facilities Management; Medicines Management; Supply Chain & Procurement; Food & Nutrition and Climate Change Adaptation. Our Estates strategy will be reviewed and refreshed in 2025.

Our Green Plan intends to meet the current NHS commitments towards environmental sustainability, by:

- Achieving at least an 80% reduction in emissions from on-site sources by 2032.
- Achieving a further 2% reduction in general waste, based on 2025's levels.
- Reducing patient service mileage by 25% based on 2020 by 2032, by delivering care closer to home and in the community settings.
- Continue to work towards the cessation of all single use plastics
- The Trust has seen over the last two years an increase in water consumption which is currently being investigated, as a result the 10% reduction in water usage has not been achieved.

We pledge to adhere to the NHS CO_2 reduction targets to eliminate our CO_2 footprint through this plan, as approved by our Board of Directors.

By working collaboratively with our peer organisations within the Integrated Care System in South Yorkshire and as an Anchor organisation within our community, we will uphold our corporate and social responsibilities. We will minimise our environmental impact and work to provide sustainable healthcare services, in contribution to the global effort to mitigate climate change impact.

The Trust is committed to driving the Green Plan forward and is fully supported by the Executive Team. Wider organisation engagement will be through senior leaders and sustainability champions.

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1.0 INTRODUCTION

1.1 THE ROTHERHAM NHS FOUNDATION TRUST

The Rotherham NHS Foundation Trust (TRFT) was established on 1 June 2005 pursuant to Section 6 of the Health and Social Care (Community Health and Social Care) Act 2003. We are regulated by NHS England and operate as a membership-based, public benefit corporation, with the Care Quality Commission (CQC) regulating the quality of the services we provide. Prior to achieving Foundation Trust status in 2005, the organisation operated as Rotherham General Hospital NHS Trust. In 2011, we integrated Rotherham Community Health Services, becoming a combined provider of both acute and community services across Rotherham, Doncaster and Barnsley.

Today, TRFT provides a full range of district hospital and community services to Rotherham and the surrounding area alongside partner organisations.

As at 31 March 2025, the Trust employed over 5,000 dedicated staff across its acute and community services, supporting a population of over 270,000 across South Yorkshire.

We deliver care across multiple sites, with the majority of our acute services based at the Moorgate Road site. Additional services are delivered from Breathing Space, Park Rehabilitation Centre, Rotherham Community Health Centre, Rotherham Intermediate Care Centre, and New Street Health Centre in Barnsley.

1.2 DEMOGRAPHIC & SOCIOECONOMIC DETAILS

Rotherham continues to experience higher-than-average levels of deprivation, with over 50,400 residents living in deprived areas. Health inequality remains a significant challenge, and improving equitable access to care for all our communities remains a core ambition. Our population is older than the national average, predominantly White British, with around 60,000 residents from minority ethnic groups.

Over the last decade the Rotherham population has increased by 4% to approximately 269,000 of which 51% are female. Three quarters of the population are of working age (between 16 and 67). The 2021 Census data shows that 91% of the population are white, 4% Pakistani, 1% African and remaining 4% are of other ethnic backgrounds. Over a third of the Rotherham population live within the 20% most deprived areas in England and around 22% of children live in low-income families. Over one in five of our households (23%) are workless compared to the England average of 13%. In addition, 32% of the Rotherham working age population have long term illness, 7% above the England average.

Overall, the health of our population is poorer than the England average. In Rotherham, the life expectancy at birth for women is 80.9 years and 77.8 years for men, compared to 83.0 and 79.1 years respectively in England. Life expectancy is

9.9 years lower for men and 9.5 years lower for women in the most deprived areas of Rotherham than in the least deprived areas, and the latest data shows this gap is widening. The average healthy life expectancy for a children born in Rotherham in 2023 is around 56 years, which is significantly lower by six years than that for England. This indicates that a child born today would be expected to live in good health without developing illnesses up to approximately 56 years of age: twelve years earlier than expected state retirement age. Working people in Rotherham live shorter lives and endure a greater proportion of their lives in ill health when compared to the national average

2.0 ORGANISATIONAL VISION

TRFT aims to build a healthier future for patients, their carers and families, staff, and for anyone else that TRFT cares for. TRFT is committed to implementing a vision that integrates hospital and community services and empowers clinicians and managers to deliver real benefits to patients and their carers. This is actioned by providing healthcare services where they are most convenient and best suit patients' needs.

Following the progress achieved during 2024/25, the Trust has set ambitious plans for 2025/26, with a continued focus on urgent care improvement and elective recovery.

Key priorities for 2025/26 include: •

- Deliver the national 78% 4-hour Emergency Access standard by embedding new front-door processes, further expanding ambulatory care pathways, and working with system partners to reduce hospital demand.
- Reducing the overall elective waiting list further to ensure no more than 1% of patients have been waiting longer than 52 weeks for treatment, with a strong emphasis on improving productivity across outpatient, diagnostic, and theatre services. • Achieving sustainable compliance with the 62-day Cancer Waiting Time Standard, targeting a consistent performance of 75% or higher
- Sustaining delivery of the Faster Diagnosis Standard through pathway redesign and further development of diagnostic pathways.
- Maintaining diagnostic excellence, ensuring the Trust remains in the top decile nationally for DM01 compliance.
- Enhancing community services by expanding Virtual Ward capacity to 80 patients, improving community response times, and continuing the integration of community urgent care services into the wider urgent and emergency care pathway.
- Embedding productivity gains across all clinical services, in line with the South Yorkshire Acute Federation's productivity metrics and GIRFT Further Faster guidance.
- System Collaboration, working closely with partners across Rotherham Place to deliver improvements in flow, prevent admissions, and support timely, safe discharges. Through these initiatives, the Trust aims to continue delivering tangible improvements for patients and communities, building a more resilient, efficient, and responsive health service for Rotherham

With respect to carbon reduction, TRFT is committed to playing its full part in achieving the NHS aims to reduce its own emissions to net zero by 2040.

2.1 SUSTAINABILITY IN HEALTHCARE

The NHS has been identified as a generator of 5% of all the UK total emissions. This is despite a successful campaign to reduce overall emissions by an impressive 18% over the past decade. However, along with the rest of the UK, greater effort than ever is being called upon to now reduce the NHS emissions to net zero by 2040[1].

2.1.1 Climate Change Act 2008

The Climate Change Act 2008 sets legally binding targets for the UK to cut greenhouse gas emissions by 80% by 2050 (based on a 1990 baseline). This is split into interim reductions of 34% by 2020 and 50% by 2025. Emissions include those from building energy use, travel, waste and the procurement of goods and services. This is the principal driving legislative act in place.

2.1.2 Net Zero

Since the Climate Change Act, the term "Net Zero" has come into common parlance. This essentially signifies that, on balance, no CO_2 emissions must be attributable to any activity. This is generally to be achieved by a reduction in energy use by improved technology and efficiency gains.

Net zero is reached when the amount we add is no more than the amount taken away.

Net zero means achieving a balance between the greenhouse gasses put into the atmosphere and those taken out.

Another factor is the restoration of the environment in areas such as forestry; peat bogs and oceanic protection, which increases CO_2 absorption capacity of the planet. Unfortunately, industrialisation and environmental degradation has already created enough emissions to the atmosphere that have set in train a global temperature rise.

It has been realised by the world's governments that a drastic cut in emissions, globally, is required to avoid the worst of catastrophic climate change, by limiting this temperature rise. To this end, in the Paris COP 25, a limit was set of 2°C increase in global temperatures by 2050. However, science has shown that this is an insufficient limit. Therefore, the recent COP 26 talks in Glasgow have endeavoured to reduce this to 1.5°C. This essentially requires CO_2 emissions to cease by 2050. COP 28 further recognised health as central to climate action.

[1] "Delivering a 'Net Zero' National Health Service"; NHS England & NHS Improvement; October 2020

Without action to limit temperature rises, the current severities of extreme weather events seen in the UK and elsewhere over the last ten years, will become more prevalent. We have seen in the last three years the heatwave of 2022 with temperatures exceeding 40 degrees and much more prevalence of floods. Extremes of cold and heat will be more likely, and this will inevitably impact on the health of citizens Action must be taken to prevent this from all elements of society. The NHS is no exception and may even be considered as a leading influence in societal behavioural change to reduce emissions and limit global temperature increase.

The NHS has issued its own target as part of its contribution to climate action. The "Delivery of a 'Net Zero' National Health Service", sets forward the requirements that the NHS be net zero by 2040. It is divided into two areas. The "NHS Carbon Footprint" concerns emissions over which the NHS has direct ownership (e.g. gas and electricity use; road transport). There is an ambition to have 80% of the reduction achieved over the period 2028 to 2032. The second area is known as "NHS Carbon Footprint Plus". This pertains to emissions over which the NHS has influence (for example: embedded emissions in suppliers' services and products). These must be at zero by 2045, with the ambition of 80% of the reduction to take place over 2036 – 39.

The emitters of carbon dioxide are wide and various, and the two above areas are summarised in Figure 1 below:

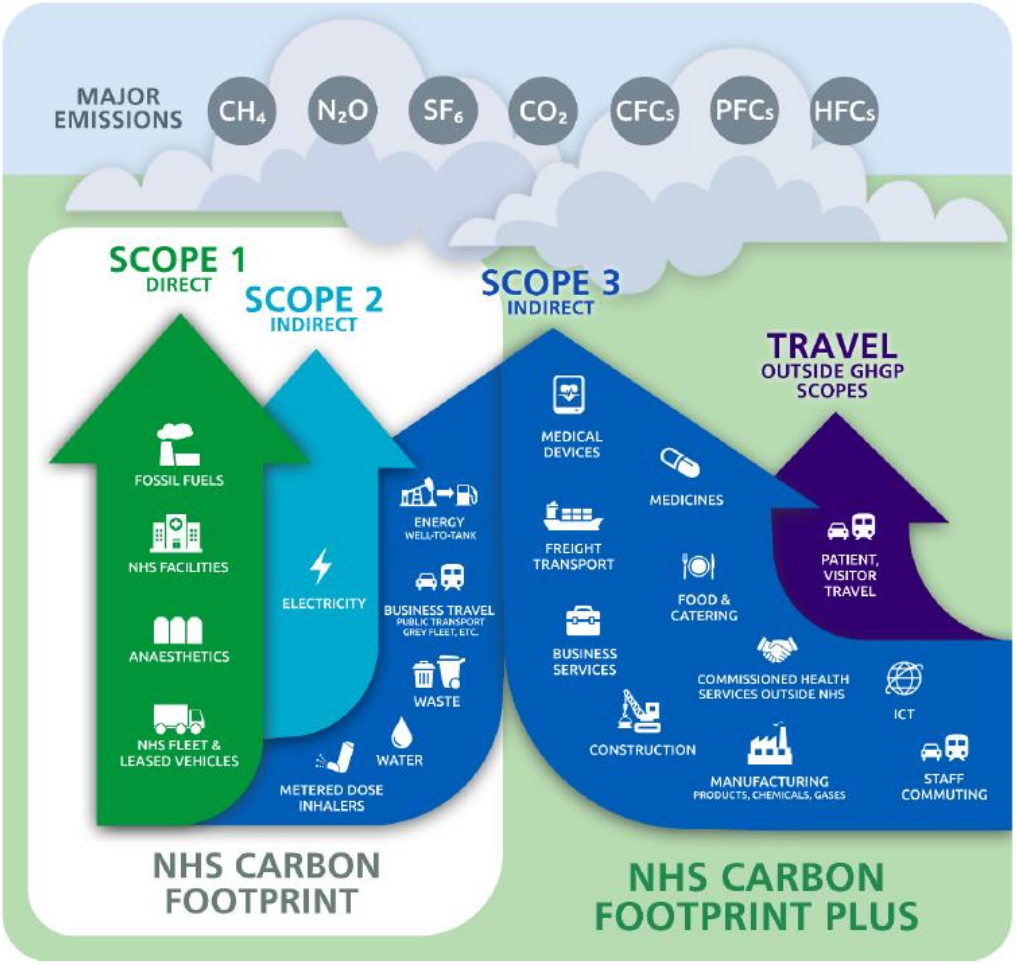


Figure 1 - NHS Carbon Footprint Sources

To explain the various "Scopes":

- Scope 1 – Emissions arising from direct combustion (natural gas; hospital owned vehicle use); fugitive emissions from refrigerants
- Scope 2 – Grid Electricity
- Scope 3 – Indirect emissions such as those arising from water supply and treatment; general and specialist waste treatment, transportation and procurement of goods and medicines

3.0 PREVIOUS GREEN PLAN PRIORITIES

The trust's Sustainable Development Management Plan (SDMP) detailed TRFT's 2016-2021 five-year plan to address climate and sustainable matters over which it had control. These priorities formed the basis for the Green plan 2022 – 2025.

It's strategy to combat sustainability issues was to adhere to the following high-level action plan which continues to be implemented and improved on:

Area	Priority	High Level Actions
Energy & Water	1	The Trust is currently working towards a De-Carbonisation Plan which will enable funding opportunities going forward from areas such as PSDS.
	2	Continue to promote energy and water efficient behavior amongst employees, patients and visitors
	Progress	Battery energy storage; LED lighting; Boiler improvements; new CHP (tri-generation); general insulation; BMS improvements; Chilled water control improvements. 100% electricity purchased from the grid is renewably sourced and will continue to be so. Since 2022 Heat pumps have now been installed. There has been an increase of Thermal insulation throughout the Trust, together with glazing improvements. BMS controls have also been implemented throughout the site.
Procurement	3	Produce a Sustainable Procurement Policy
	4	Adopt the Procuring for Carbon Reduction (P4CR) programme Travel Further work is required to enable a consistent identification of sustainability risks throughout the procurement process. A Rotherham Special Social framework will be implemented in Spring/Summer 2025 for the measurement and monitoring of supplier's sustainability initiatives.
	Progress	A sustainable procurement policy has been developed, providing guidance on the implementation of sustainable procurement principles, and providing a framework for supplier engagement and measurement. The procuring for Carbon reduction (P4CR) programme has been adopted.

Area	Priority	High Level Actions
Travel	5	Work with external organisations to raise awareness of the health benefits from utilising active travel modes
	6	Promote sustainable travel behavior amongst staff, patients and visitors.
	Progress	Implementation of Cycle to Work and ULEV purchase schemes via salary sacrifice methods; Dr Bike monthly visits and loan bikes provision; reduced rate bus season tickets; Car share scheme; Launch of sustainable travel group
Waste	7	Ensure high and compliant standards for waste management from the point of generation to the point of disposal
	8	Promote effective waste segregation and waste management behaviors amongst employees, patients and visitors Continue to work in line with NHS England guidance to achieve 60:20:20 split of Offensive, Alternative Treatment and Incineration Waste tonnages.
	Progress	98% of all waste is recycled or recovered
Food	9	Encourage healthy eating amongst employees, patients & visitors Work towards plant based catering. Currently 40% of meals/menus are vegan.
	10	Improve processes for the issuing and transfer of medicines
Pharmaceuticals	11	Maximise the use of Patient Own Drugs (PODs) Building healthy, sustainable and resilient services and communities Nitrous oxide still present in a number of areas via manifold and pipeline, aim to decommission nitrous manifold by 2026
	Progress	The use of Desflurane anesthetics within theatres has ceased.
Designing the Built Environment	12	Ensure that buildings are designed to encourage sustainability and resilience to climate change
	13	Ensure that sustainability design and construction considerations are explicit in Contractor Briefing Documents Workforce development and community engagement Reduction in the use of the lifts – emphasis on use of lifts for patient transfer or visitors/patients with difficulties with walking.

Area	Priority	High Level Actions
	14	Ensure sustainability responsibilities are included within all job descriptions, and embed sustainability delivery into Executive and Senior Managers appraisals
Workforce development and community engagement	15	Review of existing MAST training Provision to ensure supports delivery of the Green Plan. There has been increased education with regards to recycling of waste, reduction of waste. Look to grow a network of Green champions.
	16	Work in partnership with public health professionals to support employees in improving health and wellbeing Climate change adaptation
	17	Produce a Climate Change Adaptation Plan – specific plans for 'heat dome', significant flooding & storms.
Climate change adaption	18	Work in partnership with local organisations to build resilience and adaption to climate change Embedding sustainable clinical and care models Sustainable clinical and care models
	19	Investigate mechanisms to facilitate a movement towards more sustainable models of care. The Trust has a number of ongoing projects:- • Currently reviewing the reduction of pressure ulcers per 1000 bed days which will reduce the number of dressings required, reducing carbon footprint due to reduced procurement journeys. The Trust is looking to work with local partnership with the continuation and updating of reuse walking aid scheme.
Sustainable clinical and care models	20	Assess the sustainability impacts of new service models • Recently new cleaning procedures introduced for commodes, will improve sustainability, ensuring the commodes due to this change have a longer life and require less replacement.

Table 1 – 2025 – 2028 – Actions and Targets for each area

The impact of actions in Table 1 is described in Figure 2 to Figure 4 - Rotherham Foundation Trust – Waste

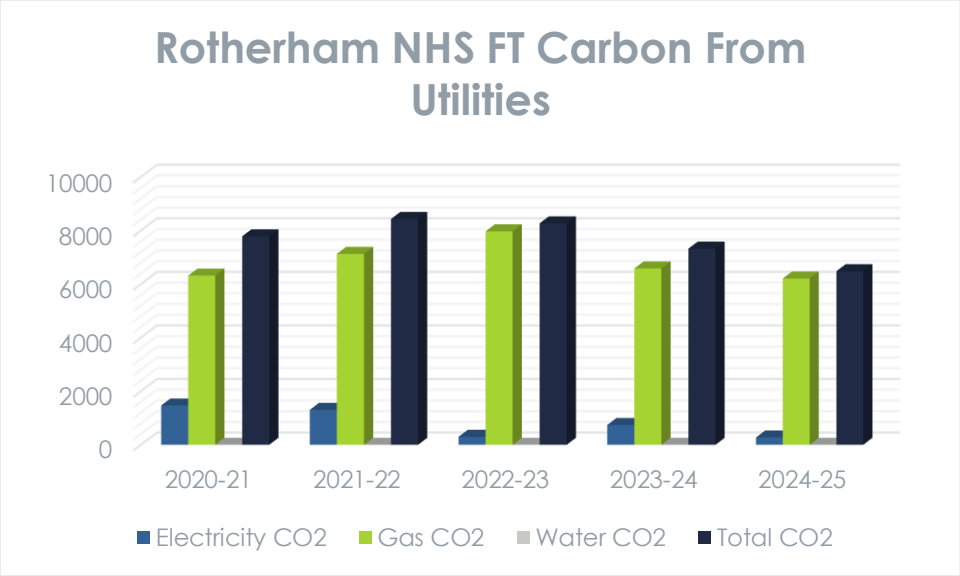


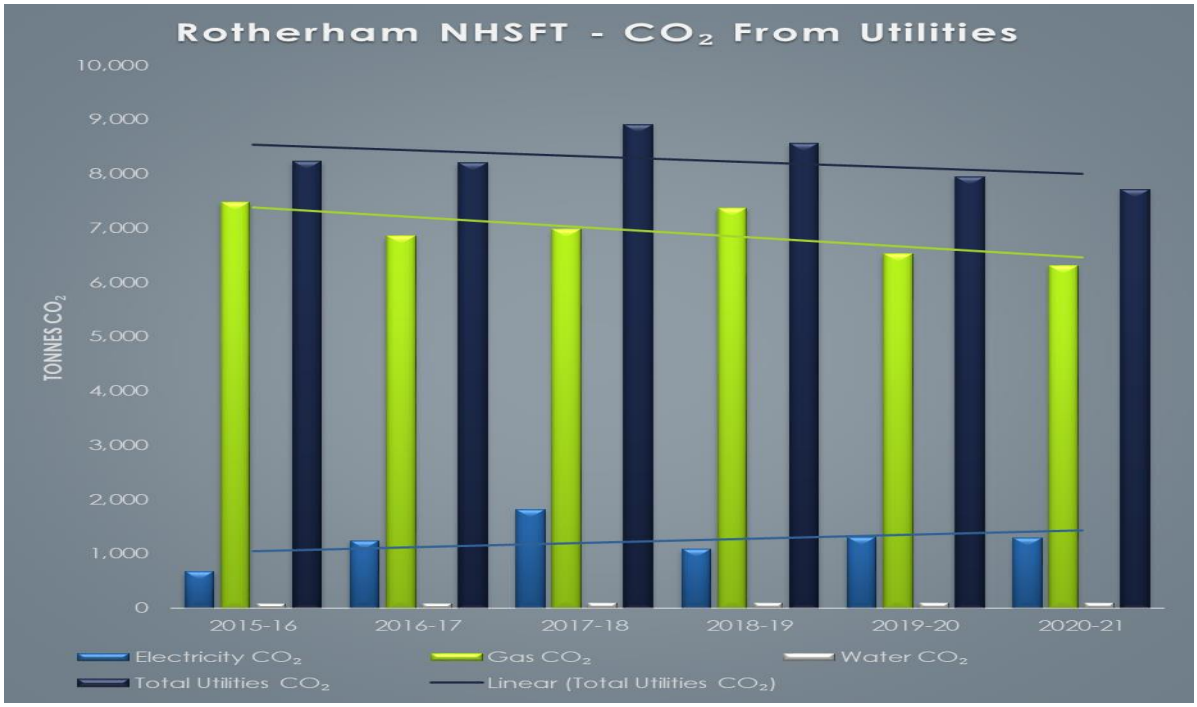
Figure 2 - Rotherham Foundation Trust - Emissions from Utilities

This bar chart illustrates the carbon emissions from utilities at Rotherham NHS Foundation Trust over a five-year period, from 2020-21 to 2024-25.

Here's a summary of the key trends:

- **Total CO^2 Emissions:** The yellow bars, representing total CO^2 emissions, show a generally increasing trend from 2020-21 to 2022-23, peaking at just under 9000 tonnes CO^2. There's a noticeable decrease in total emissions in the subsequent years, 2023-24 and 2024-25.
- **Gas CO^2 Emissions:** The orange bars, indicating CO^2 emissions from gas consumption, are the largest contributor to the total emissions throughout the period. They follow a similar trend to the total emissions, increasing initially and then decreasing.
- **Electricity CO^2 Emissions:** The blue bars represent CO^2 emissions from electricity usage. These are significantly lower than gas emissions and show a relatively stable trend with some minor fluctuations across the years.

In essence, the chart highlights that gas consumption is the primary source of carbon emissions for Rotherham NHS FT utilities. While total emissions increased initially, there appears to be a positive trend of decreasing overall carbon emissions in the later part of the observed period.



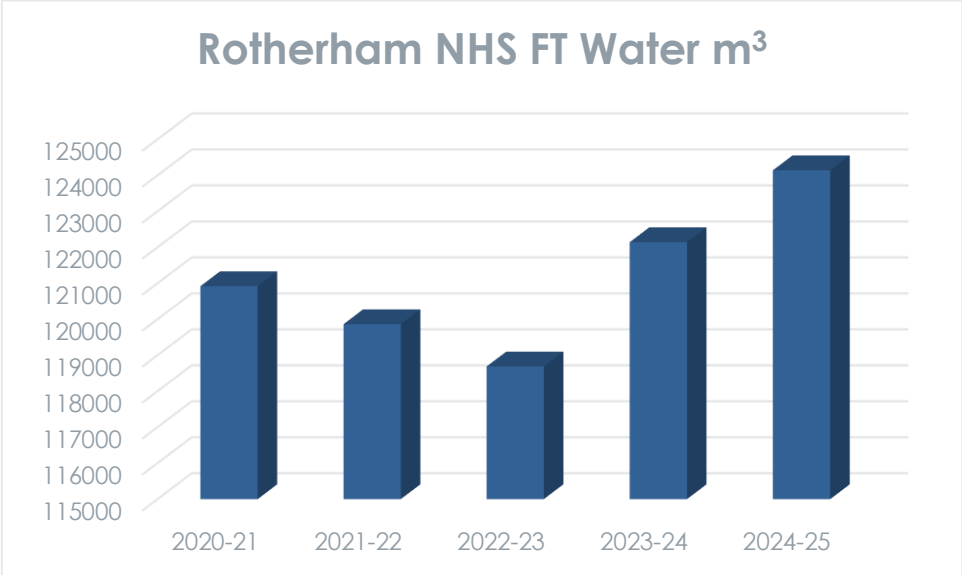


Figure 3 - Rotherham Foundation Trust Water & Treatment

The bar chart shows the water consumption in cubic metres (m^3) at Rotherham NHS Foundation Trust over a five-year period, from 2020-21 to 2024-25.

Water usage started at approximately 121,500 m^3 in 2020-21 and decreased to around 120,500 m^3 in 2021-22. There was a further slight decrease in 2022-23 to just under 120,000 m^3. However, water consumption then increased significantly in the following years, reaching approximately 122,500 m^3 in 2023-24 and peaking at around 124,500 m^3 in 2024-25.

Overall, the water consumption at Rotherham NHS FT shows a fluctuating trend over the five-year period. Following a slight decrease in the initial years, there has been a notable increase in water usage in the most recent two years, reaching the highest

level in 2024-25. This increase in water consumption in the later years might warrant further investigation to understand the underlying reasons and explore potential water efficiency measures

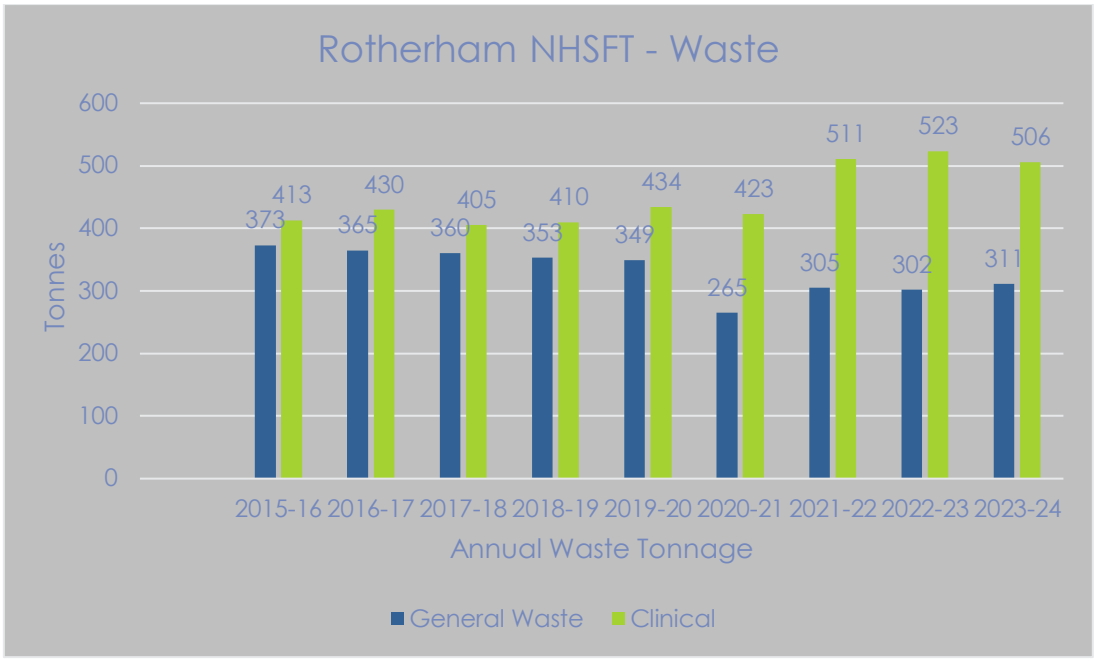


Figure 4 - Rotherham Foundation Trust – Waste

With respect to waste, clinical waste saw a rapid increase during the Covid 19 pandemic and is currently reducing. Work will continue as set by the Trusts KPI's to further reduce this waste stream, with increased segregation and recycling. However, general waste saw an increase in 2021-22, although it is now 38 tonnes less than pre-covid tonnages, and continues to reduce with improved recycling within the Trust. Within the clinical tonnage information the Offensive waste stream forms part of this and since the reduction in cases from the pandemic this waste stream continues to increase and the orange bag waste to reduce. The Trust will continue to work towards a further reduction of 4% reduction on 2021/22 tonnages.

4.0 THE GREEN PLAN

The TRFT Green Plan will inform our vision for environmental sustainability and objectives to become a Net Zero healthcare provider, through the following staged objectives:

- Stage 1 – Carbon Footprint – review and validate the carbon footprint of TRFT's emissions (covering Scope 1 and 2 and selected Scope 3 emissions).

  Stage 2 – Action Identification – identification and assessment of opportunities for reducing emissions from energy and staff travel.

- Stage 3 – Decarbonisation Action Plan – develop a Decarbonisation Action Plan. This will bring together the analysis from Stage 1 and Stage 2 to provide a roadmap of decarbonisation activities, including detail on specific energy and carbon saving interventions and impact.

4.1 WORKFORCE AND SYSTEM LEADERSHIP

TRFT's workforce are central to enabling us to deliver the Green Plan. The decisions that our workforce makes in energy use are key to this. Therefore, we will ensure that our staff teams are provided with the knowledge and tools to make the right environmental decisions. This will focus on the best use of powered equipment such as lighting; IT; heating and cooling controls. We will also maximise the best use of energy in our support services such as food provision in canteens and patient meals.

In order to do this, a board endorsed policy will drive this with target setting and appropriate monitoring. Our leadership will actively promote the Green Plan by direction and example.

4.2 ESTATES & FACILITIES

4.2.1 Energy & Water

The Estates and Facilities team has ultimate responsibility for the procurement and use of energy and utilities across all sites occupied by TRFT, including the main hospital and all community-based sites and services. As such, we will ensure that energy and utilities are consumed in as efficient a manner as possible. A programme of savings proposals has been completed as part of an Energy Performance Contract. These are summarised in the progress details in Table 1.

We will continue to explore other opportunities for saving energy and reducing waste and carbon emissions and we will endeavour to ensure that maintenance operations are equally focused on continued reliable functionality.

We will ensure that the carbon embodied in the procurement of goods, services, equipment and facilities, adopts best practice in the most efficient use of energy and carbon and in minimising carbon emissions and waste. Examples would be to ensure that insulation is replaced after work is completed and a low carbon alternative is considered and installed where feasible (for example; LED lighting; high efficiency motors).

We will also continue to examine other areas where energy use can be minimised utilising capital or revenue funded projects, which derive a financial return on investment focusing, reduce backlog maintenance and yield carbon emission reductions on, for example:

- Heat recovery (from AHUs; chiller condensers; economisers)
- Decarbonised heat (heat pump technology; hydrogen ready combustion appliances - subject to bid under PSDV for funding and other applicable carbon reduction schemes)
- Photovoltaics
- Draft proofing
- Double glazing
- Local mechanical ventilation heat recovery
- Underfloor heating
- Ensure optimal heat utilisation

Encourage biodiversity around the site, this could include the development of hedgerows as borders, wild flower areas and transition of grassed areas to alternatives such as clover that do not need management, therefore reducing the amount of green waste produced in grass clippings and fuel needed to mow.

4.2.2 Transport

We have an active programme to address transportation issues including a reduced rate public transport season ticket and bike to work scheme. We will build on this work with recently commissioned secure bicycle storage enabling our cycling commuters to confidently store their bikes. In 2022, we have built additional staff shower/changing facilities for cyclists as added inducement to leave the car at home, in favour of environmentally sustainable modes of transport, such as cycling, running and walking.

A new park and ride scheme is planned in conjunction with local supermarkets so that motorist commuters can park part way along their journey and then continue on foot or by bike to the hospital.

We will also continue the shift to electric vehicles, with a plan for a network of charging points over the coming years, increasing our electric vehicle charging capacity to at least 10% of all car parking spaces.

The estates team have just ordered their first electric van to replace the existing diesel vehicle.

In implementing our plans with regard to transport, we will ensure that we take into account the accessibility needs of disabled staff, patients and visitors.

The Rotherham NHS Foundation Trust has developed a travel plan which was published in 2023 and is valid for 5 years.

We actively encourage active travel, public transport and zero-emission vehicles via the salary sacrifice scheme.

The Rotherham NHS Foundation Trust has reduced the emissions levels of vehicles available via salary sacrifice over recent years. Due to the current high price of zero-emissions vehicles TRFT has stopped short of removing non-zero emissions vehicles completely as this will impact on the lower banded staff, who would be prevented from accessing the scheme. Currently almost 60% of salary sacrifice vehicles are now EV

TRFT actively participates in the partnerships with local authorities and local transport authorities to maximise funding and infrastructure opportunities on behalf of the ICS member organisations.

Dr Bike attends the Trust site monthly, providing availability for servicing and repairing bikes on site.

4.2.3 Waste and Recycling

At present, 98% of all waste generated by the hospital is recycled or recovered, this is a 3.3% increase on the previous Green plan update. 25.7% of this amount is fully recycled. 40% of waste is sent for energy recovery (conversion of non-recyclables into combustible material in place of fossil fuels); 26% goes to energy from waste power plants as a direct fuel.

The Rotherham NHS Foundation Trust continues to work in line with NHS England's guidance to improve segregation and classification in line with the HTM 07-01 Safe & Sustainable Management of Healthcare waste. It continues to fulfil the requirement of a 60:20:20 split of Offensive (60%) Alternative Treatment (20%) and Incineration (20%) and currently in line with this regulation has a split of 61.77% Offensive, 33.75% Alternative Treatment, and 4.48% High Temperature Incineration. The Alternative Treatment rate is higher due to the waste disposal contractor for the sharps waste developing an innovative new technology which allows the sharps to be shredded and treated moving them up the waste hierarchy and removing them from the high temperature incineration disposal, and reducing emissions.

We will build on this progress and continue to work towards yet further improvements. We are currently on target to reduce our waste tonnages by 5% as set in our previous Green plan. The final tonnages are not available at the time of compilation of the plan. Currently on 2022 tonnages the Trust has reduced its overall waste by 4% and is looking to have achieved the 5% when the end of year tonnages are available for 2024 -2025. The Trust will continue to increase recycling rates and will look to further reduce general waste by 2%.

In 2024 a further 'Bin the Bin' Initiative was carried out removing over 200 bins from offices throughout the Trusts. This has resulted in a reduction of general waste and a 50% increase in recycling since its introduction.

In line with Simpler Recycling regulations, the Trust currently segregates and recycles, plastic, cans, glass, paper, and cardboard and food waste. The recycling of food waste will continue in 2025 with the introduction of food caddies in all staff kitchens and rest rooms, which will lead to a reduction in general waste and full compliance with the new Simpler Recycling regulations to be introduced in April 2025.

We will investigate the possibility of introducing an empty blister pack recycling scheme within the Trust, to increase recycling and reduce waste.

4.3 MEDICINES

TRFT will work to reduce the carbon footprint associated with medicines and anaesthetics.

4.3.1 Anaesthetics

The anaesthetic gas desflurane, which has 20 x more Global Warming Potential than CO_2 is no longer in use within the Trust. We have worked to eliminate the use of this in favour of the lower GWP gas, sevoflurane.

Nitrous oxide is a gas that has a GWP of 265 and stays within the atmosphere for around 120 years. The trust currently has a 6 x 6 manifold of nitrous oxide, which is piped to every anaesthetic room and theatre as well as other areas of the hospital. Nitrous oxide is very rarely used now within anaesthesia and over the next 4 years will aim to decommission the manifold and provide cylinders where it is needed.

Entonox is a gas composed of 50% nitrous oxide and 50% oxygen that is used for analgesia predominantly in labour ward but also in other areas. We will explore ways to capture and scavenge the gas to prevent it being released into the atmosphere over the next 4 years.

4.3.2 Medicines Use; Procurement and Wastage

A study for the Department of Health revealed prescription drug wastage costs NHS England at least £300 million a year - and that £250 million is avoidable. In 2015/16, 9.5% of TRFT's carbon emissions were attributable to the procurement of pharmaceuticals.

TRFT is committed to tackling avoidable medicines wastage and taking necessary best practice pathways towards minimising medicine waste.

We will utilise the Procuring for Carbon Reduction (P4CR) Flexible Framework to facilitate the procurement of pharmaceuticals in a more innovative, sustainable manner.

TRFT have a number of projects ongoing with regards to the reduction of medicine waste. Monitoring of volumes of waste is carried out six monthly.

TRFT are working together with hospitals in the local area with a specific project for the recycling of inhalers. The inhalers once received by the contractor are broken down and recycled rather than sent for disposal. Although not in large quantities this will reduce and improve pharmaceutical waste tonnages and recycle rather than dispose these items.

Encourage the use of oral/enteral switches where possible – only using the IV route for medications where absolutely necessary.

In summary, TRFT will:

- Improve processes for the issuing and transfer of medicines, when patients are moved from one clinical area to another within the hospital.

- Where appropriate, maximise the use of Patient Own Drugs (PODs) that are brought into the hospital.
- Reduce pharmaceutical waste through improved prescribing, re-use of medicines, compliance and stock management.
- Explore what can be done to encourage patients to bring their own medicines into hospital for use during their stay, including an awareness campaign with the Yorkshire Ambulance Service.

This will be measured and monitored by:

- Bi - Annual progress of the pharmaceuticals section of the Green Plan will be reviewed by Pharmacy Governance and Medicines Operations Group (MOG).
- Reduction in medicine wastage and regular reporting of waste medicine tonnages will be made to Pharmacy Governance. This will be incorporated in a six monthly workplan.

4.4 SUPPLY CHAIN AND PROCUREMENT

It is likely that Procurement/Supply Chain emissions represent more than 60% of the Trust's overall emissions and this can be addressed by Sustainable Procurement of goods and services initiatives.

Sustainable Procurement is defined as a process whereby organisations meet their needs for goods, services, works and utilities in a way that achieves value for money on a whole life basis in terms of generating benefits not only to the organisation, but also to society and the economy, whilst minimising negative impact on the environment.

We will carry out a carbon foot-printing exercise to provide an emissions assessment for TRFT to have a greater insight of the opportunities for us to reach net zero. Our Procurement team will identify and engage key suppliers, aiming to improve reporting, encourage information sharing and support alignment to NHS and TRFT carbon and emissions reduction targets.

Suppliers will be required to meet key criteria such as estimated emissions contributions, TRFT's ability to influence supplier's sustainability credentials, their existing approach to decarbonisation; e.g. low emission company vehicles, product packaging, etc., and their willingness to engage with TRFT.

We will utilise the Procuring for Carbon Reduction (P4CR) Flexible Framework to facilitate the procurement of goods and services in a more innovative, sustainable manner:

- Purchase more goods from sustainable sources, with a focus on those from local, ethical and fair-trade suppliers.

- Work with suppliers to encourage them to hold an Environmental Management Standard (e.g. ISO 14001) and to disclose their carbon emissions.
- P4CR Practice (Level 3) by 2025. This has been achieved by the procurement team being provided with training and guidance on how to implement sustainable procurement principles in to contracts. This is particularly the case for implementation of social values in to tenders. A sustainable policy has been developed, providing guidance on the implementation of sustainable procurement principles, and providing a framework for supplier engagement and measurement. Work has been undertaken in collaboration with Rotherham Metropolitan Borough Council set out for a framework for the sustainability initiatives which are most relevant to the area and how to implement initiatives effectively.

  Procurement process – targets to improve sustainability outcomes are now agreed with all suppliers with an annual spend value higher than £110,000 and are held to account on these commitments.

  Supply chain mapping has been undertaken for certain areas of key spend, and TRFT procurement attended supplier engagement events to support and inform suppliers on the mounting sustainability requirements for NHS Suppliers.

  A Rotherham –specific social value framework will be implemented in Spring/Summer 2025 for the measurement and monitoring of supplier's sustainability initiatives. The framework focuses on initiatives which will generate the most significant value for Rotherham, and should allow for greater visibility of sustainability benefits the Trust is generating through its procurements.

Our ongoing objectives and targets for 2025- 2028

- Apply social value and Net Zero right from the specification stage and include it within contract management with KPI's. Social value and net zero is now included from the specification stage for all above-threshold value contracts, and a review of best practice for contract managing these components is ongoing. Procurement representatives from the Trust have met with Local authorities for discussions on an anchor-network wide approach to social value, targeting themes which are most relevant to Rotherham.
- Training for all finance and procurement teams in the application and development of meaningful social value criteria, as per PPN 06/20. The procurement team have utilised social value and sustainability resources and workshops provided by NHS England and other groups such as NOEPC, together with internal social value and sustainability leadership and advice.

- Adoption of Evergreen Supplier Framework as a mechanism to benchmark suppliers and a shift to those that actively support the NHS sustainability principles. A move to the use of the Atamis e-commerce portal which has suppliers with Evergreen credentials linked to their account profile, allowing for visibility of potential sustainability opportunities and challenges from the commencement of the procurement process.
- Apply carbon reduction plan or Net Zero commitment, as a requirement for suppliers to provide as part of a tender exercise, as set out in the April 2024 milestone of supply chain roadmap. All contracts above £5 million in value now require the supplier to commit to being net-zero in line with NHS roadmap objectives. It has also become common place for suppliers to make some form of net-zero commitment even for below-threshold contracts.
- Product interventions- at least 1 circular economy project to be considered for implementation per year. Examples Reusable PPE, Reusable Tourniquet, gloves off, EP catheters. Procurement have played a role in providing statistics for the ongoing "Gloves off" campaign, with ongoing work to move to modular O2/Nebularlser masks which is anticipated to generate significant plastic waste savings.

4.5 FOOD & NUTRITION

The NHS is one of the largest purchasers and providers of food in the UK. Working in partnership with our supply chain and service partnerships, TRFT will continue to promote and expand the procurement and delivery of sustainable foods and nutrition.

The annual Green Plan will detail the actions to ensure that TRFT procures sustainable, health and low carbon food and promotes healthy food choices. Working in partnership with our supply chain and service partnerships, TRFT will:

- Encourage healthy eating amongst staff, patients and visitors
- Continue to work in partnership with ReFood and reduce food waste across the food supply chain through improvements to food storage, preparation, ordering and meal service procedures.
- Support and enhance education in food, nutrition and sustainable food production through our Staff Wellbeing scheme.
- Continue to work closely with clinicians and dieticians in order to adopt well-balanced and appropriately portioned menus for both patients and staff.
- Continue to deliver a staff behavioural change programme to catering staff to encourage resource efficient behaviours.
- Food waste data will continue to be regularly monitored and reported.

Annual progress of the food & nutrition section of the Green Plan will be reviewed against achieving the TRFT's vision and priorities.

Identify local suppliers for pastry products, milk and potatoes. Reducing food miles by combining deliveries.

Steamplicity solution reduces energy usage by 30% and significantly reduces carbon footprint either by reducing food miles or replacing ingredients with ones that have a lower carbon impact.

- Our current food service provider sets the following targets within the Trust:-

Our Wellbeing Promise encompasses many initiatives and approaches designed to improve health and wellbeing, with our ethos being "happier & healthier lives, one dish at a time". Our goal is to build a culture that encourages healthy eating and supports mental wellbeing for the people we feed. So far, we've significantly reduced sugar, salt, and fat across 36,000 recipes. Now we're working to embed this culture and use this approach as the default position on the current contract within TRFT,

Our health and wellbeing strategy is based upon three key pillars: Healthier Food, Healthier Lives, and Healthier Futures. We are helping to educate people about a healthy diet and lifestyle, including the importance of sleep and exercise that supports positive mental health. We have introduced exciting menu changes and brands, and information about healthier options with 40% of our main course dishes being vegan as standard. We don't promote any high fat, sugar, salt products nor include them on any kind of price promotions. We only highlight products that are healthier. Our meal

deal only features products are healthier, ensuring no HFSS products form part of any offer. We've made a conscious effort to only include healthier items as upsell by our till points, such as fruit and water and healthier snacks. Our menu is based on a healthy balanced diet, promoting choice whilst encouraging the healthier options.

Sophisticated software is used to manage full recipe portfolio, enabling us to provide customers with a full ingredient footprint and allergen information. This includes the mandatory display of calorie information on shelf edge labelling making it easier for customers to make informed, healthier choices when purchasing. This works alongside our system where we include symbols on labels and menus to ensure that healthier options are made more prominent.

In The Wellspring Restaurant, we will commit to displaying kcal and kJ information alongside the following statement "adults need around 2000 kcal a day" at the point of choice for the customer. The "On Your Plate" Wellspring Restaurant magazine available on site highlights the products on our menu that are healthier or have some form of health benefit, as well as explaining the labelling and symbols we use to make healthier options stand out. The magazine highlights topics related to health and wellbeing, educating its audience on supporting their own health.

Our Food Safety Management System (FSMS) will be used across all sites and covers all food legislation and best practice.

Experienced in-house Registered Dietitians analyse all recipes, use nutritional analysis software system Saffron, the UK's leading Nutritional Analysis solution, drawing on data from the McCance & Widdowson's database (Public Health England's nutrition information data set) to provide assurance that all menu dishes comply with Food Standards and Allergen safeguards, with Reference Intake nutrition labelling supporting customers to make informed choices. We are fully compliant with CQUIN 2017-19 Indicator 1b, Health food for NHS staff, visitors and patients.

We will look to introduce Cauli deposit return schemes on hot beverage cups and food containers, along with pre-ordering solutions to reduce food waste.

Packaging switches includes the switch to CPET food trays containing 70% recycled content in our Steamplicity patient dining food trays which are recyclable at end-of-life.

4.6 CLIMATE CHANGE ADAPTION

Extreme weather can represent a threat to the effective delivery of health and care services. In addition, a rapid increase in service users during extreme weather events can increase pressure on staff dealing with elevated workloads and potential staff shortages.

TRFT recognises that it must become resilient to the effects of climate change and adopt adaptation measures to prepare for, and reduce, the impacts of a changing climate on healthcare services. Climate change adaptation is the understanding and implementation of resilience measures to enable TRFT to prepare for the effects of climate change.

Our Emergency Preparedness, Resilience and Response Group will work to improve the resilience of services and the built environment, ensuring they are fit to meet Net Zero objectives by ensuring:

- Services and infrastructures are prepared and resilient to severe weather events and other disruptions.
- We work together with other public services and local organisations within a framework for sustainable development.
- Current and future risks to health and wellbeing from a changing climate are understood and minimised.

TRFT needs to understand the health and wellbeing implications of current and projected changes in climate and adapt services accordingly. An important component of this is ensuring TRFT's infrastructure (including buildings, vehicles and the supply chain for fuel, food and key products) is prepared for, and resilient to, severe weather events and other disruptions.

Additionally, as many health and care services are increasingly being delivered in people's own homes, there is a growing need to ensure that domestic settings, as well as healthcare settings, are adapted, resilient and accessible.

TRFT's Business Continuity and Critical Incident Plan and Local Service Business Continuity Plans describe the operational command, control, coordination and communication structures required to manage the effects of a significant disruption to services. This includes flooding and severe weather conditions (e.g. excessive rain, snow, wind, ice, extreme cold or heat). As a Category One responder under the Civil Contingencies Act 2004, TRFT is a member of the South Yorkshire Local Health Resilience Partnership, with direct links to the South Yorkshire Local Resilience Forum.

The annual Green Plan will detail the actions to ensure the resilience of TRFT's services and buildings. In summary, TRFT will:

- Employ the UK Climate Change Risk Assessment tools and guidance to assess local risks to patients and staff, infrastructure, supply chain and clinical services, and inform Emergency Planning & Business Continuity procedures.
- Conduct regular climate change impact risk assessments to ensure that high level risks are registered on TRFT's Risk Register.
- Produce a Climate Change Adaptation Plan to ensure continuation of care for the most vulnerable patients during heat waves, floods and other extreme weather events.
- Design all new buildings, and ensure all existing infrastructure, has ability to cope with rising temperatures and floods.
- Assess the risk that disruptive climate changes pose to the supply chain and develop appropriate management strategies to ensure continuity of services.

- Identify risks of disruption to transport operations and put in place contingency plans to cope with extreme or unexpected events.

We will monitor progress by:

- Reporting annual progress of the climate change adaptation section of the Green Plan, reviewed against achieving the Trust's vision and priorities.
- Development of a Climate Change Adaptation Plan.

4.7 SUSTAINABLE MODELS OF CARE

Provision of care brings with it its own environmental issues. To address this, we will examine routes to reduce environmental impact by our delivery of care. We will examine the opportunities for delivering care closer to the patient's home and in the community setting and thus avoid longer journeys to and from the main hospital and treatment centres. We will explore the low carbon alternatives to existing interventions and avoid unnecessary changes to care delivery. Virtual ward and virtual clinic appointments. Introduce a pre-operative hub where multiple things can happen in one visit to prevent patients having to go back and forth to the hospital.

4.8 DIGITAL TRANSFORMATION

The Rotherham NHS Foundation Trust continues to make significant progress in embedding sustainability within its digital strategy as part of our Green Plan commitments. For 2025 the focus remains on reducing carbon emissions, increasing operational efficiency, and leveraging digital transformation to improve patient care. Key achievements and ongoing initiatives include:

Small Form Factor PC's – we continue to move towards the transition to small form factor desktop devices across the estate. These compact, energy-efficient PC's not only consume less power but also reduce material use in manufacturing and packaging, supporting circular economy goals. All desktop PCs purchased within 24/25 financial year (approx. 700) were small form factor PCs.

Low- Power Network & Telecoms Infrastructure – TRFT has fully implemented within 2025 a low-energy network and telecoms architecture, replacing legacy systems with modern equivalents designed for high efficiency. This includes intelligent switching and routing systems with power optimisation features, helping to reduce our digital carbon footprint.

End- User Device (EUD) Recycling – We have strengthened our EUD recycling and reuse process, ensuring that all redundant IT equipment is either refurbished for reuse, securely wiped and donated where appropriate, or responsibly recycled via accredited partners. This supports both sustainability and digital inclusion goals.

Ongoing Digital Transformation – Our shift to digital-first services continues to accelerate. By expanding the use of cloud-based systems, digitising clinical workflows, and supporting virtual wards, we reduce reliance on physical infrastructure and paper-based processes. This transformation enhances care delivery while reducing emissions associated with travel, printing and estates usage. One successful example of a cloud implementation completed in 2024 by TRFT includes the financial system Aggresso.

PC Power Down Across the Estate – We have successfully rolled out automated PC power down policies across all departments working closely with estates. This

initiative, aligned with the NHS's digital sustainability guidance, ensure that idle machines are powered down overnight and during periods of inactivity, significantly reducing unnecessary energy consumption.

TRFT remains committed to aligning its digital growth with national sustainability goals, supporting the NHS ambition to become the world's first net zero health system (Health and Care Act 2022). TRFT continue to complete the Digital Maturity Assessment (DMA) tool developed by NHS England to help providers and integrated care systems across England understand their level of digital maturity.

NHS England » Digital maturity assessment



5.0 GREEN PLAN FOUNDATION

The steps below will form the core of our Green Plan going forward:

- Ensure a board member is responsible for our net zero targets and Green Plan.
- Designate a Board lead to oversee our Green Plan development.
- Reduce our carbon footprint from fixed assets by continued investment in low and zero carbon solutions in building services.
- All new build and refurbishments to be completed to surpass those dictated by Part L of the building regulations.
- All new builds to achieve an EPC of A.
- All new builds to achieve a DEC of at least B on first 12-month anniversary of handover.
- Decommission the nitrous oxide manifold.
- Develop plans for clinically appropriate prescribing of lower carbon inhalers.
- Ensure that, for new purchases and lease arrangements, we solely purchase and lease cars that are ultra-low emissions vehicles (ULEV's) or zero emissions vehicles (ZEV's).
- Develop our green travel plan to support active travel and public transport for staff, patients and visitors.
- Ensure visibility is increased through significant visible leadership promoting sustainability.
- Set up strategic sessions to work through all elements and set up nominated strategic/operational leads.

6.0 TRACKING & REPORTING PROGRESS

The Good Corporate Citizenship (GCC) Tool has been developed by the NHS Sustainable Development Unit as a methodology for NHS organisations to measure and monitor their progress on sustainable development. The tool provides organisations with the means to monitor progress on the less easily quantifiable aspects of sustainable development in financial, social and environmental terms. The GCC Tool allows NHS organisations to assess their sustainable development performance across key areas and compare the result with national and regional averages.

TRFT will use the GCC Tool as a key metric to monitor the impacts from the implementation of the Green Plan. TRFT will undertake a baseline assessment for the GCC Tool in 2022, and an internal procedure will be developed to ensure the GCC Tool is completed as fully and accurately as possible and reviewed on an annual basis.

The Department of Health requires all NHS Trusts to report ERIC (Estates Return Information Collection) data. ERIC data comprises essential statistics on waste, energy and water (amongst other data sets) from Estates and Facilities. TRFT will benchmark performance with other acute Trusts, using ERIC Median Performance and relevant datasets from the Health Estates and Facilities Management Association (HEFMA), with a view to informing our performance within our peer group and in identifying further opportunities and best practice in energy and emissions reduction.

Progress on the implementation of the Green Plan will be reported annually through the Energy & Utilities Annual Report, the TRFT Emissions Baseline & Tracker, the Waste and Environmental Annual Report and TRFT's Annual Report.

7.0 SUPPORTING RESOURCES

7.1 TECHNICAL RESOURCES

TRFT will utilise one or more of the following technical resources in delivering the Green Plan:

- Delivering a net zero National Health Service report
- Greener NHS Dashboard
- Greener NHS Quarterly Data Collection documents
- Health Outcomes of Travel Tool (HOTT)
- Health Outcomes of Stationary Sources Tool (HOST)

7.2 FINANCIAL RESOURCE

Affordability is a key element of implementing the Green Plan. Many programmes will result in reduced running costs, albeit that investment may be required to implement some programmes. All programmes will follow standard procedures on cost impact and funding source, regardless of an external or internally funded investment. Where possible, external funding will be sourced, as described below.

7.2.1 Salix (Public Sector Decarbonisation Fund)

The Government backed Salix funding scheme for Public Sector Decarbonisation Fund (PSDF) will be explored to provide finance for projects to reduce carbon usage and emissions. We will put in place costed scheme submissions to enable appropriate applications for grant funding, to ensure the best opportunities materialise for TRFT.

7.2.2 Net Zero Hydrogen Fund

This funding aims to support the commercial deployment of low carbon hydrogen production projects through the 2020's https://www.gov.uk/government/publications/net-zero-hydrogen-fund-strand-1-and-strand-2

7.2.3 Internal Capital

Funding for energy and sustainability initiatives can also be considered by business case approval via internal Trust funding.

8.0 EQUALITY & DIVERSITY

In applying this plan, the Rotherham NHS Foundation Trust will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following nine protected characteristics by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation.

Alongside this, the Trust will seek to reduce health inequalities, and avoid exacerbating economic inequalities.

The application of this plan will include careful consideration of the access needs of disabled staff, patients and visitors.

9.0 MONITORING & REVIEW

This plan will be reviewed every three years as well as in accordance with any changes to relevant legislation, good practice guidelines or after a significant change in organisational structure. Where review is necessary due to legislative change, this will happen as soon as practicable after the change. Once ratified, the Green Plan will be disseminated to colleagues by way of the Hub.

Board of Directors' Meeting
5 September 2025

The Rotherham NHS Foundation Trust

Agenda item	P142/25
Report	**National, Integrated Care Board and Rotherham Place Update**
Executive Lead	Bob Kirton, Managing Director
Link with the BAF	R2: There is a risk we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities. OP3: There is a risk robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of a of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.
How does this paper support Trust Values	Together: This paper demonstrates how the Trust and partners across both Rotherham Place and the wider system work together in providing patient care and providing mutual support.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this report is to provide the Board of Directors with an update on national developments, developments across the South Yorkshire Integrated Care Board (SYB ICB) and Rotherham Place. Key points to note from the report are: • National update inc recovery update and national oversight framework • SYB update • Place update inc Neighbourhood working
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Executive Team receives a weekly verbal update covering key Place and South Yorkshire Integrated Care Board (SYICB) level activities in addition to specific papers periodically, as and when required.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Board note the content of this paper.
Appendices	

1.0 Introduction

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

2.0 National Update

2.1 **The NHS performed a record number of checks for treatments, cancer checks and other tests for June, as 18-week performance hit its best level in 3 years.**
NHS staff pulled out all the stops to treat a record number of patients in any June, with 103,563 – or 2% – more treatments delivered than the same month last year (1.56 million vs 1.45 million). The proportion of patients waiting less than 18 weeks for treatment in June was 61.5%, the highest since June 2022. The longest waits of over 52 and 65 weeks also fell.

This progress came amid a surge in people coming forward for care, with 141,809 more referrals onto the waits list – or 3.2% – than the year before (1.83 million vs 1.69 million); meaning the waiting list rose slightly by 9,712, to 7.37 million. That equates to an estimated 6.23 million patients waiting for care. Over the past decade, excluding the pandemic, June has traditionally seen an average 32,000 increase in the waiting list. It was also a record June for the number of diagnostic tests and checks delivered (2.5 million).

Separate data showing the impact of last month's industrial action by resident doctors has also been published, showing the results of a more robust approach by NHS leaders with staff working around the clock to keep services open for patients. More care was delivered during the July 2025 resident doctors' strike than in the 5-day June 2024 walkout, with NHS analysis estimating that an additional 11,071 appointments and procedures went ahead.

2.2 As part of the NHS Oversight Framework (NOF), NHS England will assess NHS trusts'* capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards will be asked to assess their organisation's capability against a range of expectations across 6 areas derived from the insightful provider board, namely:

- strategy, leadership and planning
- quality of care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight

These will inform a self-assessment which is intended to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. The purpose of this is to focus trust boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability.

3.0 South Yorkshire Integrated Care Board (SYICB)

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

4.0 Rotherham Place

4.1 Places have been invited to participate in the National Neighbourhood Health Implementation Programme (NNHIP) to join the first wave of the programme. The NNHIP seeks to build on success to date and the new approaches set out in the 10 Year Health Plan – taking a test, learn and grow approach – to transform the health and care of neighbourhoods. The aim of this new national programme is to accelerate the work you are doing, or planning to do, by learning together, sharing solutions, tackling challenges and delivering improvement, adapting those solutions to your own circumstances. More than that, it will be working at scale both within your Place and alongside Places across the country simultaneously, accelerating the learning. Rotherham Place partners submitted a bid on the 8th August, a response is expected by the September the 5th. Beyond this Rotherham will continue to develop their neighbourhood working approach through 2 workshops in September to develop the vision and delivery plan for this work.

Bob Kirton, Managing Director
September 2025

Enclosure 07

Chief Executive Report

Integrated Care Board Meeting

2 July 2025

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

Purpose of Paper

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

Key Issues / Points to Note

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

Is your report for Approval / Consideration / Noting

To note

Recommendations / Action Required by the Committee

The Board is asked to note the content of the report

Board Assurance Framework

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

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

population health and health care.		outcomes, experience, and access.	
Priority 3 - Enhancing productivity and value for money.	✓	Priority 4 - Helping the NHS to support broader social and economic development.	✓

In addition, this report also provides evidence against the following corporate goals (place ✓ beside all that apply):

Goal 1 – Inspired Colleagues: To make our organisation a great place to work where everyone belongs and makes a difference	✓
Goal 2 – Integrated Care: To relentlessly tackle health inequalities and to support people to take charge of their own health and wellbeing.	✓
Goal 3 – Involved Communities: To work with our communities so their strengths, experiences and needs are at the heart of all decision making.	✓

Are there any Resource Implications (including Financial, Staffing etc)?
No
Have you carried out an Equality Impact Assessment and is it attached?
N/a
Have you involved patients, carers and the public in the preparation of the report*?*
N/a
Appendices
N/a

Enclosure 07

Chief Executive Report

Integrated Care Board Meeting

2 July 2025

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for May and June 2025.

2. Integrated Care System Update

2.1 Government Spending Review

The Government has announced that NHS England's budget is to rise by 3% on average in real terms over the next three years, including accounting for inflation. However, the Department of Health and Social Care will be asked to deliver £9bn in efficiency savings by the end of this Parliament. The additional funding will support:

- Up to £10bn in technology and digital transformation by 2028/29, which is an almost 50% increase from 2025-26. This will support digital investment by developing the single patient record, further expansion of the NHS App and continued adoption of the Federated Data Platform.
- Additional funding by 2028/29 to train more GPs.
- Allocation of funding for 700,000 additional urgent NHS dentist appointments per year over the Spending Review.
- A commitment to expanding mental health support teams to all schools in England by 2029/30 and employing 8,500 additional mental health staff by the end of the parliament.

We recognise that spending on health has increased above that of other governmental departments. However, we still anticipate a challenging financial environment given increased demand, advancing technology and NHS pay settlements. There has been funding for the social determinants of health, including £3.5bn for employment support, £39bn for a new Affordable Homes Programme and £1.2bn for skills. In addition, the Education budget will rise by £2bn, part of which will fund the expansion of free school meals to all families who receive Universal Credit, and the proposal for free breakfast clubs, will improve children's access to nutritious meals and improve health.

Capital spending has remained flat, although this was increased in the recent Budget.

2.2 National changes to ICBs

On 1 April 2025, the Chief Executive of NHS England wrote to NHS trusts and integrated care boards on 'Working together in 2025/26 to lay the foundations for reform'. This followed the Prime Minister's announcement in March 2025 that NHS England will become part of the Department of Health and Social Care (DHSC) over the coming two-year period. This included a change in the role of ICBs and a reduction in operating.

Since then, NHS England has released a ‘Model Integrated Care Board – Blueprint’ document, which outlines how ICBs will have a narrower responsibility focussed on the strategic commissioning of NHS services and system leadership for population health. As part of this reduced focus, we are also required to reduce our operating costs by 51% by December 2025. As part of the changes the delivery of more patient-facing services, such as Continuing Healthcare (CHC), safeguarding and medicines support to primary care, are expected to transfer to other organisations over time. However, in the meantime they remain with the ICB and their costs are to be covered within the new resourcing envelope.

This will require us to reduce our annual operating costs from £61.7m to £30.2m which is based on a national figure per weighted capitation. This is a major change for our people. The ICB’s workforce will reduce from 800 whole time equivalent (WTE) staff to 425 WTE. We are supporting colleagues through this change which will require redundancies.

At the end of May, we submitted a high-level plan of how we would achieve this and are now working on the detailed organisational design and structure that will underpin it. This new structure will enable us to remain committed to the four aims of integrated care systems:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development

However, in future, this will primarily be achieved through the strategic commissioning of NHS services.

In other parts of England, ICBs are merging or ‘clustering’ with a single leadership covering multiple ICBs. South Yorkshire will remain as one of 12 ‘standalone’ ICBs, which is welcome. However, we continue to explore partnership working with other neighbouring ICBs where possible.

The ICB will continue to have a central role in shaping NHS services as the strategic commissioner and we will continue to play a full role in our Integrated Care Partnership, which we convene jointly with the four local authorities. Our new structure will ensure that we maintain a strong place focus with senior colleagues in each of our functions having a place-facing role.

We are also working to maintain and strengthen our cross-South Yorkshire partnerships such as the Acute Hospitals Federation, MHLDA Alliance, Primary Care, VCSE and others. These will be vital to us as we seek to commission more integrated pathways of care offering a more sustainable and consistent experience across South Yorkshire.

We’re grateful to our partner organisations, particularly the NHS provider trusts, our four local authorities and SYMCA, for supporting us to work through these changes, mitigate the risks and take the opportunities to build on our strong partnerships.

2.3 Financial Plan 2024/25

NHS South Yorkshire has submitted a breakeven plan to NHS England for the 2025/26 financial year. The ICB and local NHS providers together need to deliver about £270m in efficiencies this year, which is about 6.9%. This is a significant challenge, but the scale is comparable with other systems across the NHS. The plan includes £79m of deficit support funding from NHSE.

At the end of May, the South Yorkshire system reported a small adverse variance against plan of £2.9m (comprising ICB -£0.8m and NHS trusts -£2.1m). There is a System Efficiency Board for SY which oversees the progress of the transformation plans in place to deliver the plan.

2.4 National 10 Year Health Plan

We continue to anticipate the National 10-Year Health Plan to be published in the summer. At the NHS Confederation Expo Conference in June, leaders trailed the likely scope of the 10-Year Plan, with a particular focus to be expected on neighbourhood health and enabling integrated neighbourhood working alongside improving quality of care. This was shared in addition to specific references to enabling new ways of working for outpatients and maximising the use of technology to enable the analogue to digital shift.

2.5 Integrated Care Partnership (ICP) Board

The South Yorkshire Integrated Care Partnership (ICP) met on Wednesday 25 June to focus on children and young people and launch the Health Equity Panel Report. It received a presentation from Professor Alan Walker, Independent Chair of the Health Equity Panel (HEP), and the Board had the opportunity to reflect on the findings and recommendations from the Panel, including the implications of extending healthy life expectancy and reducing health inequalities across South Yorkshire, to inform future work for the Partnership.

The ICP Board also received an update on the Child Health Equity Collaborative and the Safe Place to Sleep Programme. The Child Health Equity Collaborative is a partnership of the UCL Institute of Health Equity, Barnardo's and three partner integrated care systems (Birmingham and Solihull, Cheshire and Merseyside, and South Yorkshire). The Child Health Equity Collaborative is focusing action on the social determinants of health as central to improving outcomes among children and young people. The Safe Place to Sleep Programme is a SYMCA-funded programme to contribute to addressing cost of living challenges starting by tackling bed poverty, with an aim to ensure that every child in South Yorkshire, aged 5 and under, has a safe space to sleep.

2.6 Health and Growth Accelerator

The £18m Health and Growth Accelerator, part of the Get Britain Working White Paper and Pathways to Work commission will launch soon to support those who are economically inactive to get back to work. This focuses on achieving a systemic shift towards enabling work and fostering a healthier, more inclusive, and economically active population in South Yorkshire.

It is anticipated that 950 people will be prevented from becoming economically inactive in Year 1 and this will support reduced pressure on primary care through workplace-based interventions. The interventions will include:

- Extending the Work Well social prescribing offer
- Scaling of health provision and VCSE provision
- Vocational support offer of physio for pain and for physio for MSK
- Mental health prevention offers around emotional resilience skills training
- Allied Health Professional Interventions in Occupational Health

By April 2026 we anticipate being able to offer a single directory of support across work and health that includes vocational and health support, all through one access point.

2.7 NHS Urgent and Emergency Care (UEC) Plan

Nationally, NHS England has published the NHS Urgent and Emergency Care (UEC) Plan 2025/26, which includes £450m of funding for same-day emergency care and urgent treatment centres, mental health crisis assessment centres and new ambulance fleet. The plan anticipates that 800,000 fewer patients each year to wait more than four hours at A&E. The plan includes improving ambulance response times for those with a stroke, heart attack, sepsis or major trauma; ensure a minimum of 78% of patients who attend A&E treated in four hours; improve vaccination uptake by 5%; and tackle delays in waiting to be discharged when medically fit.

In addition, the North East and Yorkshire region has been awarded £25m of capital to improve UEC delivery, one of the larger allocations, and individual trusts have been recognised for performance. For Example, Barnsley Hospitals have been awarded £3m for having some of the lowest 12-hour waits in the Emergency Department.

Urgent and emergency care performance has improved, particularly over the last month. SY is implementing the 45-minute ambulance handover (rapid release protocol) in a phased approach, Sheffield went live on 2 June and saw zero breaches of the 45 minutes in the first week, Doncaster will go live on 16 July and Rotherham and Barnsley will go live in August. We've co-designed our 2025/26 strategic plan focused on delivery, impact, and winter resilience. Place-based teams are leading vital improvements, from virtual wards to access redesign, enhancing both performance and patient care.

2.8 Endoscopic Retrograde Cholangio-Pancreatography (ERCP)

The Rotherham NHS Foundation Trust (TRFT) has published a report regarding substandard care provided to a small group of patients between 2017-2021. The service for the patients, who underwent a specialised endoscopy (ERCP) procedure, was suspended in July 2021 due to concerns around a cluster of adverse incidents and complications.

A Royal College of Physicians (RCP) review of the service recommended reviewing the care of nearly 1,000 patients who died within 30 days or had a complication. External experts undertook the reviews of 68 patients who had died or who had a complication. Deficiencies, consistent with those reported in the RCP review, were

found in the care of 58 patients with potential harm to 24 patients.

The Trust communicated with patients and their families in line with duty of candour in early June 2025, with face-to-face follow-up meetings also offered. The RCP's recommendations have been implemented by TRFT and the ICB is working closely with them to ensure high-quality, effective and safe care is provided.

Endoscopic Retrograde Cholangio-Pancreatography (ERCP), is a specialist type of endoscopy undertaken to diagnose and treat problems in the liver, gallbladder, bile ducts, and pancreas. ERCP is an invasive procedure which carries well-recognised risks. Patients requiring an ERCP procedure often have complex health conditions which may be life-limiting such as frailty.

3. NHS South Yorkshire

3.1 Children and Young People Alliance Conference

The Children and Young People Alliance held their 4th Annual Conference on Thursday 12 June in Doncaster. This year's conference theme was 'one big coming together and one big thank you' and was about celebrating the dedication, impact and partnerships that make the alliance's collective work so powerful.

Throughout the event, young people themselves, and organisational partners, spoke about the work that is going on to improve the health, wellbeing and lives of young people living in South Yorkshire.

The speakers included Nigel Harrison from Yorkshire Sport Foundation and Beth Stout from Golddigger Trust, as well as showcases from Roundabout, Sheffield Hallam University and Barnardo's.

3.2 Eyup campaign

NHS South Yorkshire has launched a partnership with mental health service Shout to offer 24/7 text support across the region. The partnership offers free urgent mental health support that is confidential for anyone struggling to cope. In partnership with charity Mental Health Innovations, anyone in the area experiencing anxiety, stress, loneliness, depression, self-harm, suicidal thoughts, or other mental health challenges can now use the service by texting the word 'EYUP' to 85258.

Whilst Shout already offers a text service for mental health support, this new service has been launched to specifically support people in South Yorkshire. The 'Eyup' text word has been developed with input and support from the local young people's charity, Chilypep. Chilypep held engagement sessions with young people from South Yorkshire to develop a specific text word that has meaning and significance to people living here.

The partnership enables the ICB to meet NHS England's advisory specifications for implementing a 24/7 crisis text message service, integrated with their local services, including the 111 phone service provision.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

The Neuro-oncology service at Sheffield Teaching Hospitals NHS Foundation Trust has been named a centre of excellence for the care and treatment of brain tumours by the Tessa Jowell Brain Cancer Mission (TJBCM). The Tessa Jowell Centre of Excellence designation recognises and awards adult neuro-oncology centres that provide excellent treatment, care and research opportunities for patients with brain tumours and provides targeted support to centres to improve and develop services.

The department is one of fourteen centres across the UK to receive the excellence status this year, following extensive assessment of the services and feedback collected from almost 1500 patients by The Brain Tumour Charity.

4.2 Doncaster

A specialist South Yorkshire Paediatric Dental Surgery Hub to improve children's oral health across the region has been launched in Doncaster. The South Yorkshire and Bassetlaw paediatric elective surgical hub pilot launched in March 2025 to provide essential surgical care for children requiring exodontia (tooth extractions). The hub is located in Doncaster and is led by specialist consultants in paediatric dentistry from Sheffield Teaching Hospitals NHS Foundation Trust.

4.3 Rotherham

The Rotherham NHS Foundation Trust children's and young people's services have scored positively in a survey by the Care Quality Commission. The Children and Young People's Survey 2024 asked patients receiving care, and their parents or carers, about their experience. The trust's top scores included parents feeling staff provided written information about caring for their child at home, there was enough hospital food choice for their child, they were informed who to contact if worried about their child when at home, and staff attempting to provide distractions to the child during operations and procedures.

4.4 Barnsley

Barnsley Hospital has extended its successful tobacco dependency treatment programme into Children's Services, providing crucial support to patients aged 12 and over. The service extends to parents and carers and addresses the need to protect children from the harms of tobacco which can occur through smoking or exposure to second-hand smoke. From July to December 2024, over 1,800 people admitted to the hospital were recorded as having smoked in the previous two weeks, 82% of whom received specialist care from tobacco dependency advisors during their admission.

5. General Updates

5.1 NHS Confederation Expo

This year NHS South Yorkshire and partners spoke across a range of subjects at the NHS Confederation Expo in Manchester:

- Dr Jason Page and Hannah Young presented on Targeted Lung Health Checks, more than 700 cancers have been detected since the programme started in 2021.
- Jodie Deadman and Jacqui Yeates, together with colleagues from Bernardo's talked about spoke about Bump, Birth and Beyond.
- Nicola Ennis spoke about shifting the dial on child health.
- Katherine South and Rotherham colleagues spoke about their award-winning Hydration work with Care Homes.
- Chair Pearse Butler led a discussion on fixing financial flows to incentivise care closer to home.

5.2 Awards

The Sheffield Teenage and Young Adult Cancer Service, which is based at Sheffield Teaching Hospitals NHS Foundation Trust, were the only team in the north of England to scoop a top award from the CCLG: Children's & Young People's Cancer Association. The team support cancer patients aged 13 to 25 from across the whole of South Yorkshire, North and North East Lincolnshire, North Derbyshire and North Nottinghamshire, and were recognised for going above and beyond in meeting the unique challenges faced by teenage and young adult cancer patients.

The NHS South Yorkshire Star Awards recent winners were:

- May: May's Star Awards winners were the T2Day team, led by Ani Kumar and Amy Moore, who are helping improve the health of young adults living with diabetes and people who are at risk of diabetes across South Yorkshire.

- June: June's Star Awards winner was Lucy Koc. Lucy is a key member of our PCDN team and has brought amazing clinical, educational and organisational skills to our team. Her experience in neurology makes her passionate about the team's current Hypertension Project. Her experiences fuel her desire to ensure health promotion and prevention work is successful and benefits people across the city.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 2 July 2025

Board of Directors Meeting
5th September 2025

Agenda item	P143/25
Report	**Integrated Performance Report**
Executive Lead	Bob Kirton, Deputy Chief Executive
Link with the BAF	D5, D6, P1, R2
How does this paper support Trust Values	The Integrated Performance Report supports the Trust's *Ambitious* value in ensuring we are constantly striving to deliver stronger performance across all of the core domains.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Integrated Performance Report (IPR) provides a monthly overview of the Trust's performance across four key areas: Operational Delivery, Quality, Finance, and Workforce. This report covers data from **July 2025**, where available, and outlines performance in relation to established national, local, or benchmarked targets. Statistical Process Control (SPC) charts are used throughout this report. A brief explanation of the main features of these charts is provided at the back for your reference. This month includes an additional DRAFT matrix page, to assess whether those indicators without a target benefit from being seen more clearly, this is viewable in the F&P section for comment. This IPR is currently under review and any additional indicators that need including to ensure visibility of all the National Oversight Framework metrics will be there in subsequent reports.
Due Diligence	The Finance and Performance, Quality Committee Committees and People Committee have received the relevant elements of the Integrated Performance Report or identical information, with the Executive Directors approving the content for their domain.
Board powers to make this decision	In order to be assured of the performance of the organisation, the Board needs to have visibility of the Trust's performance against core metrics.
Who, What and When	The Managing Director is the Lead Executive for reporting on the performance of the organisation through the Integrated Performance Report on a monthly basis.

Recommendations	It is recommended that the Board of Directors note the Trust's performance against the metrics presented in the Integrated Performance Report and receive assurance on the basis of this report.
Appendices	Integrated Performance Report – July 2025

Board of Directors Meeting

Integrated Performance Report - July 2025



Performance Matrix Summary

NHS The Rotherham NHS Foundation Trust

Assurance

Variation	Pass	Hit or Miss	Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • MaST – Core (%) • Turnover (12 month rolling %)	**GOOD: CELEBRATE AND UNDERSTAND** • 1:1 Care in Labour • Fill Rate (%) – Registered • 52+ weeks – CYP • 52+ weeks • Patients waiting < 18wks for 1st OP Apt • Bed Occupancy • Patients on VW	**CONCERNING: CELEBRATE BUT TAKE ACTION** • Average time to be Seen • Discharges before 5pm
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • CHPPD Rate (%) – Registered/Un-Registered combined • Clinic Utilisation – Elective and 2ww • Mean LoS (Non-Elective) • Urgent 2 Hour Response	**STATIC: INVESTIGATE AND UNDERSTAND** • Readmissions • Care Hours per Patient Day • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Patient Falls (Moderate and above) - Community • C. diff infections • Patient Falls (Moderate and above) – Acute • VTE Risk Assessments • Breast milk first feed • Pressure Ulcers (Cat 3 and above) – Acute • Combined Positivity Score • Moderate and above maternal harms • No of Stillbirths • Combined Positivity Score • Medication Incidents (Moderate and above) – Acute • Sickness Rates (%) • Waiting List Size • RTT • OP to PIFU • 31 Day Treatment • 62 Day Treatment • FDS • 4hr Performance • Avg Amb Handover • >12 hours in A&E • 12hr Trolley Waits • Bed Occupancy • LoS >21 Days • DM01 • Discharge Ready Date • DNA (%) • SHMI • Massive PPH • 3rd and 4th degree tears • *LOS > 7 Days • *Mean LOS (elective) • *A&E Attendances from Care Homes • *Admissions from Care Homes • Ambulance Handovers >45 mins (%)	**CONCERNING: INVESTIGATE & TAKE ACTION** • Pressure Ulcers (Cat 3 and above) – Community • UECC Positivity Score • Criteria to Reside is No • Capped Theatres Utilisation
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • Stillbirth rate • MaST – Job Specific (%)	**CONCERNING:INVESTIGATE & TAKE ACTION** • Moderate and above Harms – Community • Moderate and Above Harms – Acute	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • Sickness Rates (12 month rolling %)

How to read the ICONs in this report:

Have we achieved in month?

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

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

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

Performance Matrix Summary - Quality

NHS The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE**	**GOOD: CELEBRATE AND UNDERSTAND** • 1:1 Care in Labour • Fill Rate (%) – Registered	**CONCERNING: CELEBRATE BUT TAKE ACTION**
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • CHPPD Rate (%) – Registered/Un-Registered combined	**STATIC: INVESTIGATE AND UNDERSTAND** • Readmissions • Care Hours per Patient Day • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Patient Falls (Moderate and above) - Community • C. diff infections • Patient Falls (Moderate and above) – Acute • VTE Risk Assessments • Breast milk first feed • Pressure Ulcers (Cat 3 and above) – Acute • Combined Positivity Score • 3rd and 4th degree tears • Massive PPH • Moderate and above maternal harms • No of Stillbirths • SHMI • Combined Positivity Score • Medication Incidents (Moderate and above) – Acute	**CONCERNING: INVESTIGATE & TAKE ACTION** • Pressure Ulcers (Cat 3 and above) – Community • UECC Positivity Score
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION** • Moderate and above Harms – Community	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

Quality

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
SHMI	"As expected"	"As expected" (107.7)	Mar-25	N/A	P		-	S
Readmissions (%)	-	5.7	Jun-25	-	-			S
VTE Risk Assessments (%)	95.0	95.1	Jul-25	☑	?		-	S
Combined Positivity Score (%) – excl UECC	95.0	96.1	Jul-25	☑	?		-	S
UECC Positivity Score (%)	95.0	76.4	Jul-25	☒	F		-	C
Complaints (per 10k Contacts)	8.0	12.4	Jul-25	☒	?		-	S
Patient Safety Incident Investigations	3	2	Jul-25	☑	?		-	S
Moderate Harms and above per 1000 bed days – Acute	-	2.9	Jul-25	-	-	H	-	C
Moderate Harms and above per 1000 contacts – Community	-	0.9	Jul-25	-	-	H	-	C
Medication Incidents - Moderate and Above per 1000 bed days – Acute	0.1	0.0	Jul-25	☑	?		-	S
Pressure Ulcers Cat per 1000 contacts - Community	0.1	0.9	Jul-25	☒	F		-	C
Pressure Ulcers per 1000 bed days - Acute	0.8	1	Jul-25	☒	?		-	S
Patients Falls (Moderate and Above per 1000 bed days)	0.2	0.2	Jul-25	☑	?		-	S
C. difficile Infections	4	2	Jul-25	☑	?			S

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

SHMI: Summary Hospital-Level Mortality Indicator July 2025

Data, Context and Explanation

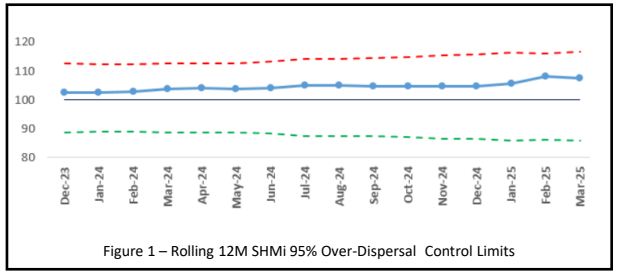


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

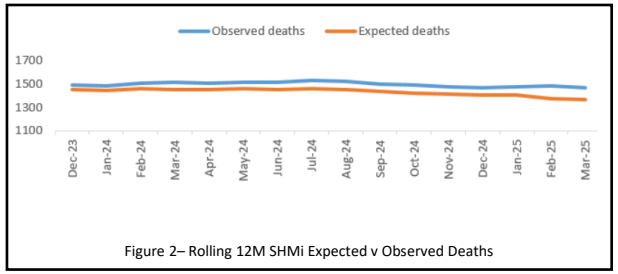


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

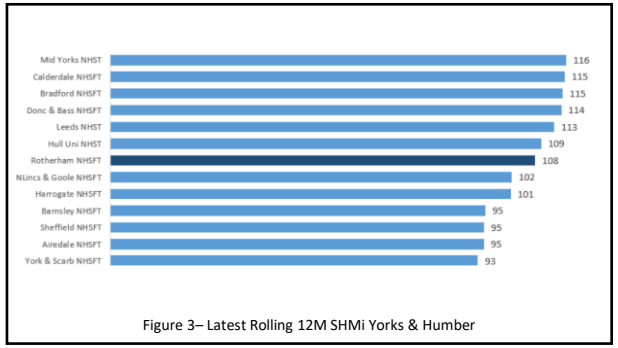


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

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

Covid activity was added back into the SHMI data Dec 2023

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

Metric	Current	Target	Exec Owner	Organisational Lead
Latest Rolling 12Month SHMI - Mar 25	107.7	-	Jo Beahan	John Taylor
Expected Deaths	1365	-		
Observed Deaths	1465	-		
Trust Banding	Expected	-		

What actions are planned?

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

What is the expected impact?

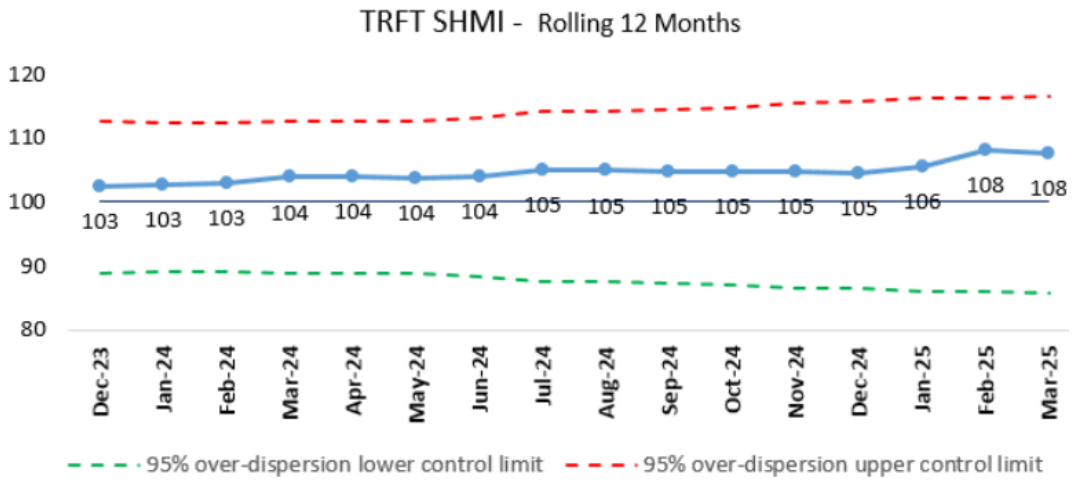
- Investigations or reviews resulting from SHMI investigations will give the Trust Assurance when there are significantly more deaths observed than expected
- Intelligence from SHMI investigations/reviews may lead to changes/improvements in practice

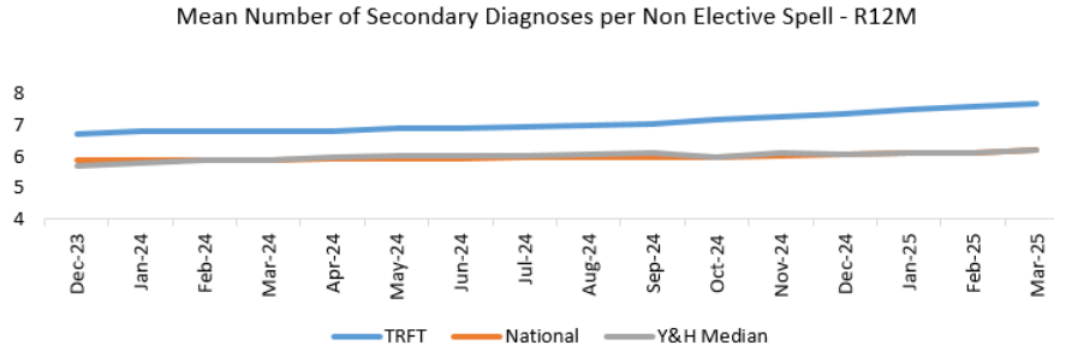
Potential risks to improvement?

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

SHMI: Summary Hospital-Level Mortality Indicator - Update

SHMI Update





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

The increases since Aug 2024 appear to be caused by TRFT submitting SDEC activity in the ECDS rather than the IP dataset. This is known to increase the SHMI because the expected number of deaths decreases more than the observed. This was a NHS mandated change, which many Trusts haven't adhered too.

Interpretation Guidance NHS England June 2024

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

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

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

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

SHMI: Summary Hospital-Level Mortality Indicator

SHMI: Coding & Alerts

SHMI – New Diagnostic Group Alerts

TRFT currently has no alerts for its diagnostic groups.

There have been no new VLAD (Risk Accumulation) Alerts.

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

SHMI – Diagnostic Group Alerts Under Review

A run of more deaths than expected between Nov 2024 & Jan 2025, in the **Septicaemia** diagnosis group, triggered a VLAD Alert.

The number of deaths in this run was 36. 8 of these deaths had completed SJRs. These were reviewed at the July TMG meeting. 7 were judged to have been definitely not preventable and 1 judged to had a slight chance.

All SJRs with Sepsis in the MCCD 1a are routinely sent to and reviewed by the Deteriorating Patient Group and Sepsis QI Group.

A coding review has been requested.

The coding review and further analysis will be reviewed at the September TMG and the alert closed or further investigations requested.

A run of more deaths than expected between Jan & Feb 2025, in the **Pneumonia** diagnosis group, has triggered a VLAD Alert.

A coding review has been requested and completed SJRs will be reviewed for patients in this group.

Theses review reports and the background SHMI data will be discussed at the September TMG Trust Mortality Group. Decisions will be made with regards to any further required investigation/reviews.

SHMI: Summary Hospital-Level Mortality Indicator

SHMI: Coding & Methodoly

SHMI Coding Metrics –

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

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

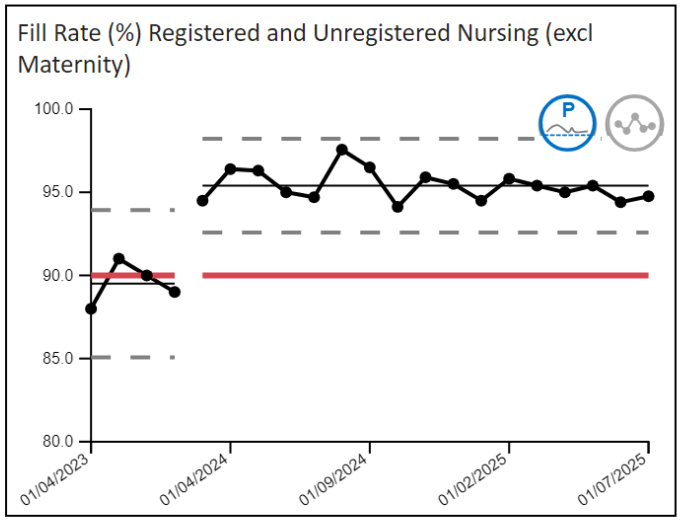
SHMI Changes – Methodology, Process or Specification

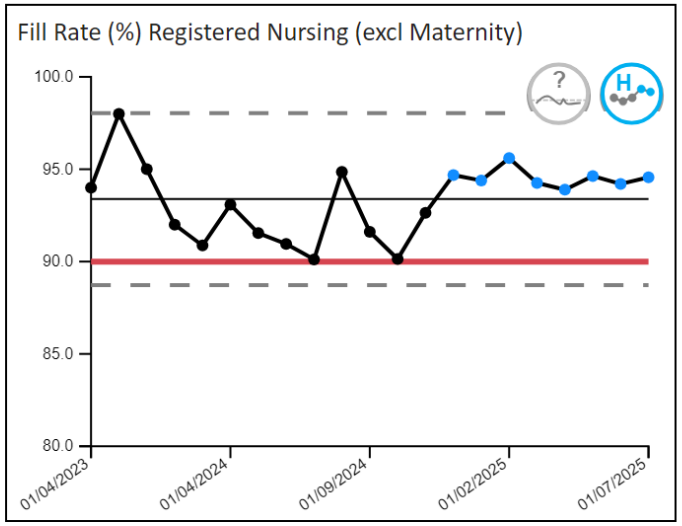
No new changes

TRFT Rank of 13	4th Highest	2nd Highest	1st Highest	5th Highest	4th Highest
Yorks & Humber Region Non Spec Provider Trusts	**% of Spells: Primary Diagnosis is a Sign & Symptom**	**% of Spells: Invalid primary diagnosis code**	**MEAN Secondary Diagnoses per Spell Non**	**% of Spells with palliative care**	**% of deaths with palliative care**
Harrogate NHSFT	19.8	8.2	5.6	2.3	37
Rotherham NHSFT	14.5	3.2	7.7	2.3	46
Donc & Bass NHSFT	13.7	0.6	5.2	2.2	52
Mid Yorks NHST	8.8	0.5	6.6	2.4	46
Bradford NHSFT	7.3	0.2	4.1	1.4	46
NLincs & Goole NHSFT	17.7	0.0	4.6	1.1	24
Sheffield NHSFT	10.0	0.0	5.2	1.8	39
Barnsley NHSFT	14.6	0.0	7.7	3.3	64
York & Scarb NHSFT	13.5	0.0	6.2	1.2	27
Airedale NHSFT	14.5	*	4.7	1.2	25
Leeds NHST	5.4	*	6.7	2.1	35
Hull Uni NHST	8.8	*	6.4	2.4	36
Calderdale NHSFT	5.8	*	7.5	3.6	53
England	14.8	2.7	6.2	2.1	45

Subtheme: Care hours per patient day

Data, Context and Explanation





- Care Hours Per Patient Day (CHPPD) is the formal, principal measure of workforce deployment in ward-based settings. CHPPD should be used alongside clinical quality and safety outcome measures to understand and reduce unwarranted variation, and support delivery of high quality, efficient patient care.
- CHPPD for July was 7.2 against a planned of 7.5
- Days RN was 94% of planned
- Days CSW was 86% of planned
- Nights RN was 98% of planned
- Nights CSW was 107% of planned
- Safer Nursing Care Tool is used twice a year with the summer data collection having begun.
- Newly registered nurses planned to arrive in September/October is 102 adult RN, 5 paediatric RN, 7 RM and 25 AHP. Welcome events are planned as part of on-boarding

Metric	Target	Value	Exec Lead	Ops Lead
Fill Rate (%) Registered Nursing (excl Maternity)	90.0	94.6	Helen Dobson	Cindy Storer
Fill Rate (%) Registered and Unregistered Nursing (excl Maternity)	90.0	94.8	Helen Dobson	Cindy Storer

What actions are planned?

- Continued roll out of the Exemplar Accreditation programme to triangulate CHPPD with patient outcomes.
- Welcome event for NRN in August 25
- Summer data collection for SNCT analysis with each ward manager, matron and HoN to establish professional judgement.
- New Mandate for reducing unavailability's starts August 25

What is the expected impact?

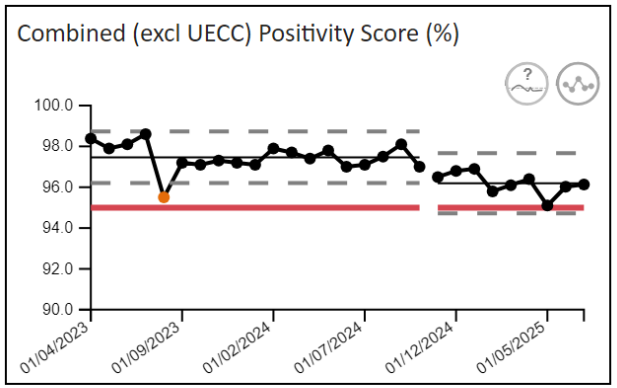
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.
- Ensure funded establishments match levels of acuity and activity.

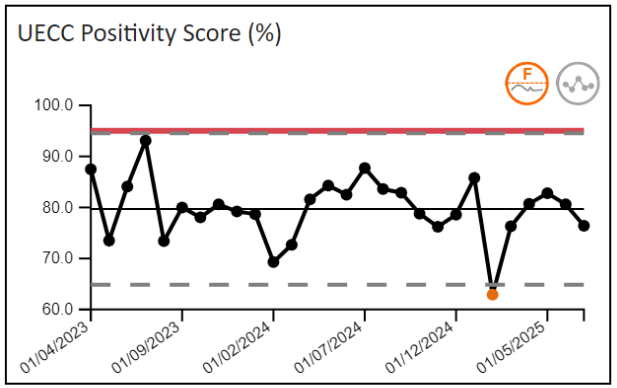
Potential risks to improvement?

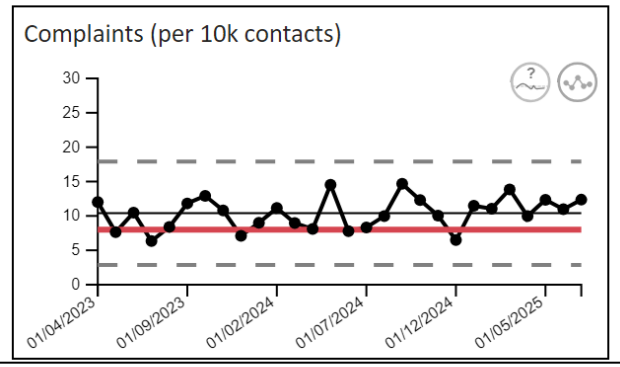
- Additional winter beds not yet fully closed.
- Roster KPI not being met.
- High rates of sickness absence in some areas – mainly affecting day shifts

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.
- Since October 2024, positivity scores have slightly decreased. This correlates with smaller teams, especially those in Community now using FFT for their areas.
- Some areas receive fewer than 5 responses, which affects the percentage of negative feedback since a few negative comments can make the negative score seem higher. This has impacted the overall negativity score for the Trust.
- Teams can view their FFT scores on the hub, and results are shared in Care Group learning to PEC.
- The number of complaints has been a consistent rate of written complaints per month over the last three years, despite the rising numbers of patients being seen.
- PALS is seeing a rise in contacts but has seen a 60% reduction in concerns

Metric	Target	Value	Exec Lead	Ops Lead
Combined (excl UECC) Positivity Score (%)	95.0	96.1	Helen Dobson	Cindy Storer
UECC Positivity Score (%)	95.0	76.4	Helen Dobson	Cindy Storer
Complaints (per 10k contacts)	8.0	12.4	Helen Dobson	Cindy Storer

What actions are planned?

Analysis of FFT by category against national average – demonstrates lower FFT scores for emergency departments nationally and the Trust not an outlier. Inpatient FFT higher than national average.
Review of CDC and paediatric SLT who have small response rates and high negativity scores affecting Trust average
Launch of Trust You Said We Did for patient experience.

What is the expected impact?

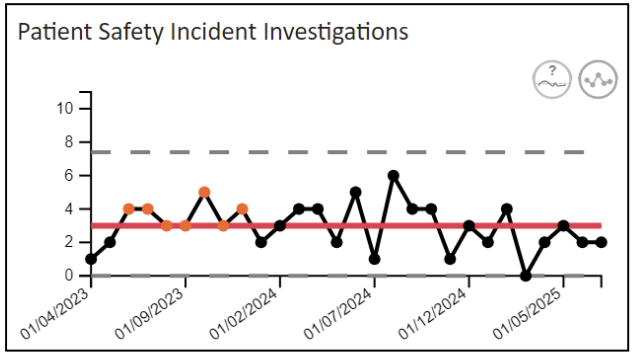
- FFT Positivity score above 95.
- Reduction of the number of formal complaints/concerns due to the PALS service.
- Patient flow through the hospital improves to reduce waiting time in UECC.

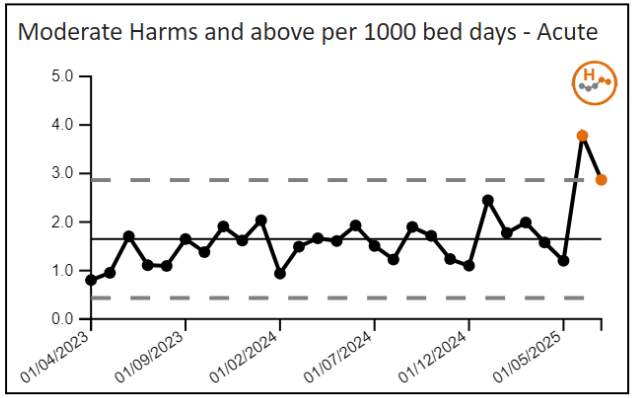
Potential risks to improvement?

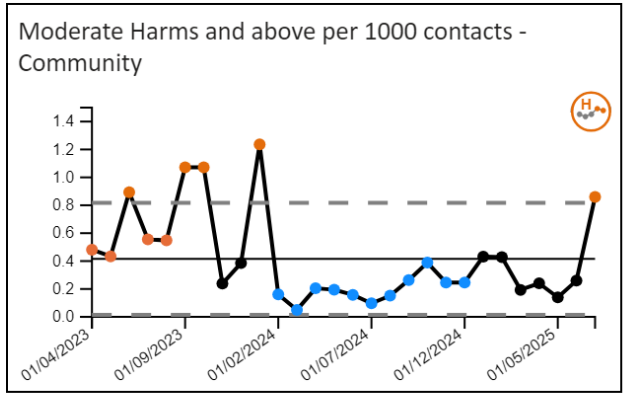
- Opportunity to review and make necessary improvements to patient experience

Subtheme: Care Incidents (1)

Data, Context and Explanation







- Patient Safety Incident Investigations are completed when a patient has been involved in a moderate harm incident and significant learning identified. Number of PSII remain consistent per month.
- The updated Patient Safety Incident Response plan now provides clear guidance on what the national criteria is for PSII and the Trust guidance for the type of incident response required when a patient safety incident occurs.
- There were 2 locally mandated PSII for July 2025.
- All moderate harm and above incidents are discussed at the Incident Review Group to determine what level of investigation is required and what immediate actions need to be taken.
- Due to the implementation of the > 104 day cancer harm incidents being reviewed at the Harm Free Panel, there were a number of previously unreported cases added to the Datix system which is shown in the numbers for acute harms in July.

Metric	Target	Value	Exec Lead	Ops Lead
Patient Safety Incident Investigations	3	2	Helen Dobson	Victoria Hazeldine
Moderate Harms and above per 1000 bed days - Acute	-	2.9	Helen Dobson	Victoria Hazeldine
Moderate Harms and above per 1000 contacts - Community	-	0.9	Helen Dobson	Victoria Hazeldine

What actions are planned?

- All >104 day cancer pathway harm incidents are now reported as no harm unless at the Harm Free Care Panel there is an indication of the harm rating needing to be increased
- Quality Governance and Assurance Team have commenced co-ordination and investigation of all PSIIs (with the exception of CG3) from July 2025.

What is the expected impact?

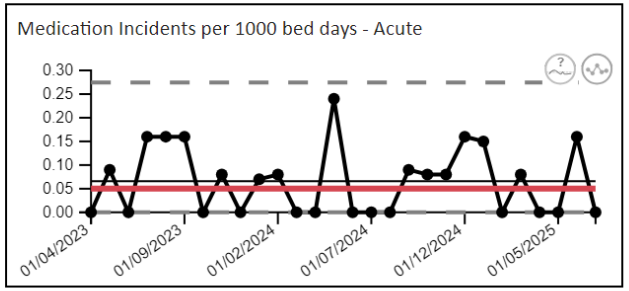
- Stabilisation of PSII's with adequate evidence of shared learning.
- An established working group will identify any key actions and potential risks.

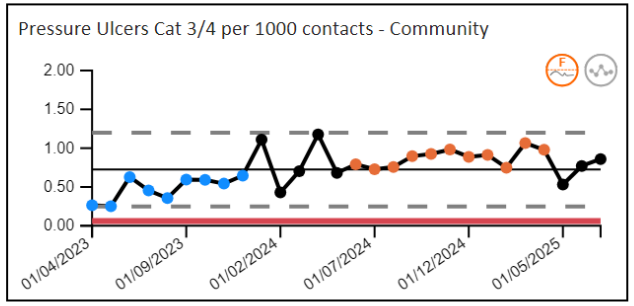
Potential risks to improvement?

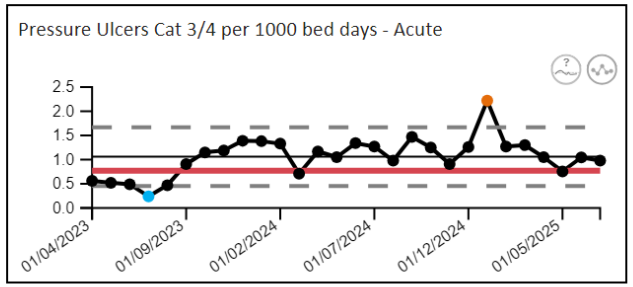
- Current capacity issue within Tissue Viability team which will mean a potential impact on Quality

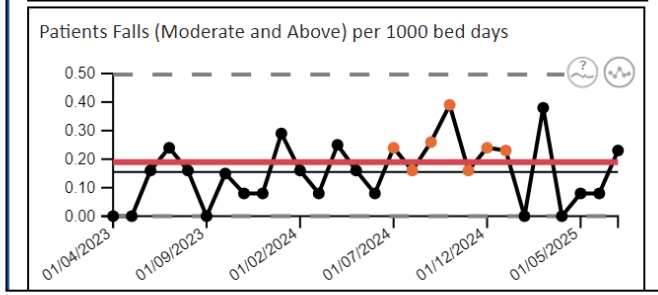
Subtheme: Care Incidents (2)

Data, Context and Explanation









- Medication incidents in Acute remain in common cause.
- Pressure ulcers (PU) remain a concern and are considered, the main, an avoidable harm associated with healthcare delivery. The rate of PU in Acute remains in common cause, however in Community the PU rate has shown a deterioration with an increased rate of PU.
- The reported Cat 3 and 4 are all reviewed and graded by Tissue Viability, some are downgraded when assessed even though this assessment work has shown an improvement in initial grading by the community staff.
- Pressure Ulcer Identification Tool audit has demonstrated improved compliance.
- The number of patient falls at moderate harm remains consistent.
- The patients who suffered a moderate harm due to a fall were all reviewed and discussed at incident review group.

Metric	Target	Value	Exec Lead	Ops Lead
Medication Incidents per 1000 bed days - Acute	0.1	0.0	Jo Beahan	Victoria Hazeldine
Pressure Ulcers Cat 3/4 per 1000 contacts - Community	0.1	0.9	Helen Dobson	Victoria Hazeldine
Pressure Ulcers Cat 3/4 per 1000 bed days - Acute	0.8	1.0	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.2	0.2	Helen Dobson	Victoria Hazeldine

What actions are planned?

- Medication incidents at moderate harm and above remain low, incidents related to critical medication have been identified and will be presented at the next Medication Safety Committee.
- The trust has completed the implementation plan to come into line with the National Guidance of having only Category 1, 2, 3 and 4.
- There is a joint review of beds and mattresses led by Head of Projects for TRFT and BHNFT – with a proposal of procurement opportunities to be presented to the trust in October 2025.
- The newly recruited Falls Prevention Lead will contribute to QI projects and falls prevention education to help reduce the total number of all falls and moderate harm falls.

What is the expected impact?

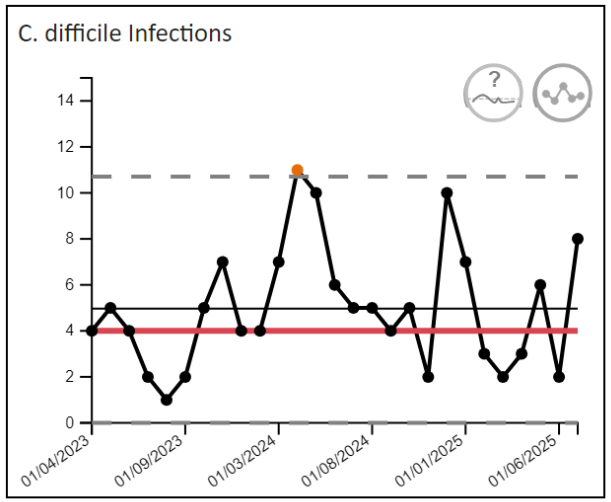
- Reduction in the number of critical medication incidents.
- Converting to hybrid mattresses will mean that patients requiring pressure relieving equipment will have it immediately and reduce the incidence of PU's.
- Reduction in the total number of falls.
- Key themes identified from moderate harm falls will drive a Qi initiative.

Potential risks to improvement?

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

Subtheme: Infection Prevention & Control

Data, Context and Explanation



- Clostridium difficile infection (CDI) is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It can usually be treated with a different type of antibiotic.
- The 25/26 trajectory has been set at 44.
- All cases of CDI are reviewed at the monthly harm free care panel. The emerging themes are linked to timely sampling, antimicrobial stewardship and prescribing practices.
- Action are in place to address (see planned action box).
- Plans to include E-Coli monitoring in future reports.

Metric	Target	Value	Exec Lead	Ops Lead
C. difficile Infections	4	8	Helen Dobson	Jen Hilton

What actions are planned?

- Monthly Harm Free panel continues with shared learning on timely stool sampling and antibiotic prescribing main themes.
- Launch of SY SIGHT campaign to promote good hygiene practices
- Antimicrobial prescribing Quality Priority for 25/26 – launch of Stop, Switch, Continue Campaign
- Grand round for findings of sepsis audit and recommendations (blood culture sampling and timely administration of IV antibiotics)

What is the expected impact?

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

Potential risks to improvement?

- National patterns of increases in rates of CDI
- Antibiotic prescribing practices in primary care for ‘admission avoidance’
- Deep clean programme schedule

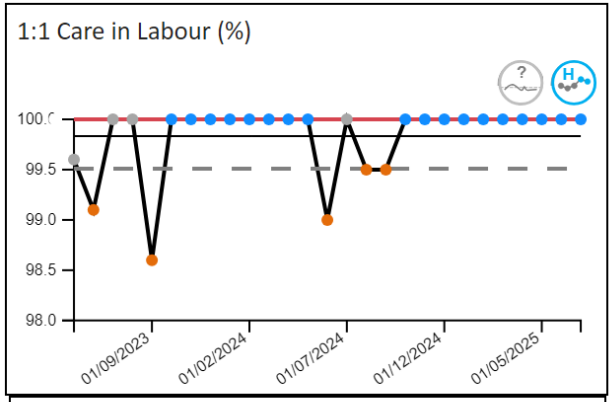
Maternity

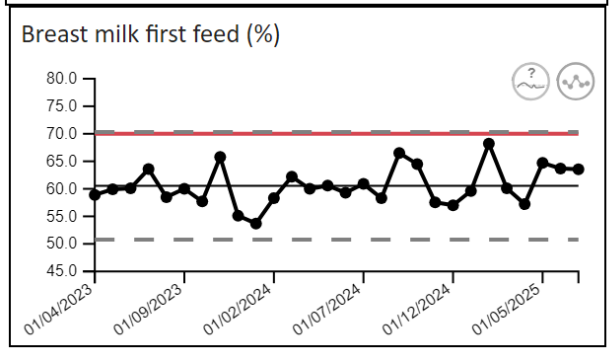
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	100.0	Jul-25	☑	?	H	-	G
Breast milk first feed (%)	70.0	63.6	Jul-25	☒	?			S
Number of Stillbirths	0	1	Jul-25	☒	?		-	S
3rd and 4th degree tears - All	-	2	Jul-25					S
Massive PPH	-	5	Jul-25					S
Maternal Harm - Moderate and above Incidents (Harm Free)	-	0	Jul-25					S

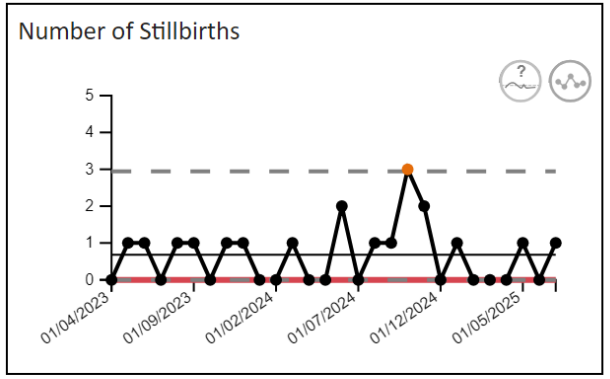
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Maternity

Data, Context and Explanation







- No concerns currently with 1:1 care in labour. (When there has been dips in the compliance this has been due to the baby being born before arrival).
- Breast Milk First Feed continues to be below the Trust target, and at 63.6 % against a Trust target of 70% in the month of July..
- In July 2025 1 stillbirth occurred in this month. Quarter 1 data 2025 for TRFT shows a stillbirth rate of 3.1 per 1000 births.
- National rates (Stabilised and adjusted) were:
  - 2022: 3.33/1000 births
  - 2023: 3.9/1000 births
  - 2024 data not yet available.
- Our Local stillbirth rates (Stabilised and adjusted) have also seen an increase from 2022 to 2024:
  - 2022: 2.68/1000 births MBRRACE data
  - 2023: 2.88/1000 births MBRRACE data
  - 2024: 3.66/100 births MBRRACE data

Metric	Target	Value	Exec Lead	Ops Lead
Number of Stillbirths	0	1	Helen Dobson	Sarah Petty
Breast milk first feed (%)	70.0	63.6	Helen Dobson	Sarah Petty
1:1 Care in Labour (%)	100.0	100.0	Helen Dobson	Sarah Petty

What actions are planned?

- **1:1 care in labour** – continue to monitor for variation.
- **Breast milk first feed** – Work is ongoing within the Greenoaks antenatal waiting area to speak to expectant mothers about the benefits of breastfeeding much earlier in pregnancy. Information videos are also to be played on waiting area TVs. The infant feeding Midwife will be presenting data from a thematic review of jaundice babies and babies re-admitted with feeding concerns at the clinical effectiveness meeting to share learning and develop further actions.
- **Stillbirth rate**: - The annual perinatal learning event is planned for later this year. This has been a successful learning event in previous years where all 2024 perinatal deaths will be reviewed again by a panel of internal and external experts. Any commonalities or themes will be highlighted.

What is the expected impact?

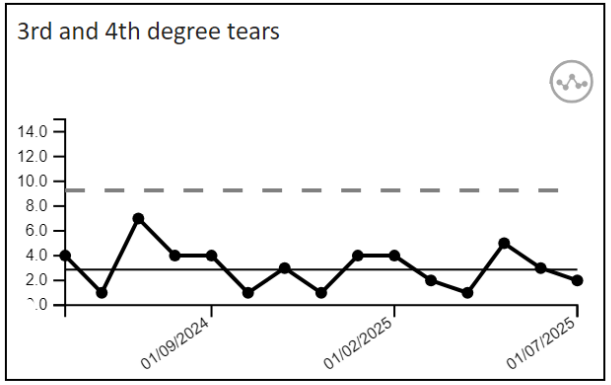
- Safety of women and babies will be maintained on labour ward
- Rates of first feed breastmilk will increase for all women who are cared for at TRFT.
- Learning from recently released reports and pending national recommendations will inform the work undertaken at TRFT to monitor, learn and improve services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

Potential risks to improvement?

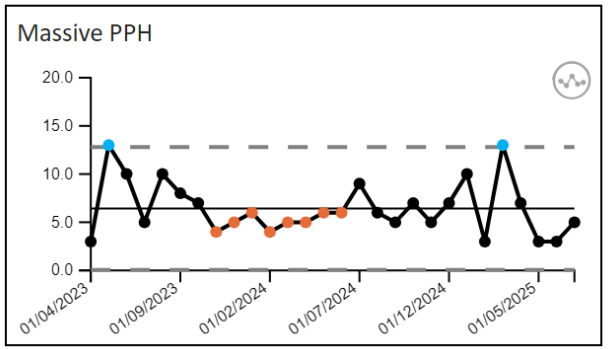
- If staffing levels were not maintained, 1 to 1 care in labour may be impacted.
- Lack of focus on public health work streams for pregnant women. Women are often disadvantage within the Rotherham's birthing population. TRFT maternity need to maintain focus on the health promotional needs of all women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

Subtheme: Maternity - Maternal Harms

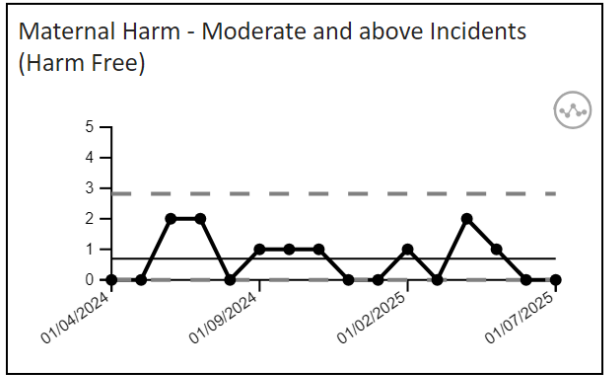
Data, Context and Explanation



3rd and 4th degree tears have an MDT review to ensure that all care was appropriate. In the month of July, 2 cases were noted. Any learning from reviews is shared via learning points and newsletters as required. All cases that were reviewed in this month were found to have received appropriate care.



Post Partum Haemorrhage (PPH) over 1500mls – July's data shows a rate of 2.1% (5 cases) against a Target of 2% of all births. A thematic review continues and the learning is shared via Trust Safety Panel, Safety Champion meetings and labour ward forum. OBS:UK study continues.



In July 0 cases remained moderate following MDT review.

Metric	Target	Value	Exec Lead	Ops Lead
Maternal Harm - Moderate and above Incidents (Harm Free)	-	0	Helen Dobson	Sarah Petty
Massive PPH	-	5	Helen Dobson	Sarah Petty
3rd and 4th degree tears	-	2	Helen Dobson	Sarah Petty

What actions are planned?

- Dashboards with the trends and themes are shared via governance meetings, safety champion meetings and labour ward forums for discussion.
- Actions identified for any learning from the MDT review of moderate harms is added to datix.
- Learning from the review of any cases and good care identified is shared via the maternity newsletter and learning points in each areas.

What is the expected impact?

- That by utilising the PSIRF model the teams will have an awareness of any commonalities, trends or themes. Actions will then be proportionate to the problem.

Potential risks to improvement?

- Maintaining safe staffing levels to ensure that women get the most appropriate care with the most appropriate staff member.
- Ensure that learning from any case reviews is shared via maternity mast sessions.
- Number of staff trained in PSIRF.

Performance Matrix Summary – Finance and Performance (standard view)

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** • 52+ weeks – CYP • 52+ weeks • Patients waiting < 18wks for 1st OP Apt • Bed Occupancy • Patients on VW	**CONCERNING: CELEBRATE BUT TAKE ACTION** • Average time to be Seen • Discharges before 5pm
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • Clinic Utilisation – Elective and 2ww • Mean LoS (Non-Elective) • Urgent 2 Hour Response	**STATIC: INVESTIGATE AND UNDERSTAND** • Waiting List Size • RTT • OP to PIFU • 31 Day Treatment • 62 Day Treatment • FDS • 4hr Performance • Avg Amb Handover Time • >12 hours in A&E • 12hr Trolley Waits • Bed Occupancy • LoS >21 Days • DM01 • Discharge Ready Date • DNA (%) • *LOS > 7 Days • *Mean LOS (elective) • *A&E Attendances from Care Homes • *Admissions from Care Homes • *Ambulance Handovers >45 mins (%)	**CONCERNING: INVESTIGATE & TAKE ACTION** • Criteria to Reside is No • Capped Theatres Utilisation
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

Performance Matrix Summary – Finance and Performance (for review)

The Rotherham NHS Foundation Trust

DRAFT

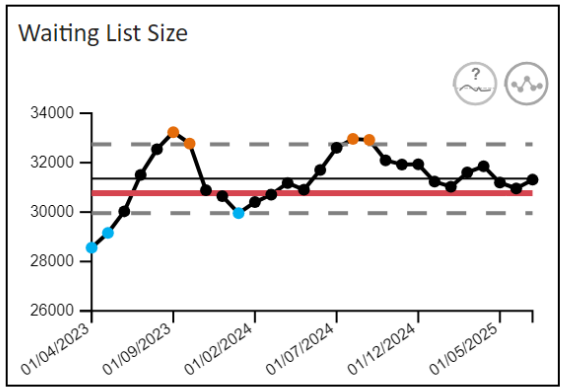
Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail	Assurance: No Target
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE**	**GOOD: CELEBRATE AND UNDERSTAND** • 52+ weeks – CYP • 52+ weeks • Patients waiting < 18wks for 1st OP • Bed Occupancy • Patients on VW	**CONCERNING: CELEBRATE BUT TAKE ACTION** • Average time to be Seen • Discharges before 5pm	**GOOD: INVESTIGATE AND CELEBRATE**
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • Clinic Utilisation – Elective and 2ww • Mean LoS (Non-Elective) • Urgent 2 Hour Response	**STATIC: INVESTIGATE AND UNDERSTAND** • Waiting List Size • RTT • OP to PIFU • 31 Day Treatment • 62 Day Treatment • FDS • 4hr Performance • Avg Amb Handover • >12 hours in A&E • Discharge Ready Date • DNA (%) • 12hr Trolley Waits • Bed Occupancy • LoS >21 Days • DM01 • Ambulance Handovers >45 mins (%)	**CONCERNING: INVESTIGATE & TAKE ACTION** • Criteria to Reside is No • Capped Theatres Utilisation	**STATIC: INVESTIGATE AND UNDERSTAND** • LOS > 7 Days • Mean LOS (elective) • A&E Attendances from Care Homes • Admissions from Care Homes
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**	**CONCERNING: INVESTIGATE AND TAKE ACTION**

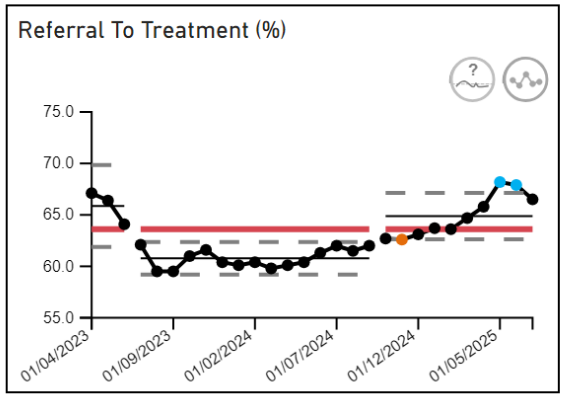
Elective Care and Cancer

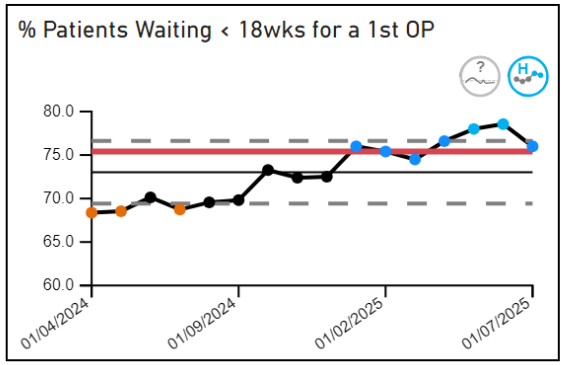
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	30,764	31,310	Jul-25	✗	?			S
Referral To Treatment (%)	64	66.5	Jul-25	✓	?			S
Number of 52+ Weeks	723	599	Jul-25	✓	?	L		G
Number of 52+ Weeks - CYP	50	44	Jul-25	✓	?	L		G
% Patients Waiting < 18 Wks for 1st OP	75.4	76	Jul-25	✓	?	H	-	G
OP Activity moved or Discharged to PIFU (%)	2.97	2.90	Jul-25	✗	?			S
DM01 (%)	1.0	0.8	Jul-25	✓	?			S
Faster Diagnosis Standard (%)	80.0	78.0	Jun-25	✗	?			S
31 Day Treatment Standard (%)	96.0	97.3	Jun-25	✓	?			S
62 Day Treatment Standard (%)	77.0	67.6	Jun-25	✗	?			S

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

Subtheme: Waitlist & RTT







Data, Context and Explanation

- Following a period of operational pressure over winter, which impacted on our ability to increase activity, and saw growth in the waiting list, we had started to see the waiting list reduce, however, the impact of industrial action (IA) and the holiday season has seen the waiting list increase in July, to 31,310. June saw 7,580 new patient pathways commenced, with only 7,152 ending.
- In addition, we saw a further decrease in RTT Standard performance, with the Trust achieving 66.5% in July 2025 compared to 67.9% in June. This is due to ongoing validation of the waiting list, IA and reduced activity due to the holiday season. Despite the decrease, the Trust achieved the trajectory for July.
- The RTT standard was achieved across several specialties, including Geriatric Medicine, Clinical Haematology, Paediatrics, and Paediatric Cardiology. However, Respiratory, General Medicine and Ophthalmology did not achieve the RTT Standard in July.
- 76% of patients waited less than 18 weeks for a first outpatient appointment in July 2025, which is above the target of 75.4%.

What are the key changes/impacts?

- A national validation sprint was completed for Q1, resulting in an increase of patients waiting <18 weeks being removed form the waiting list, which led to a decrease in RTT performance, however, there was a positive reduction in the waiting list.
- A second validation sprint has commenced with a similar impact, however with IA and reduced capacity due to the holiday season July saw the waiting list increase by 352.

Metric	Target	Value	Exec Lead	Ops Lead
Waiting List Size	30,764	31,310	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	63.6	66.5	Sally Kilgariff	Andrea Squires
% Patients Waiting < 18wks for a 1st OP	75.4	76.0	Sally Kilgariff	Andrea Squires

What actions are planned?

Focus on Pre-operative Assessment:

- Continue roll-out of electronic triage (now live in ENT, OMFS, MEOC) with next step of making scores visible on PowerBI, enabling better prioritisation and efficient use of clinic and theatre capacity.
- Adjust appointment slots based on triage scores, ensuring low-scoring patients have shorter or remote appointments, releasing face-to-face capacity for higher-need patients.
- Discontinue routine swabbing for all patients (approved by IPC and consultants) with rollout from September, reducing unnecessary steps and freeing up pre-assessment capacity ahead of procedures.
- Meeting held with Warrington Hospital to share good practice around Super Clinics to support Gynaecology to trial a new outpatient model to increase capacity. Further discussions taking place in the service on next steps

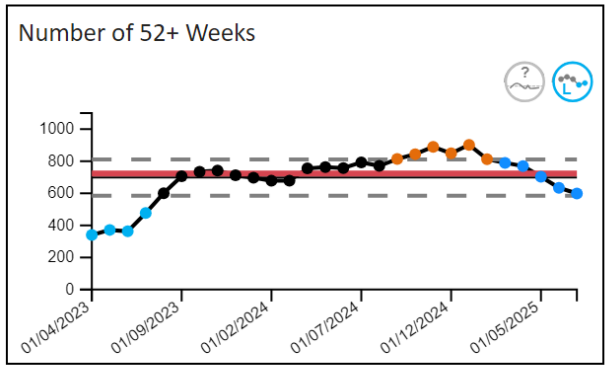
What is the expected impact?

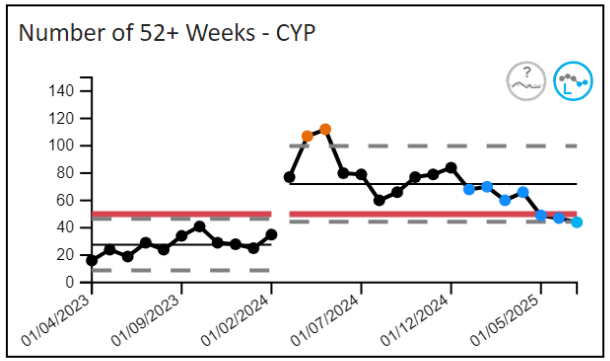
- Improved prioritisation of patients, quicker identification of those requiring urgent treatment, and more efficient utilisation of theatre and pre-op capacity to reduce RTT breaches.
- Creates additional capacity by shortening or moving low-complexity appointments to virtual, enabling more high-priority patients to be seen sooner and reducing backlog pressure.
- Frees up staff time and pre-assessment resources, shortens the pathway for patients, and helps avoid unnecessary delays to treatment.

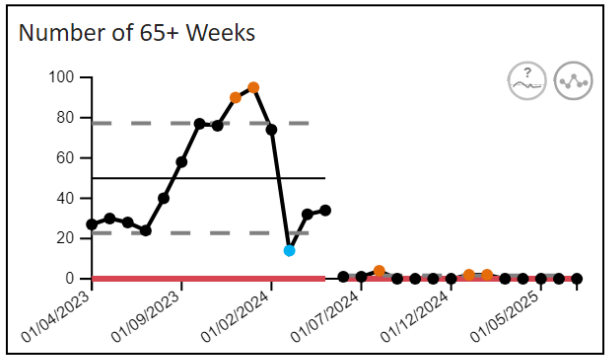
Potential risks to improvement?

- Operational pressures (e.g. HDU capacity, elective demand) may delay planned actions
- Waiting list additions continue to exceed removals
- Potential impact of increased validation may adversely impact RTT due to removals below 18 weeks and may uncover further long waits
- Further risk of industrial action may impact on ability to deliver elective activity

Subtheme: Long Waiters







Data, Context and Explanation

- The Trust had committed to reducing the number of patients waiting over 52 weeks to 723 in July 2025. We achieved this ambition, with 599 patients waiting for treatment over 52 weeks. The Trust remains in second quartile nationally.
- The number of patients waiting more than 52 weeks for treatment continued to reduce, with a reduction of 35 in July. Challenges remain with patients waiting over 52 weeks in OMFS, Gynaecology, T&O, and General Surgery. Insourcing and outsourcing options continue to be prioritised for these specialties.
- The Trust had committed to reducing the number of children and young people waiting over 52 weeks to 50 in July 2025. We achieved this ambition, with 44 CYP waiting.
- NHSE have set a target of no more than 1% of patients wait longer than 52 weeks for treatment. 2.05% of patients waited longer than 52 weeks in June 2025, this reduced to 1.9% in July 2025. Plans are in place to reduce this in line with the agreed trajectory.

What are the key changes/impacts?

- The steady reduction being seen in all long waiters are an impact of a number of initiatives over the last year, including the recent validation sprint but also improved theatre utilisation and outpatient productivity i.e. reduced DNAs, GIRFT Faster further ect

Metric	Target	Value	Exec Lead	Ops Lead
Number of 52+ Weeks	723	599	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks - CYP	50	44	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	0	0	Sally Kilgariff	Andrea Squires

What actions are planned?

- Expand electronic triage and link scores to PowerBI – enables earlier identification and prioritisation of long-waiting patients requiring treatment, ensuring they are booked sooner.
- Introduce appointment slot changes based on triage scores – frees up face-to-face capacity so that higher complexity and long-waiting patients can be scheduled earlier.
- Run GIRFT-led workshop with schedulers – refine pre-assessment booking to reduce bottlenecks, ensuring long waiters progress smoothly to theatre without further delay.
- Specialty recovery plans to be presented at Elective Delivery Group

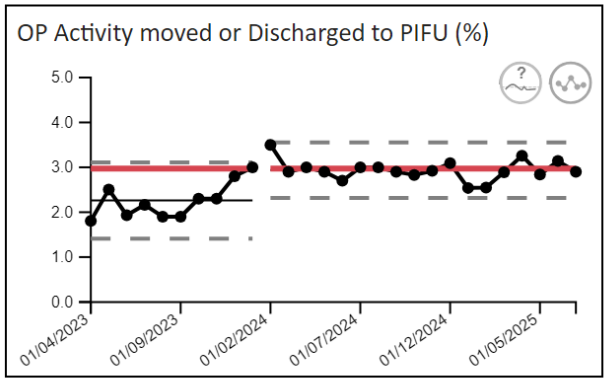
What is the expected impact?

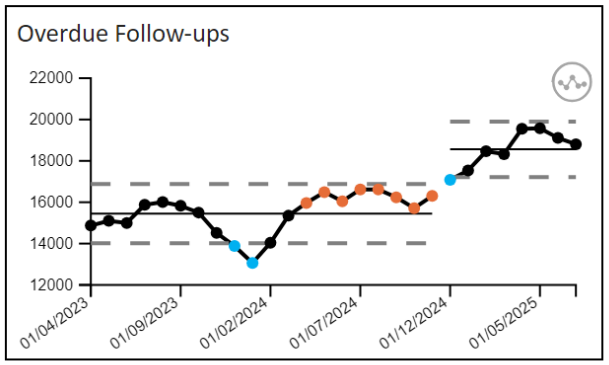
- Long-waiting patients can be flagged earlier and prioritised more effectively, reducing risk of further delay and ensuring the longest waiters are brought forward for treatment.
- Increases pre-op and theatre capacity for complex or higher-need patients, creating space to treat more long waiters sooner.
- Streamlined pre-assessment booking process minimises delays and last-minute cancellations, helping to move long waiters through the pathway more quickly into theatre.

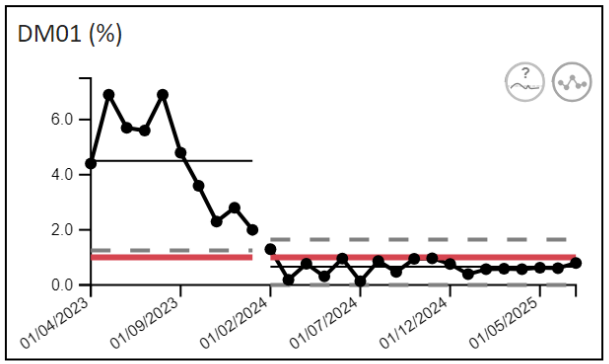
Potential risks to improvement?

- Operational pressures (e.g. HDU capacity, elective demand) may delay planned actions
- Waiting list additions continue to exceed removals
- Potential impact of increased validation may adversely impact RTT due to removals below 18 weeks and may uncover further long waits
- Further risk of industrial action may impact on ability to deliver elective activity

Subtheme: Diagnostics & Follow-ups







Data, Context and Explanation

- The Trust has a target of 2.97% for the number of patients moved to PIFU in July 2025 and achieved this target with performance of 2.9%. The Trust is part of a NHSE working group which aims to pilot a 'PIFU as Standard' model. This work is progressing across 2 specialties initially (ENT and Gastroenterology), before being rolled out more widely.
- The total number of patients waiting for follow up appointments reduced from 19,114 in June to 18,806 (reduction of 308) in July 2025.
- The Trust continues to exceed the DM01 standard in July 2025, also achieving its internal ambition to maintain performance at 99% for 25/26. The Trust has maintained this achievement since May 2024.

What are the key changes/impacts?

- Increased outpatient activity has been supported using new model – Super Clinics in ENT, OMFS and Urology. This is having a positive impact on reducing waits for a first outpatient appointment, as well as reducing the number of patients waiting for a follow-up appointment

Metric	Target	Value	Exec Lead	Ops Lead
OP Activity moved or Discharged to PIFU (%)	2.97	2.9	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	-	18,806	Sally Kilgariff	Andrea Squires
DM01 (%)	1.0	0.8	Sally Kilgariff	Andrea Squires

What actions are planned?

- Implementation of reviewed clinic templates in ENT and OMFS, delivering an additional 1,190 new appointments and 1,455 follow-up appointments.
- Commence Stage 1 clerical (admin) validation of 4,000 overdue and DNA follow-up records, with results to inform next steps (bulk closure, wider clerical validation, or clinical protocol validation).
- Ongoing weekly on-site GIRFT support for service managers, with focus on demand management and establishing Super Clinics (including sharing best practice with Warrington to support Gynaecology).
- Begin embedding Patient Initiated Follow-Up (PIFU) pathways in Gastroenterology and ENT to sustainably reduce follow-up demand.

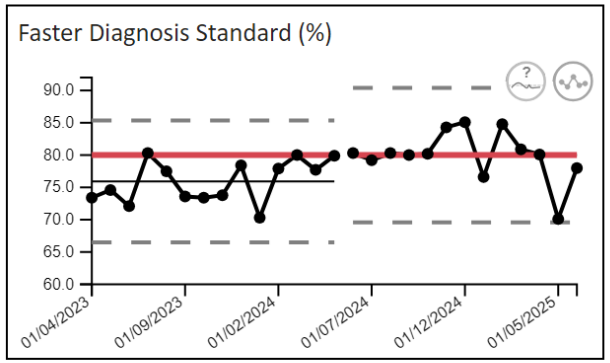
What is the expected impact?

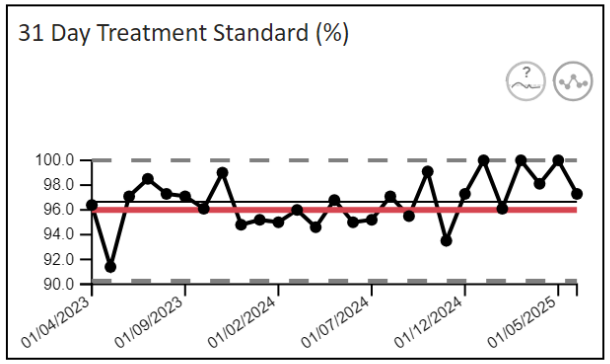
- Immediate increase in outpatient throughput, reduction in backlog, and improved patient access to both new and follow-up appointments.
- Cleanses the follow-up waiting list, identifies patients who no longer require appointments, and informs whether bulk closure, further clerical validation, or clinical validation is needed.
- Improved efficiency in managing demand, ability to see higher volumes of patients in fewer sessions, and adoption of best practice models to reduce outpatient delays.
- Long-term reduction in follow-up demand, empowering patients to trigger appointments when clinically needed, reducing unnecessary routine follow-ups.

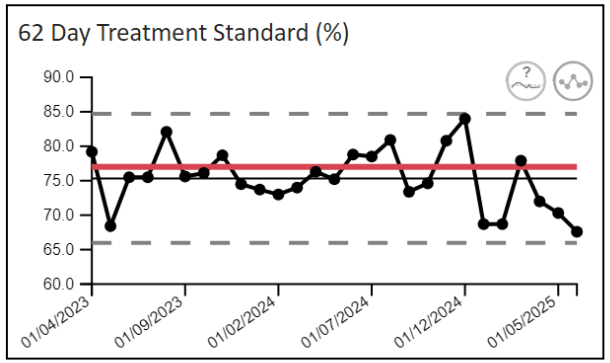
Potential risks to improvement?

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

Subtheme: Cancer







Data, Context and Explanation

- In June 2025, the Trust target was to achieve 80% against the 28-day Faster Diagnosis Standard (77% national standard). Though we did see strong improvement, we did not achieve this ambition with performance of 78%. This relates to the booking delays seen in endoscopy in May, impacting on the Lower and Upper GI pathways. A robust recovery plan is in place, and we expect to recover by July 2025.
- The 31-day standard was achieved, and delivery of the 96% target has been sustained for 8 consecutive months now.
- The 2025/26 national planning guidance has set the objective to improve the 62-day performance to 75%, and the Trust has a system target of 77%. Unfortunately, we did not achieve this standard in June due to delays in the LGI, Gynaecology and Urology pathways. Limited Theatre capacity and availability of HDU beds continued to impact in June 2025.
- A full recovery plan is in place to recover the 62 day backlog by September 2025

What are the key changes/impacts?

- The FDS has been impacted in month by delays in the endoscopy booking process. Changes to endoscopy processes including ring fenced capacity has been put in place, and recovery is progressing well.

Metric	Target	Value	Exec Lead	Ops Lead
Faster Diagnosis Standard (%)	80.0	78.0	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	96.0	97.3	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	77.0	67.6	Sally Kilgariff	Andrea Squires

What actions are planned?

- Support Endoscopy insourcing (13/08/25 – 31/08/25) to maintain improved Lower GI and UGI FDS positions and create additional diagnostic capacity to reduce bottlenecks.
- Implement additional weekend activity – 2 extra lists per month for ENT/OMFS Head & Neck cases extended, and weekend sessions for Skin services (36 patients per session, Aug–Oct), subject to staffing.
- Stabilise workforce capacity – phased consultant return in Gynaecology (from 18/08/25) and locum consultant in Breast to restore clinic and theatre capacity.
- Operational plans in place to increase Urology clinic and theatre capacity

What is the expected impact?

- Protects recent FDS improvements in Lower GI and UGI, reduces diagnostic bottlenecks, and supports earlier pathway progression to improve future 62 Day performance.
- Creates extra capacity to clear backlogs, shortens time to first OPA (particularly for Skin, currently day 27), improves FDS compliance in August, and reduces risk of 62 Day breaches in September.
- Restores lost clinic and theatre capacity, supports recovery of Gynaecology FDS from September and 62 Day from October, and consolidates Breast performance following earlier consultant vacancy.
- Increases diagnostic and treatment throughput, and provides sustained improvement in both FDS and 62 Day performance into Q3.

Potential risks to improvement?

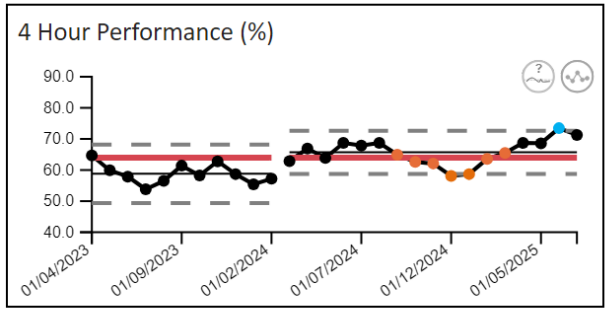
- Limited capacity in diagnostics, clinics, and workforce, particularly in urology, may constrain delivery of targeted interventions
- Operational pressures and emergency demand (e.g. HDU capacity for LGI) may delay planned actions
- Cancer Alliance funding for the Cancer Service Improvement Team has not been secured for 2025/26, reducing the capacity to support delivery of planned improvements
- Increasing treatment capacity to reduce the backlog of patients waiting over 62-days will result in a higher submission of breaches, which will have a negative impact on performance
- Further risk of industrial action may impact on ability to deliver theatre capacity

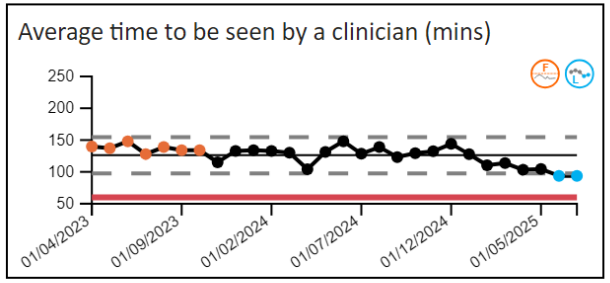
Non-elective and Flow

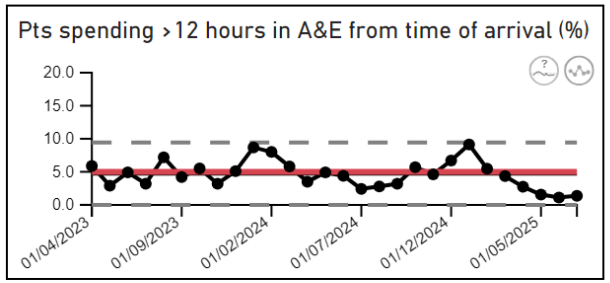
Metric	Trust Target	Latest Data	Period	Achieved (in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	66.0	71.3	Jul-25	☑	?			S
Average Ambulance Handover Time (Mins)	18:31	17:24	Jul-25	☑	?		-	S
Ambulance Handovers > 45 mins (%)	0	2.8	Jul-25					S
Average time to be seen by a clinician (mins)	60.0	93.8	Jul-25	☒	F	L		C
Patients spending >12 hours in A&E from time of arrival (%)	5	1.3	Jul-25	☑	?			S
12hr Trolley Waits	0	17	Jul-25	☒	?			S
Bed Occupancy (%)	92.0	87.9	Jul-25	☑	?			S
Length of Stay over 21 Days	64	42	Jul-25	☑	?		-	S
Patients where Date of Discharge = Discharge Ready Date (%)	83.0	80.9	May-25	☒	?			S
Criteria to Reside is No (%)	10.0	19.1	Jul-25	☒	F		-	C

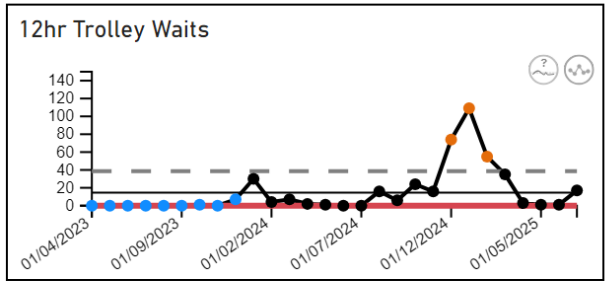
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Emergency Care - Waiting Times









Data, Context and Explanation

- National guidance for 25/26 sets an objective for all Trusts to achieve the 4 hour performance standard of 78%. The trust has a trajectory to deliver this by March 26, which continues to be achieved. We are currently exceeding this trajectory, with performance of 71.3% against 66% in July 2025.
- Average time to see a clinician is reducing which remains consistent in month.
- The number of patients spending more than 12 hours in the department is a key national focus. We have successfully reduced the number of patients to 1.3 against a trajectory of 5 for July, which places the Trust in 10th position nationally.
- The Trust has committed to zero trolley waits in line with national guidance. However, July saw an increase due to operational flow challenges, as well as an increase in the number of patients awaiting Mental Health Admission with our Mental Health partners.

What are the ley changes/impacts?

The 4 hour improvement plan is driving improvements across all key UEC performance metrics, enabling the service to delivery planned trajectories for 2025/26.

Metric	Target	Value	Exec Lead	Ops Lead
4 Hour Performance (%)	66.0	71.3	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	60.0	93.8	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	5.0	1.4	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	0	17	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Bed reconfiguration for Care Group 1 to be implemented from September which will support capacity and flow at peak times
- Workforce - 1 specialty doctor and 2 Senior clinical fellows to commence September within Emergency Medicine
- Additional 3 Acute Medical Unit Consultants in post August/September which will support timely clerking of patients alongside provision of Senior Medical SDEC cover

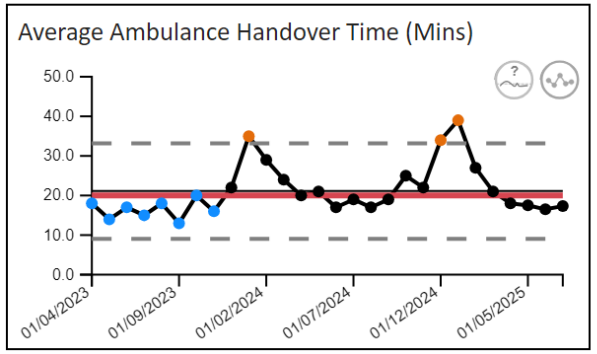
What is the expected impact?

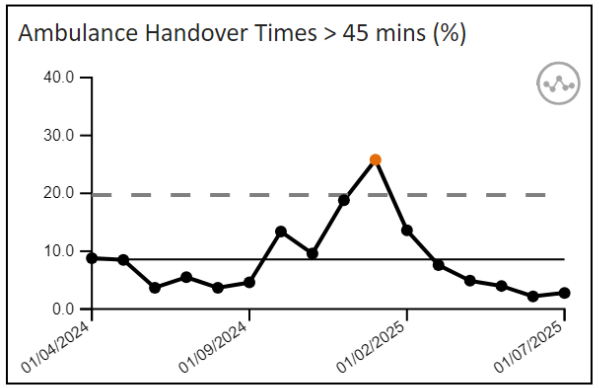
- Reduce delays waiting for admission to wards
- Reducing patients spend over 12 hours in the department
- Reduce the average time spent in the department by admitted patients
- Improvement in 4 hour performance
- Reduction in over crowding
- Empowerment of ward managers to support flow and patients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

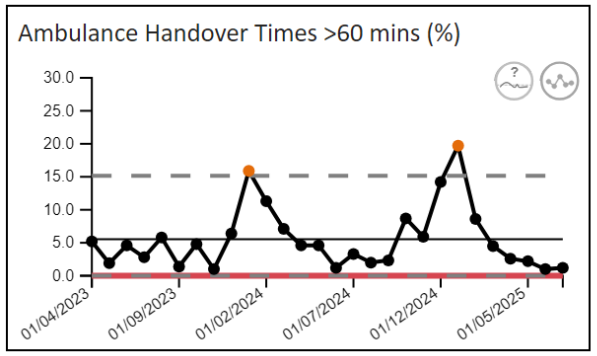
Potential risks to improvement?

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

Subtheme: Emergency Care - Ambulance







Data, Context and Explanation

- The Trust trajectory for Ambulance Handover is to meet 22 mins by March 26. We are currently exceeding the trajectory, with July performance of 17.3, against 18.3 minutes, focus will be to maintain this over the winter period.
- The Trust compliance with Ambulance handover times >30 minutes and > 60 minutes has significantly improved with consistent reduction seen since January 2025.
- National focus has moved to Ambulance Handover within 45 minutes. The Trust has implemented a number of actions to ensure delivery of this target going forwards. Currently performance in July was 2.8% (64 ambulances), against a target of 0.
- The longest ambulance handover delay was 1hr 54 mins due to no Trolleys available.

What are the key changes/impacts?

The trend around ambulance handover times has seen 4 months under 20 mins average. This is due to overall improvements in flow and capacity in department.

Metric	Target	Value	Exec Lead	Ops Lead
Average Ambulance Handover Time (Mins)	18.3	17:24	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times <15 mins (%)	65.0	50.8	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	0.0	1.2	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times > 45 mins (%)	-	2.8	Sally Kilgariff	Lesley Hammond

What actions are planned?

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

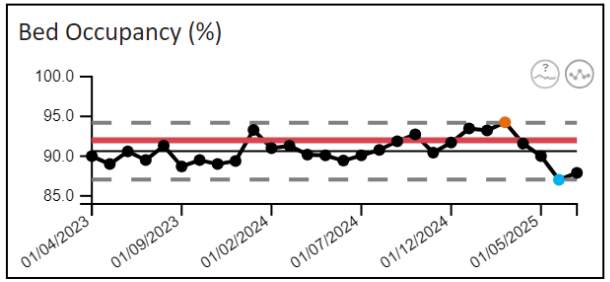
What is the expected impact?

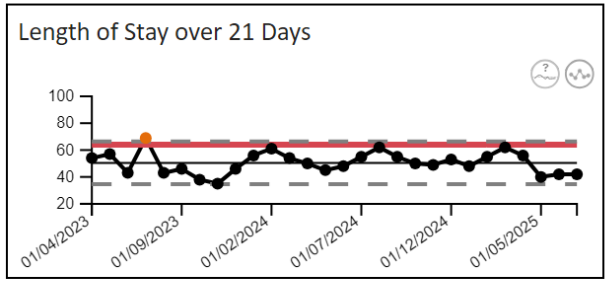
•There will be an improvement in ambulance handover times and TRFT sustained high levels of performance.
•Pilots will support reduction in conveyance to ensure all pathways in and out of hospital are utilised
•Patients seen by the right clinician at the right time in the right place first time

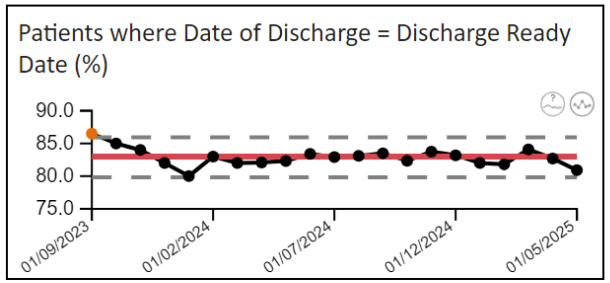
Potential risks to improvement?

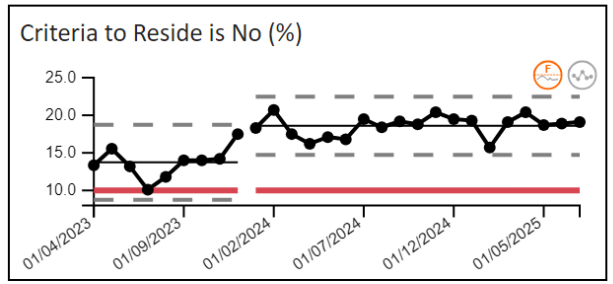
•High demand resulting in possible increase in ambulance attendances or batching of ambulances
•Ongoing demands for UEC services
•Peaks in demands for services
•Flow within the Trust/organisation and Place
• IPC challenges in relation to bed occupancy

Subtheme: Inpatient Flow









Data, Context and Explanation

- Bed occupancy for July is 87.9% this includes both core and escalation capacity in line with national reporting requirements. If the escalation beds were excluded General and Acute bed occupancy would be 90.27%. (B5 128.89% and SU 106.07%).
- 92% is recognised as optimum bed occupancy. It should be expected that we would see values fluctuate between 87% and 94% based on current patterns and Winter pressures.
- Criteria to Reside continues to fluctuate, showing natural variation between 22% and 14%, consistently not achieving the target of below 10%. Nationally there is variation in recording process, TRFT has been acknowledged via the regional team to be reporting accurately and work continues to focus on place-based collaboration to achieve a reduction.
- Length of stay >21 days remains in line with natural variation and achieving the target for the month

What are the key changes/impacts?

Improvements are being seen since additional oversight and ownership around LLOS has been introduced, increased frequency of reviews and senior nurse walk rounds are in place. To get patients in the right place at the right time being seen by the right clinician.

Metric	Target	Value	Exec Lead	Ops Lead
Bed Occupancy (%)	92.0	87.9	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	64	42	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	83.0	80.9	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	10.0	19.1	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Length of Stay meetings – Actions discussed in operational meeting with ward managers
- Focus on criteria to reside (C2R) and internal delays – Deep dive completed and learning taken
- Every minute matters week in July around C2R to focus on recording
- Board round standardisation across medical wards with support from Ward managers and Clinical Nursing lead for patient flow
- Pilot of discharge form for IDT

What is the expected impact?

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

Potential risks to improvement?

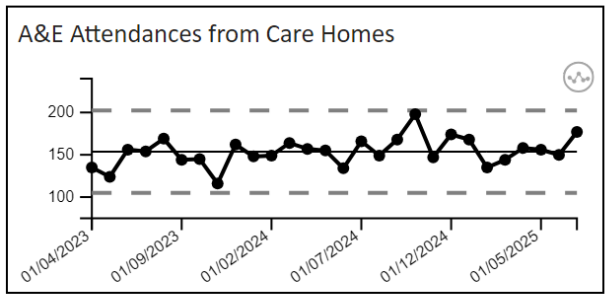
•Increase demand through UECC sustained
•Continued pressures across the system in health and social care and discharge delays become more frequent
•De-escalation of inpatient beds not possible due to ongoing pressures

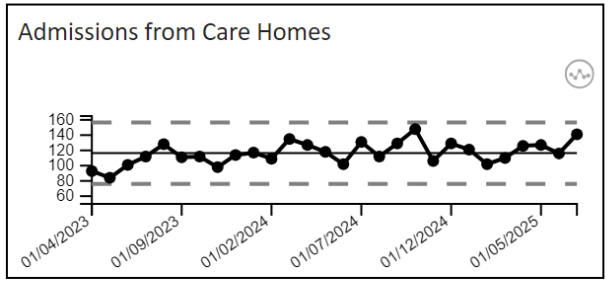
Community

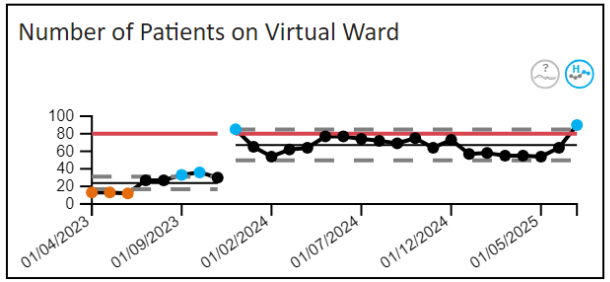
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	-	177	JuL-25		-		-	S
Admissions from Care Homes	-	141	JuL-25		-		-	S
Number of Patients on Virtual Ward	80	90	Jul-25	☑			-	G
Urgent 2 Hour Community Response (%)	70.0	85	May-25	☑			-	G

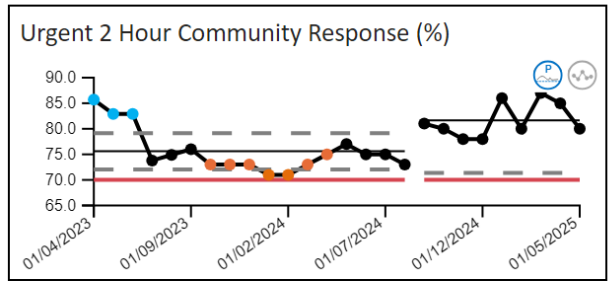
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Community









Data, Context and Explanation

- The Community Teams, including the Trusted Assessors, continue to in reach into the Acute setting to facilitate early supported discharges for care homes residents.
- Community Teams continue to work with YAS. YAS colleagues joined the TOCH early January, IDT are now part of the TOCH Team.
- The number of patients on Virtual Wards has increased in month. The average occupancy in July was 90%, a significant statistical increase from 63.8% last month, and above the 80% Trust trajectory.
- The National standard for the 2 hour urgent community response is 70% of appropriate referrals. Performance is now sustainable with July seeing 80% achievement.

What are the key changes/impacts?

- To optimise patient outcomes a cohort of heart failure patients are receiving specialist input from VW clinicians and all heart failure acute discharges are stepping down onto virtual ward, this approach is improving patient care and optimising occupancy.
- The new MSDEC model provides a streamlined direct referral process, with no requirement for triage, improving processes and interfaces with primary and secondary care.

Metric	Target	Value	Exec Lead	Ops Lead
A&E Attendances from Care Homes	-	177	Sally Kilgariff	Lesley Hammond
Admissions from Care Homes	-	141	Sally Kilgariff	Lesley Hammond
Number of Patients on Virtual Ward	80	90	Sally Kilgariff	Lesley Hammond
Urgent 2 Hour Community Response (%)	70.0	80.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Improve sickness and absence rates – Engagement Events & We Said, We Did feedback
- Improve step down admissions to virtual ward utilising heart failure pathways and improved MSDEC processes for more efficient interfaces
- Test remote technology with a small number of heart failure patients – on-track for go–live, training has taken place.
- The VW Acuity Tool is live on S1 & Power BI
- Live with Community Mobile X-Ray Pilot – continuing to promote

What is the expected impact?

- Reduce conveyance from Care Homes to UECC and admissions 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, utilising the Acuity Tool
- Continue to increase patient volumes and improve systems and processes, along with staff well-being.

Potential risks to improvement?

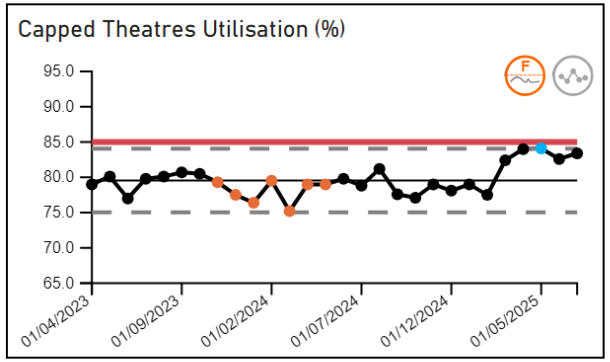
- Resource availability may impact on the ability to deliver improvement work.
- Workforce retention and wellbeing may impact on the ability to deliver improvement work

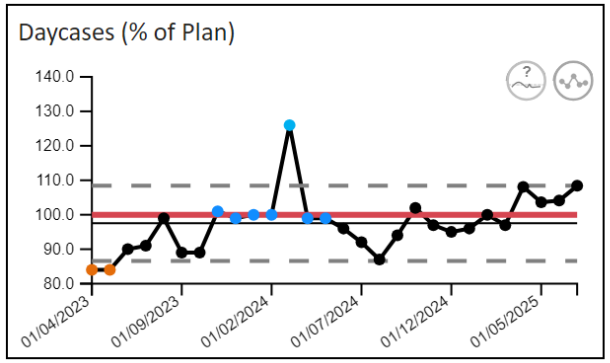
Productivity Priorities

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%) – Elective and 2WW	85.0	94.2	Jul-25	☑	P		-	G
Capped Theatres Utilisation (%)	85.0	83.4	Jul-25	☒	F			C
Did Not Attend (%)	7.0	6.8	Jul-25	☑	?			S
First Outpatients (% of Plan)	100	102.1	Jul-25	☑	?			S
Inpatients (% of Plan)	100	135.1	Jul-25	☑	?	H	-	G
Daycases (% of Plan)	100	108.4	Jul-25	☑	?		-	S
Length of Stay over 7 days	-	169	Jul-25	-	-		-	S
Mean Length of Stay (Non-elective)	6.8	4.9	Jul-25	☑	P			G
Mean Length of Stay (Elective excluding Daycases)	-	1.7	Jul-25	-	-			S
Discharged before 5pm (%)	70.0	67.9	Jul-25	☒	F	H		C

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

Subtheme: Theatres





Data, Context and Explanation

- National planning guidance has set a trajectory of 85% capped theatre utilisation (operating time of planned theatre sessions).
- Trust Capped Theatre Utilisation has improved month on month and is performing well above average. July saw performance of 83.4% against a target of 85%, further improvements are being progressed to achieve the 85% standard.
- Anaesthetic staffing sickness has continued through July with the loss of 13 sessions lost in month. This has also impacted trauma capacity, with resulting elective cancellations
- The Trust Daycase rate is 84.2% (Model Hospital Data) which is inline with the peer average, but below the 85% national target.

What are the key changes/impacts?

- Electronic Triage is now fully embedded with full time nursing assigned to task. Working well rolling out training to all nurses to ensure service is resilient
- Developing plan for self-assessment for LA patient
- Changes made to pre op telephone call to reduce cancellations on the day

Metric	Target	Value	Exec Lead	Ops Lead
Capped Theatres Utilisation (%)	85.0	83.4	Sally Kilgariff	Darren Howlett
Daycases (% of Plan)	100.0	108.4	Sally Kilgariff	Darren Howlett

What actions are planned?

- Theatre staffing paper to be approved by Care Group 2
- Increased anaesthetic SAS additional session payments for a 6-month period for uncovered theatre sessions
- Deep dive into cancellation on the day rates and mitigating actions implemented
- Continue to increase cases per list in Ophthalmology
- Reducing distribution of Octensian wash which is now only given to Orthopaedic Patients.
- Reduction in Bloods and Swabs has paused due to concerns within Infection Control team. This is being investigated further before progressing.

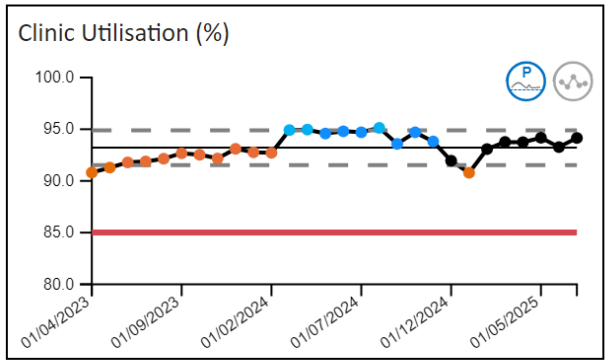
What is the expected impact?

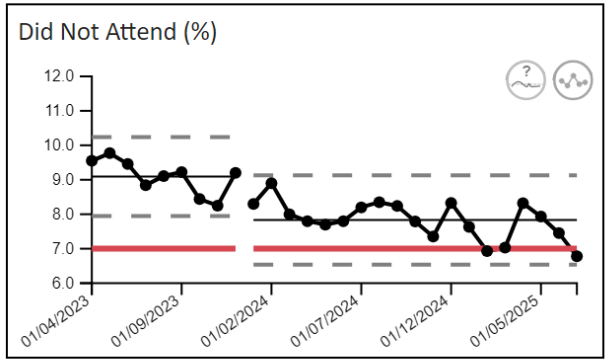
- Reduced gaps in emergency theatre will lead to less cancellations of extended trauma
- Reduced cancellation on the day rates
- Improved overall utilisation and avoidance of 65 week breaches
- Increased day case rate in Ophthalmology
- Cohesive on the day theatre co-ordination and management of sickness
- Implement HVLC lists in identified specialties including ENT and Urology in September

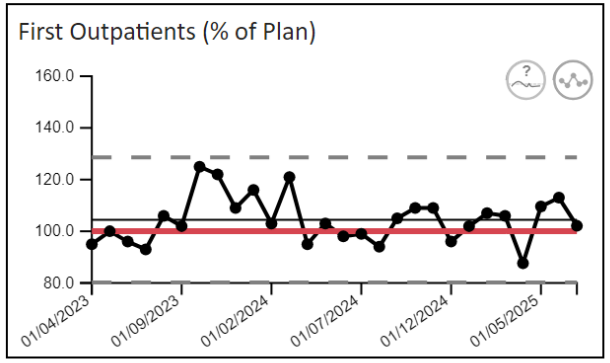
Potential risks to improvement?

- Anaesthetic challenges continue to impact on the ability to run theatre activity which significantly impacts all specialties, expected to have up to 8wte missing In August 2025
- Concerns within ENT theatre staffing
- Theatre staffing although improving with reduced sickness remains a concern

Subtheme: Outpatients







Data, Context and Explanation

- Clinic Utilisation is key to productivity and continues to be a key focus for the Trust. Clinic utilisation was 94.2% in July, an increase from 93.3% in June, and significantly above the 85% standard.
- Trust DNA rates have shown sustained improvement. Work is focused on meeting the needs of our local population when attending for outpatient appointments to improve attendance via digital reminders and targeted patient engagement with the use of AI DNA technology.
- The Further Faster programme (GIRFT) supports each speciality in addressing their own specific productivity challenges in relation to outpatients in line with the GIRFT handbooks. The Trust has received on site support from the GIRFT team to focus on our most challenged specialties (Orthopaedics, Gynaecology, General Surgery, OMFS and ENT).

What are the key changes/impacts?

- Clarity on booking rules and templates has enhanced booked utilisation towards full planned capacity
- Enhanced and targeted communication with specific patients to has reduced DNA rates
- Continued productivity gains from the above have enabled the positive delivery of the First Outpatients plan.

Metric	Target	Value	Exec Lead	Ops Lead
Clinic Utilisation (%)	85.0	94.2	Sally Kilgariff	Kevin Wilkinson
Did Not Attend (%)	7.0	6.8	Sally Kilgariff	Kevin Wilkinson
First Outpatients (% of Plan)	100.0	102.1	Sally Kilgariff	Kevin Wilkinson

What actions are planned?

- Increased capacity to deliver first outpatient appointments across numerous specialities to support activity levels are on-going. Funded via ERF.
- Development of PIFU module on Patient Hub to support management of patients in PIFU.
- Review Utilisation capacity and understand un-booked slots.
- Review data on discharged at 1st Appointment to understand where triage may have biggest impact.
- Triage process being improved to enable clinicians to discharge with Advice and Guidance
- Clinic templates review on going to standardise in line with GIRFT action
- DNA AI tool being tested in ENT. Plan to roll out wider upon completion of trial.

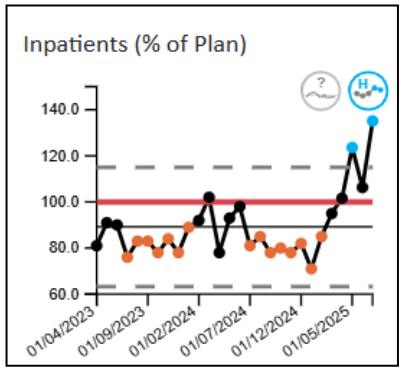
What is the expected impact?

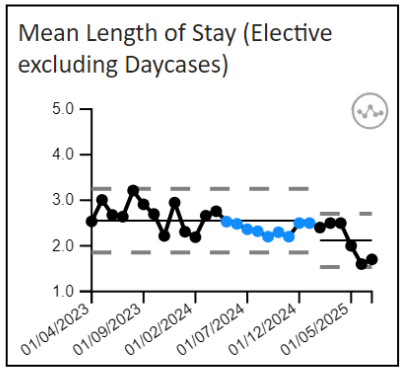
- Continued improvement of clinic utilisation into 2025/26.
- Sustained reduction in patients that DNA to 7% into 2025/26
- Sustained outpatient delivery at 100% into 2025/26.

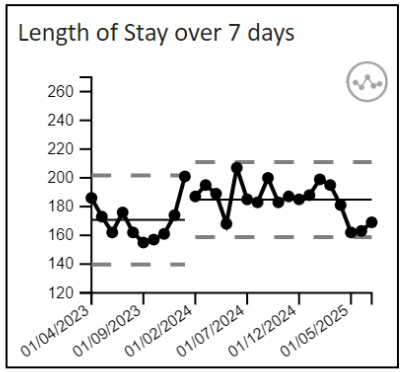
Potential risks to improvement?

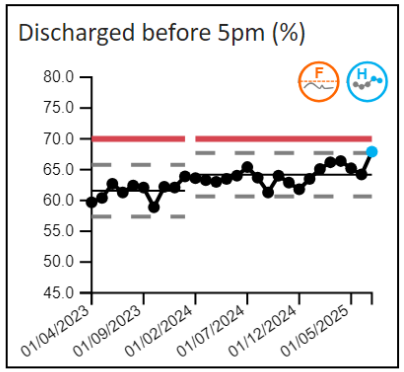
- Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
- Patient availability may impact on the ability to improve clinic utilisation, particularly short notice backfilled appointments.
- GP collective action and impact on referrals to specialities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

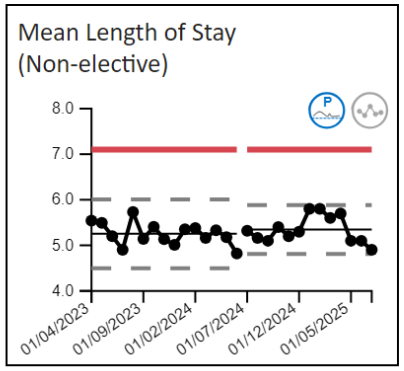
Subtheme: Inpatients











Data, Context and Explanation

- Inpatient % of plan is currently being delivered above plan, at 135.1% in July 2025.
- Mean length of stay for elective inpatients has shown an in month reduction, with July 2025 performance at 1.7 days.
- The number of patients with a LoS of 7+ days remains below the mean, and work continues to focus on getting patients to the right place and follow the home first approach.
- Patients discharged before 5pm is now reflecting a statistical improvement, with July performance of 67.9%, against target of 70%.
- Mean length of stay for Non-elective patients has remained below the target of 6.8 days, with July performance of 4.9 days.

What are the key changes/impacts?

- Increased focus on long length stay reviews and discharge at ward level is showing impact on length of stay and reducing number of long stay patients across 7, 14 and 21 days.

Metric	Target	Value	Exec Lead	Ops Lead
Inpatients (% of Plan)	100.0	135.1	Sally Kilgariff	Jodie Roberts
Length of Stay over 7 days	-	169	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	6.8	4.9	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	-	1.7	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	70.0	67.9	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Ongoing LLOS reviews focusing on patients not known to IDT and patients under 7days LOS
- Focus on Internal delays to reduce patients with no criteria to reside- pathway 0
- Focus on LOS in surgical specialities particularly elective patients
- Focus from PLACE partners to reduce number of complex patients with NCTR- pathways 1-3
- Bed reconfiguration
- Increased focus on discharges before 12pm
- Extended opening of community ready unit at weekend.

What is the expected impact?

- Increase number of patients discharged before 5pm to 70%
- Reduction of 7 day LOS patients
- Continued reduction in average LOS for elective inpatients
- Increased number of discharges before 5pm
- Bed Reconfiguration will introduce right size bed base and ensure flex / surge capacity.

Potential risks to improvement?

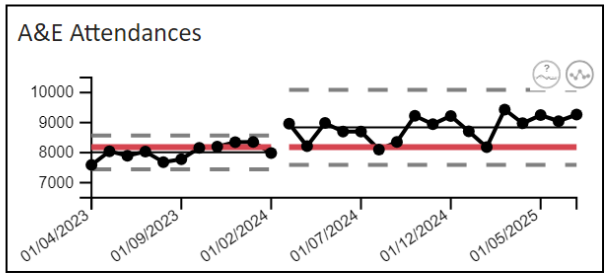
- Increased complexity of patients and availability of home care and bed based placements
- Increased number of beds open to deal with demand with limited medical support to support discharge planning
- Limited capacity in social care
- Ability for the CRU to manage significant increase in numbers and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

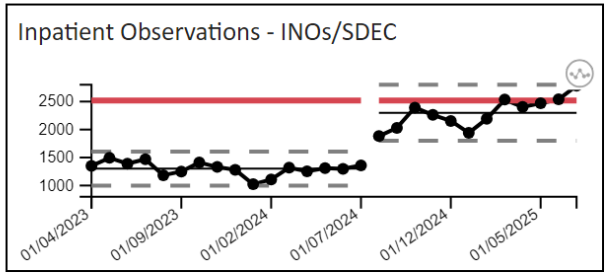
Activity

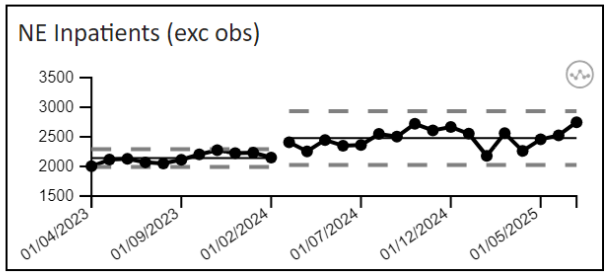
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances [Block]	8,661	9,048	Jul-25	-	?		-	S
Inpatient Observations – INOs/SDEC [Block]		2,532	Jul-25	-	-		-	S
Non-Elective Inpatients [Block]	-	2,730	Jul-25	-	-		-	S
Outpatients Follow Up - Attendances [Block]		15,817	Jul-25	-	?	H	-	C
Daycases [ERF]	2,124	2,301	Jul-25	-	?		-	S
Inpatients - Electives [ERF]	317	428	Jul-25	-	?	H	-	G
Outpatients New - Attendances [ERF]	6,838	6,982	Jul-25	-	?		-	S
Outpatient Procedures - New and Follow Up [ERF]	6,633	6,109	Jul-25	-	?	H	-	G
Referrals [Outpatient Demand]	-	8,808	Jul-25	-	-		-	S
2ww Referrals [Outpatient Demand]	-	1,121	Jul-25	-	-		-	S

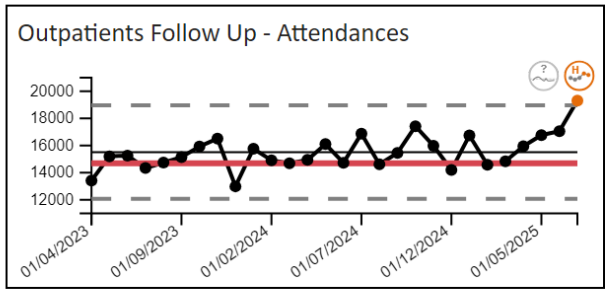
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Block









Data, Context and Explanation

- Activity plans are based on 24/25 month 12 actual
- Activity plans have been re-priced to reflect the revised tariff for the recent pay award
- Despite re-casting activity plans to 24/25 outturn, demand on UECC attendances, NEL and SDEC continues to increase
- NEL activity plans have been adjusted to take account of the full-year-effect of introduction of SDEC
- National focus remains on reducing follow-up attendances
- In line with the national direction of travel we will review any digital options within the market to aid follow-up reductions
- A joint costing exercise of the block lines is underway involving South Yorkshire Commissioners and Providers to understand the costs now versus 19/20 uplifted to today's prices
- The intention is that the re-basing will inform 26/27 planning
- There are no guarantees of additional funding being made available as a consequence of the above exercise

What are the key changes/impacts?

- The increase in SDEC/INO numbers can be attributed to the change in reporting and service set ups. In August 2024 the Trust captured patients needing Medical, Surgical, Gynae and Children's same day assessments and care in their SDEC model, which has resulted in a consistency across the service. Prior to this some patient would be classified as having a mix of OP, IN and INO care.

Metric	Target	Value	Exec Lead	Ops Lead
A&E Attendances		9,264	Sally Kilgariff	Jodie Roberts
Inpatient Observations - INOs/SDEC	2,520	2,783	Sally Kilgariff	Jodie Roberts
NE Inpatients (exc obs)	-	2,747	Sally Kilgariff	Jodie Roberts
Outpatients Follow Up - Attendances		19,315	Sally Kilgariff	Jodie Roberts

What actions are planned?

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

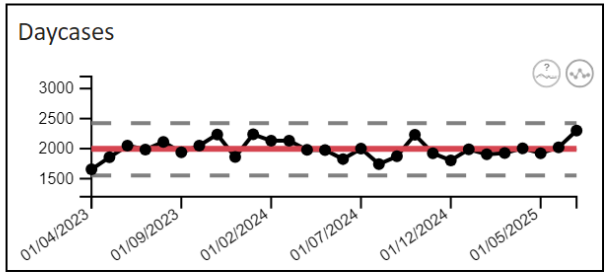
What is the expected impact?

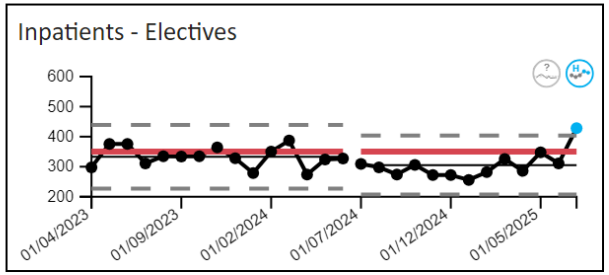
- Ensure accurate record keeping for A&E attendances
- Identify areas of above national/peer average new to follow-up ratios and initiate further review to understand why

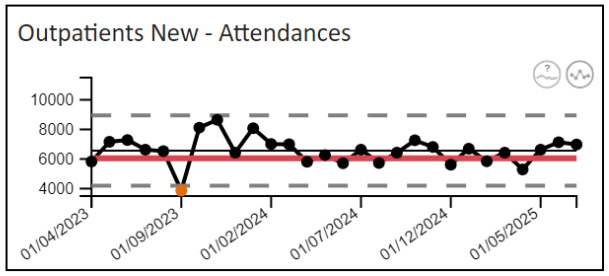
Potential risks to improvement?

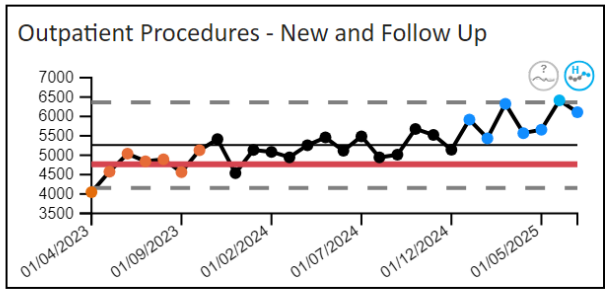
- Despite being on block, all key lines require scrutiny to ensure the Trust a) understands how this is impacting on financial performance b) we maintain an accurate position to safeguard changes to future contracting models
- Continuing increase in non elective demand, which is unfunded due to block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

Subtheme: ERF









Data, Context and Explanation

- ERF activity targets are based on 24/25 month 12 actuals
- Activity plans have been re-priced to reflect the revised tariff for the recent pay award published by NHS England
- ERF lines operate on a cost and volume basis as per National Planning Guidance
- ERF over performance could result in Commissioners issuing Activity Management Plans with the potential to restrict further activity exceeding allocated ERF financial envelopes
- DC and Elective performance continues to exceed planned levels and this is being driven by Gynaecology, Gastroenterology, Trauma & Orthopaedics and Urology
- It is a positive start to the year in terms of delivering against the ERF plan

What are the key changes/impacts?

- Underperformance in Outpatient Procedures is linked to recording/processing issue. Contracts, Clinical Coding and the EPR team are working together to investigate and resolve the issue. In the meantime, manual coding will be required to fix the issue until a solution has been developed by the system provider

Metric	Target	Value	Exec Lead	Ops Lead
Daycases		2,301	Sally Kilgariff	Jodie Roberts
Inpatients - Electives		428	Sally Kilgariff	Jodie Roberts
Outpatients New - Attendances		6,982	Sally Kilgariff	Jodie Roberts
Outpatient Procedures - New and Follow Up		6,109	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Oversight of amended activity recording due to data mapping issues will continue to be monitored
- Any newly identified recording issues will be managed through the correct governance process in-year
- Increased scrutiny of Contract Monitoring to identify trends in variances
- 25/26 activity schemes have been agreed with some already being delivered
- Alignment of capacity and demand linked to contracted activity will be transacted

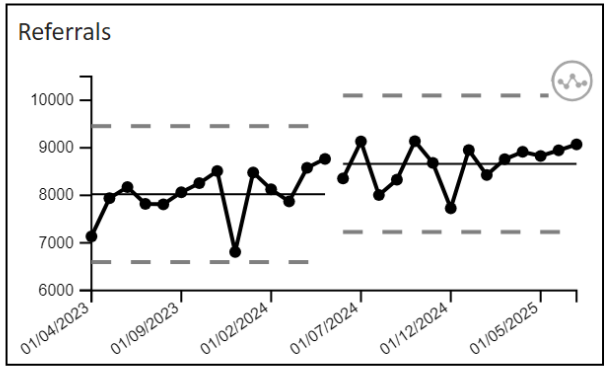
What is the expected impact?

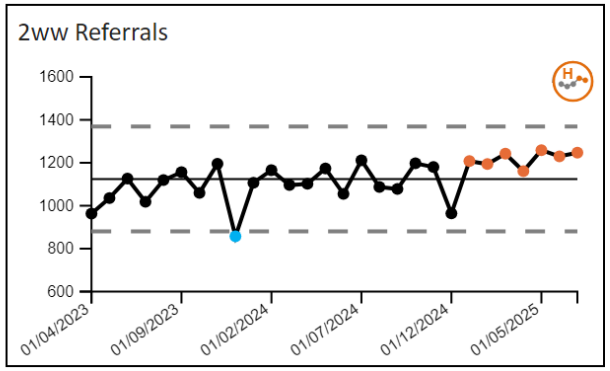
- Ensure corrected activity recording continues to be transacted in Contract Monitoring to attract the correct level of income for the work delivered
- Any significant deviations in activity can be addressed early to ensure no loss of income for work delivered
- Early commencement of 25/26 additional activity to support delivery of performance targets
- Aligning capacity/demand and targets will demonstrate areas requiring further support in 25/26

Potential risks to improvement?

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

Subtheme: OP Demand





Data, Context and Explanation

- Changes in referral patterns are key drivers affecting the Trust's ability to deliver waiting time and waiting list metrics
- Even small changes in specific specialties can generate significant increases in waits
- Referral patterns and trends are available in the Contract Monitoring Power BI data
- Significant changes generate discussion with Commissioners to identify what is driving the variation
- Recommencement of the Rotherham Commissioner/Provider Clinical Referrals Management Committee (CRMC) will support discussions regarding referral patterns and actions will be agreed to determine management plans

What are the key changes/impacts?

Metric	Target	Value	Exec Lead	Ops Lead
Referrals	-	9,072	Sally Kilgariff	Jodie Roberts
2ww Referrals	-	1,247	Sally Kilgariff	Jodie Roberts
Referrals % Growth (12 month rolling)	-	6.1	Sally Kilgariff	Jodie Roberts

What actions are planned?

- A more detailed review of referrals by specialty will be introduced into monthly Contract Compliance meetings held with Care Groups
- Identify whether duplicate referrals are being made to a range of services (often due to long waits)
- Identify appropriateness of 2WW referrals
- Increasing use of pre and post referral Advice & Guidance
- Ensure Advice & Guidance activity is correctly reported and the associated income generated
- Capacity and Demand planning

What is the expected impact?

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

Potential risks to improvement?

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

Finance

Jul-25

Key Headlines	Month			YTD			Forecast Variance £000s	Prior Month Forecast variance £000s
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s		
I&E Performance (Actual)	(66)	(66)	**(1)**	(932)	(935)	**(3)**	**(18,473)**	**(21,197)**
I&E Performance (Control Total)	(2)	(2)	**0**	(675)	(675)	**0**	**(18,464)**	**(21,187)**
Efficiency Programme (CIP)	1,249	549	**(700)**	4,331	1,651	**(2,680)**	**(9,121)**	**(10,035)**
Capital Expenditure	1,375	839	**536**	6,716	1,853	**4,863**	**0**	**0**
Cash Balance	1,374	6,067	**4,693**	6,432	17,210	**10,778**	0	0

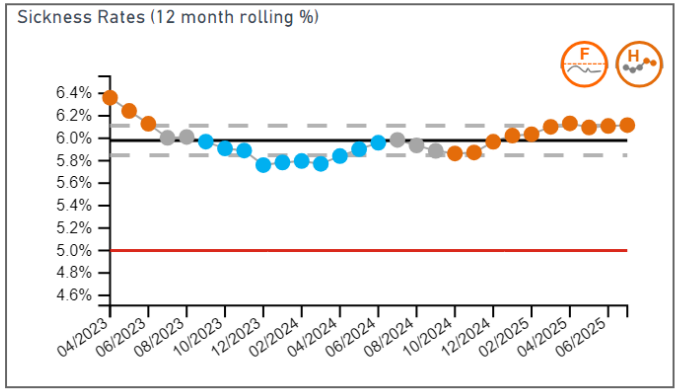
People and Culture

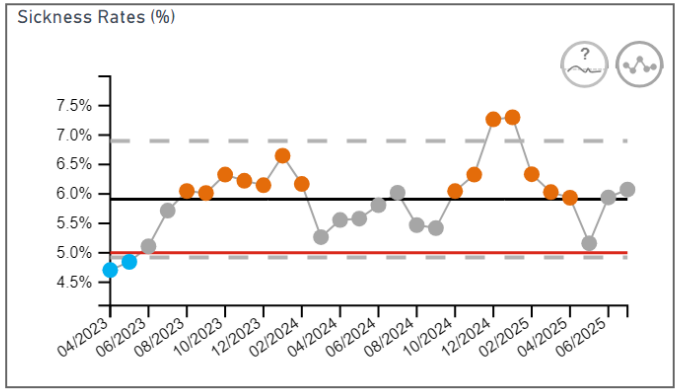
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Sickness Rates (12 month rolling %)	5.0	6.1	Jul-25	☒	F	H	-	VC
Sickness Rates (%)	5.0	6.1	Jul-25	☒	?			S
Short Term Sickness Absence - In Month (%)	-	2.0	Jul-25					S
Long Term Sickness Absence – In Month (%)	-	4.0	Jul-25					S
Turnover (12 month rolling %)	8.0-9.5	7.9	Jul-25	☑	P	L		VG
Vacancy Rate (total %)	-	4.8	Jul-25	-	-		-	S
MAST – Core (%)	85.0	91.8	Jul-25	☑	P	H	-	VG
MAST – Job Specific (%)	85.0	85.8	Jul-25	☑	P	L	-	C
Appraisal Rates (12 month rolling %)	90.0	57	Jul-25	☒	-	-	-	-
Appraisals Season Rates (%)	90.0	40	Jul-25	☒	-	-	-	-

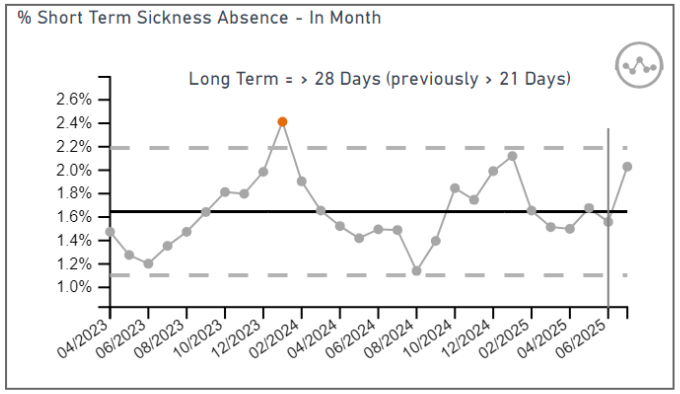
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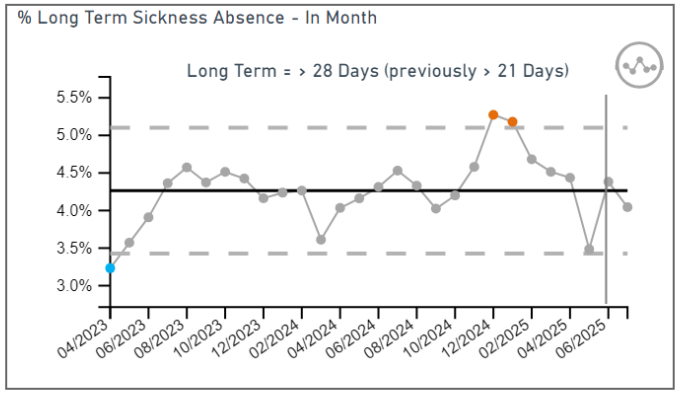
Subtheme: People (1)

Data, Context and Explanation









- Levels of sickness absence are static at 6.1% both in month and rolling 12 month. The new supporting attendance policy went live in June 2025 and therefore some caution should be exercised with comparisons pre June 2025 (6.0, 6.1 due to rounding).
- The Trust's start to the year is broadly similar to 2024/25 significant work is taking place by managers and the people team to reduce absence. The major opportunity in terms of the number of days lost to sickness absence is to markedly improve on the high levels of absence seen in Q3 and Q4 last year.
- A range of strategic, tactical and operational interventions are in place linked to the winter plan to deliver improvement and a deep dive will be brought to Board in November 2025, it is further proposed a Board strategy session takes place in December on this subject.

Metric	Target	Value	Exec Lead	Ops Lead
Sickness Rates (12 month rolling %)	5.0	6.1	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	5.0	6.1	Daniel Hartley	Paul Ferrie
Short Term Sickness Absence - In Month (%)	-	2.0	Daniel Hartley	Paul Ferrie
Long Term Sickness Absence - In Month (%)	-	4.0	Daniel Hartley	Paul Ferrie

What actions are planned?

- HWB and Attendance work programme in place informed by evidence based tools, best practice and audit work, visit to top performing Trust in September
- New weekly internal controls meeting in place with Care groups to increase service accountability for attendance as part of Trust performance framework
- OH contract mobilisation for launch of improved service offer September 2025
- Targeted support to wards A4 and A5 as proof of concept for ward/team based interventions taking place Sep/Oct.

What is the expected impact?

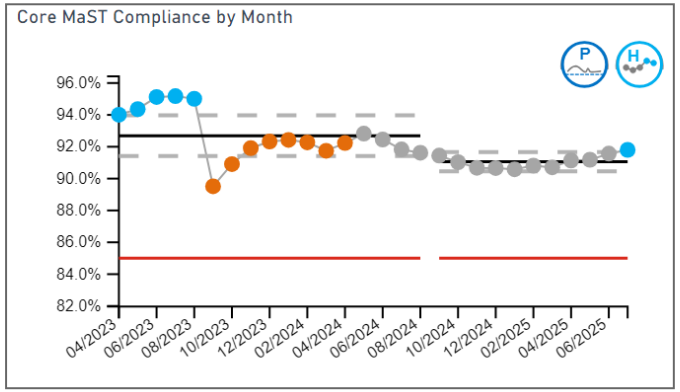
- Improved staff health
- Greater accountability through leadership and line management for sickness absence performance
- Improvement in both long term and short term sickness absence rates

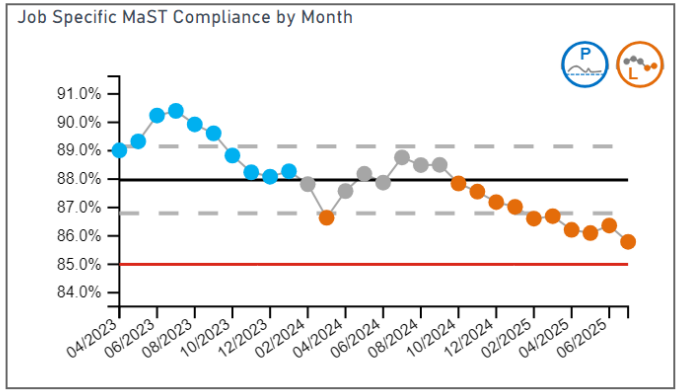
Potential risks to improvement?

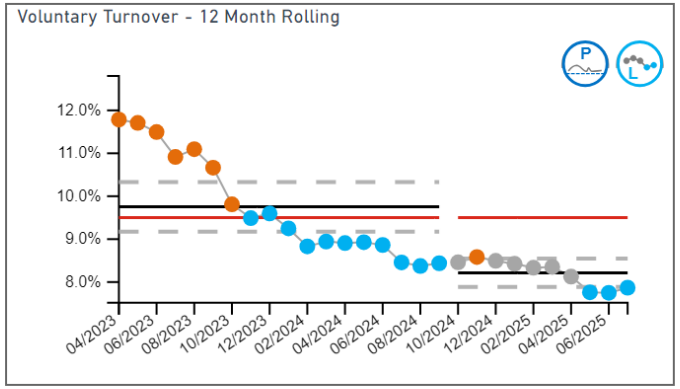
- Continued impact of ill health of staff on attendance
- Lack of manager compliance with welcome back to work conversations and supporting attendance policy application
- Lack of universal application of principles of preventing ill health, protecting people from poor HWB and wellbeing and ensuring employees receive support when needed

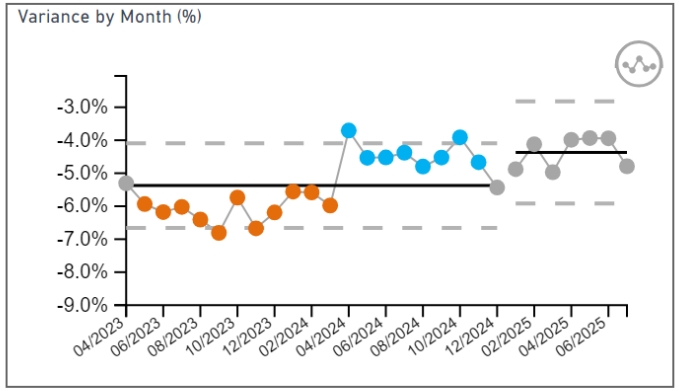
Subtheme: People (2)

Data, Context and Explanation









- MAST core compliance remains in a positive position, with job specific compliance reducing but still above target.
- Turnover rates continue to be very strong and have marginally gone outside of the parameters set, which will be considered at People and Culture committee. Specific data breakdowns for local management are provided for care groups and local teams for action.
- Appraisal rates are presented as a metric but not as an SPC as it is not clear that the annual nature of such is effectively presented in SPC format. This will be reviewed further for November Board, along with other improvements in presentation of the People and Culture IPR.

Metric	Target	Value	Exec Lead	Ops Lead
Turnover (12 month rolling %)	-	7.9	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	-	4.8	Daniel Hartley	Paul Ferrie
MAST - Core (%)	85.0	91.8	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	85.0	85.8	Daniel Hartley	Paul Ferrie
Appraisals Season Rates (%)	90.0	40.0	Daniel Hartley	Paul Ferrie
Appraisals (12 month rolling %)	90.0	57.0	Daniel Hartley	Paul Ferrie

What actions are planned?

- Trust Mandatory Learning Oversight Group is being established to overhaul the approach to MAST. Guided by NHSE approach this focusses on the core requirements and is designed to optimise, rationalise and redesign. This was a we said we did commitment.
- Continued focus on leadership, manager and staff accountability for MAST
- All services are required to develop we said we did plans to drive engagement and retention

What is the expected impact?

- A move away from a specific input focussed approach to MAST to clearer measures of safety and effective risk management.
- Less burdensome commitment for staff, freeing up time to care and improving compliance rates
- Maintenance of strong retention rates and improved engagement

Potential risks to improvement?

- Adequate time and focus provided by staff and managers for appraisal and MAST completion.
- Insufficient focus on culture to drive improvement in services through we said we did plans to drive engagement and retention

APPENDIX Assurance

Variation/Performance

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

APPENDIX: SPC Summary Icons Key

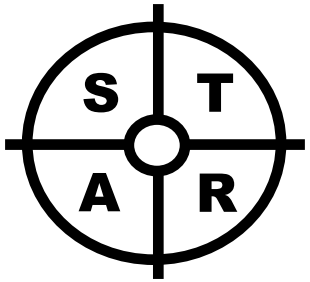
Assurance Icons

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

Variation Icons

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

Data Quality STAR Key



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

Metric Log

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

Metric Log

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

Metric Log

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

Metric Log

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

Metric Log

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

Metric Log

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

Metric Log

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

Board of Directors' Meeting
5 September 2025

Agenda item	P144/25
Report	**Finance Report**
Executive Lead	Chris Thickett, Chief Finance Officer
Link with the BAF	D9: We will not be able to sustain services in line with national and system requirements because of a potential deficit in 2025/26 leading to further financial instability.
How does this paper support Trust Values	This report supports the Trust's vision to always ACT the right way and be PROUD to provide exceptional healthcare to the communities of Rotherham by adhering to the core values – (A)mbitious, (C)aring and (T)ogether and focussing on our strategic ambitions: (a) (P)atients - We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them; (b) (R)otherham - We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve; (c) (O)ur partners - We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care; (d) (U)s - We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work; (e) (D)elivery - We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation. Exercising strong financial management, control and governance is a key component element in the Trust achieving these ambitions.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐

Executive Summary (including reason for the report, background, key issues and risks)	This detailed report provides the Board of Directors with an update on:
	
	• Section 1 – Financial Summary for July 2025 (Month 4 2025/26):
	
	  ○ A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management.
	
	• Section 2 – Income & Expenditure Account for July 2025 (Month 4 2025/26:
	
	  ○ Financial results for July 2025.

	- The Trust is on plan to the control total plan deficit in-month of £2K and the year-to-date plan deficit of £675K. The South Yorkshire ICS has received notification that it will not receive quarter 2 deficit support funding, but it will be possible to recoup this if the system recovers its financial position. As the system is forecasting to recover, the Trust has covered the shortfall in income in month 4 through reserves, and SYICB is centrally recording the adverse position on deficit support funding for the system. The costs of Industrial Action are not being funded by NHS England and have also been covered by reserves this month and included as a risk to NHSE. - NHS England measures the Trust's I&E performance against its control total having adjusted for depreciation on donated assets, impairments, and accounting for Private Finance Initiatives under IFRS 16 – (total of £260K). • Section 3 – Income and Expenditure Account Forecast Out-Turn o A forecast out-turn deficit to the planned control total, for the year ending 31st March 2026, of £18,464K. o The Trust will be reporting externally to the ICB and NHSE that it will be delivering its planned break-even position as actions are being taken to recover this position, and the use of reserves will enable the Trust to deliver its plan. This also assumes that the Trust will receive its full allocation of non-recurrent deficit support funding and that actions can be taken to reduce additional capacity which is currently unfunded. • Section 4 – Capital Expenditure for July 2025 (Month 4 2025/26) o Year to date capital expenditure is £1,853K against a plan of £6,716K an under-spend of £4,863K. o Final budget allocations for 2025/26 are being monitored at the Capital Monitoring Group, chaired by the Chief Finance Officer an update will be provided against the schemes in September 2025. • Section 5 – Cash Flow 2025/26 o A cash flow graph showing actual cash movements between April 2024 and July 2025. A month-end cash value as at 31st July 2025 of £17,210K, which is £10,778K better than plan due to the timing of income receipts and an underspend on capital expenditure.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report to the Board of Directors has been prepared directly from information contained in the Trust's ledgers and is consistent with information reported externally to NHS England. o The overall financial position for I&E has been reviewed collectively by and agreed with the senior Finance Team together with the Director of Finance.

	○ CIP performance has been discussed with the Efficiency Board chaired by the Managing Director. ○ The capital expenditure position has been discussed and reviewed by the Capital Monitoring Group, chaired by the Director of Finance. ○ More comprehensive and detailed reports of the financial results have been presented to the Executive Team.
Board powers to make this decision	Within Section 4.5 of Standing Financial Instructions – Budgetary Control and Reporting – paragraph 4.5.1 states that *"The Director of Finance will devise and maintain systems of budgetary control. These will include:* *(a) Financial reports to the Board, in a form approved by Finance & Performance Committee on behalf of the Board."*
Who, What and When (What action is required, who is the lead and when should it be completed?)	• CIP performance was discussed at the Efficiency Board meeting held on 20 August 2025. • Capital expenditure was reviewed at the Capital Monitoring Group held on 18 August 2025.
Recommendations	It is recommended that the Board of Directors note the content of the report.
Appendices	None.

1. Key Financial Headlines

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

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

Key Headlines	Month			Year to Date			Forecast	Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	Variance £000s
I&E Performance (Actual)	(66)	(66)	(1)	(932)	(935)	(3)	(18,473)	(21,197)
I&E Performance (Control Total)	(2)	(2)	0	(675)	(675)	0	(18,464)	(21,187)
Capital Expenditure	1,375	839	536	6,716	1,853	4,863	0	0
Cash Balance	1,374	6,067	4,693	6,432	17,210	10,778	0	0

1.2 In July 2025, the Trust was on plan against its control total performance in-month and year to date. NHS England measures the Trust's I&E performance against its control total having adjusted for depreciation on donated assets, impairments and accounting for Private Finance Initiatives under IFRS 16 - Leases.

1.3 Capital expenditure is behind plan year to date having spent £1,853K of the £6,716K plan. The capital programme is continuing to be monitored by the Capital Monitoring Group chaired by the Chief Finance Officer.

1.4 The cash position at the end of July 2025 is £17,210K this is better than plan by £10,778K due to the timing of income receipts and under-spend on capital expenditure.

2. Income & Expenditure Account for July 2025 (Month 4 2025/26)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered a control total on plan in month for July 2025 and year to date.

Summary Income and Expenditure Position	Annual Plan £000s	Month			Year to Date			2025/2026 Monthly Trend / Variance
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	
Clinical Income	363,384	30,420	29,963	(457)	120,623	121,244	620	
Other Operating Income	24,054	2,309	3,490	1,180	8,340	10,624	2,284	
Pay	(242,832)	(20,697)	(21,995)	(1,299)	(82,241)	(89,147)	(6,906)	
Non Pay	(99,244)	(9,450)	(9,822)	(372)	(37,567)	(40,351)	(2,784)	
Non Operating Costs	(4,716)	(402)	(355)	47	(1,498)	(1,253)	245	
Reserves	(41,638)	(2,246)	(1,347)	900	(8,590)	(2,052)	6,538	
Retained Surplus/ (Deficit)	(992)	(66)	(66)	(1)	(932)	(935)	(3)	
Adjustments	992	64	65	1	256	260	3	
Control Total Surplus/ (Deficit)	0	(2)	(2)	0	(675)	(675)	0	

2.2 Clinical Income is adverse to plan in-month due to notification that South Yorkshire ICS will not receive quarter 2 deficit support funding. It will be possible to recoup this if the system recovers its financial position. As the system is forecasting to recover, the Trust has covered the shortfall in income through reserves this month, and the SYICB is centrally recording the adverse position for the system. Year to date, clinical income is favourable to plan due to the over-performance on elective recovery activity in Care Groups £999K and the use of ERF reserves to cover the underperformance on the central target of £994K, the latter relates to the opportunity to deliver above the 2024/25 outturn priced at current tariff. At Month 4, the actual elective activity is a high-level estimate as there is a higher than usual level of un-coded activity due to the date the data was taken in month 4.

2.3 Other Operating Income is ahead of plan in-month and year to date with increased income from staff recharges (£445K), which will be an offset to the pay over-spend, increased research, education and training income (£615K), increased car parking income (£168K) and increased one-off income on SLAs of £(993)K.

2.4 Pay costs are over-spending by £6,906K. Bank and agency expenditure is not currently being maintained within the gross establishment budget, and contributing to this is £2,057K under-delivery against the planned cost improvements. The costs of Industrial Action have been covered by reserves in-month and reported as a risk to NHS England as it has been confirmed that there is no additional funding this year.

2.5 Non-Pay costs are over-spending by £2,784K year to date. The overspend is related to Drugs and Clinical Supplies £2,135k, under-delivery against cost improvement plans of £638K, and premises costs £621K.

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

2.7 £6,538K has already been released from Reserves in month, this is to cover the under-delivery of CIP, overspends referred to above and additional capacity over and above funded bed capacity.

3 Forecast Out-Turn Performance to 31st March 2026

3.1 The table below shows the forecast out-turn position for the financial year 2025/26. The Trust is forecasting to deliver a £18,464K deficit to plan.

Summary Income and Expenditure Position	Annual Plan £000s	Forecast Outturn (Full Year) £000s	Forecast variance (Full Year) £000s	Actual variance (YTD) £000s	Forecast variance remainng months £000s	Total variance £000s	2025/2026 Monthly Trend / Variance
Clinical Income	363,384	364,769	1,385	620	764	1,385	
Other Operating Income	24,054	29,802	5,747	2,284	3,464	5,747	
Pay	(242,832)	(266,813)	(23,981)	(6,906)	(17,075)	(23,981)	
Non Pay	(99,244)	(108,057)	(8,814)	(2,784)	(6,030)	(8,814)	
Non Operating Costs	(4,716)	(4,065)	651	245	406	651	
Reserves	(41,638)	(35,101)	6,538	6,538	0	6,538	
Retained Surplus/ (Deficit)	(992)	(19,465)	(18,473)	(3)	(18,470)	(18,473)	
Adjustments	992	1,002	10	3	7	10	
Control Total Surplus/ (Deficit)	0	(18,463)	(18,464)	0	(18,464)	(18,464)	

3.2 With appropriate management action the Trust expects to deliver its overall financial plan by 31st March 2026, a break-even control total deficit and will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE. Delivery of the financial plan assumes that ERF income and efficiency targets will be met, costs for periods of Industrial Action are affordable within current budgets, actions will be taken with regards additional capacity and planned reserves will be used. Recovery plans are continuing to be monitored, and schemes are being funded to support elective delivery. This also assumes that the Trust will receive its full allocation of non-recurrent deficit funding.

3.3 Within Clinical Income, the estimated year-to-date Elective Recovery Fund over delivery against Care Group targets is reflected of £999K and the central under delivery of £994K is currently offset by the use of ERF reserves but remains an opportunity to deliver above its 2024/25 outturn (priced at current tariff). No further under or over delivery of ERF is forecast. The increase in the remaining months is on other variable income contracts.

3.4 Other Operating Income, increases are forecast in income from research, development, education & training (£1,541K), staff recharges (£1,688K), car parking income (£504K)

and SLAs (£1,696K). This additional income will equally be offset by further increases in pay and non-pay expenditure.

3.5 Pay is showing a significant deterioration in performance this includes undelivered annual CIP budget of £7,889K, and premium agency and bank costs forecast variance to plan of £14,503K. Pay is not being managed within budgeted establishment.

3.6 Non-pay costs are similarly showing a significant deterioration in performance linked to continued increasing costs most notably within premises £1,752K, undelivered CIPs £3,147K, and drugs and clinical supplies £5,299K.

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

3.8 Cost reduction and CIP delivery are key to improving the forecast outturn position. This is still a significant risk to the Trust delivering against its overall plan. The Improvement Group and financial recovery meetings are being held monthly with Senior Leaders and Executive Directors to address the financial and operational challenges, and to identify solutions.

4. Capital Programme

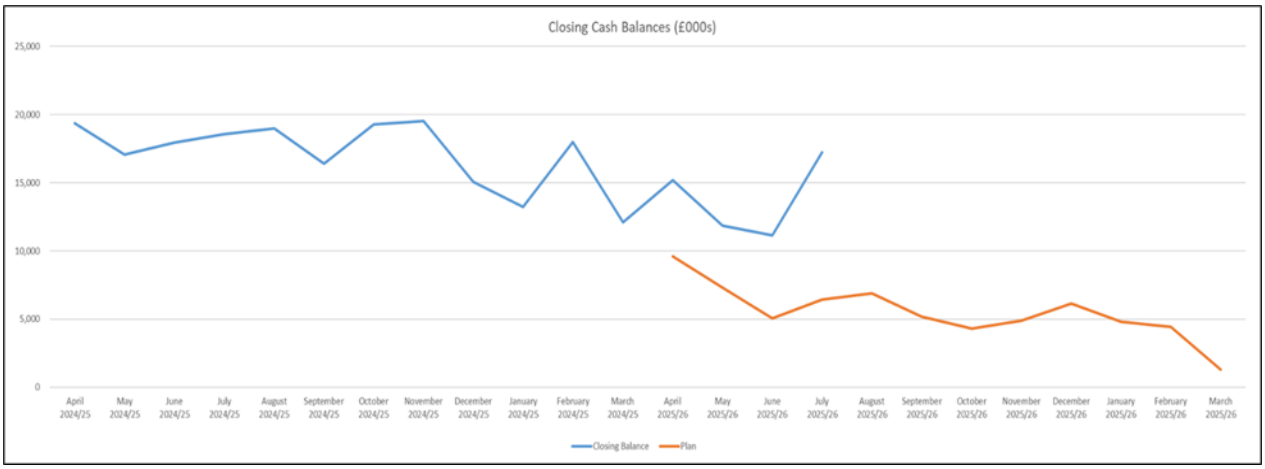
4.1 During July 2025 the Trust incurred capital expenditure of £839K against a plan of £1,375K. Year to date capital spend is £1,853K against a plan of £6,716K, an underspend of £4,863K. Most of the spend year to date is due to the outstanding commitments from 2024/25 and the SDEC scheme.

	2025/26 Annual plan / budgets						Month			Year to Date			Forecast	Prior month
	Budgets - capital allocation	Estates Safety Capital - Public Dividend Capital (PDC)	Return to Constitutional Standards - PDC	Total allocation per plan	Additional PDC allocation in-year	Total capital	Plan	Actual	Variance	Plan	Actual	Variance	Variance	Forecast variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£000s	£000s
Estates Strategy	4,604	5,082	8,922	18,608	1,025	19,633	750	511	239	3,250	1,130	2,120	0	0
Estates Maintenance	2,000			2000		2000	400	238	162	2,650	308	2,342	0	0
Information Technology	2,035			2,035		2,035	125	135	(10)	350	368	(18)	0	0
Medical & Other Equipment	3,030			3,030		3,030	100	(46)	146	450	47	403	0	0
Other	262			262		262	0	0	0	16	0	16	0	0
TOTAL	**11,931**	**5,082**	**8,922**	**25,935**	**1,025**	**26,960**	**1,375**	**839**	**536**	**6,716**	**1,853**	**4,863**	**0**	**0**

4.2 Capital budgets for 2025/26 are being monitored at the Capital Monitoring Group, chaired by the Chief Finance Officer.

5. Cash Management

5.1 Compared to plan, there is an in-month favourable variance on cash of £4,693K. The closing cash balance at 31st July 2025 is £17,210K compared to a plan of £6,432K, the favourable variance to plan of £10,778K is due to the timing of income receipts and the underspend on capital expenditure.



Chris Thickett
Chief Finance Officer
26 August 2025

Board of Directors' Meeting
5th September 2025

The Rotherham NHS Foundation Trust

Agenda item	P145/25
Report	**Responsible Officer Annual Report (2024/25) and Statement of Compliance**
Executive Lead	Dr Jo Beahan, Medical Director & Responsible Officer
Link with the BAF	
How does this paper support Trust Values	Demonstrates that medical staff are supported and engaged by the Trust to ensure that they have opportunity to reflect on clinical practice.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this report is to present to the Board details of activity related to Medical Appraisal and Revalidation, as per NHS England and GMC regulations. The attached report sets out the information that a designated body is expected to report upwards, through their Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards. There are 310 Doctors connected to TRFT as their designated body. The appraisal rate for 24-25 was 94.5%. Key areas to flag; Recruitment to Appraisal AMD ongoing Agreement of model for medical appraiser funding There has been a 14% expansion in the number of Doctors connected to the Trust with bank Doctors being a challenge. There has been a peer review by Barnsley. The report provides assurance that the processes for medical appraisal and revalidation are well embedded. There are processes supported by NHSE, PPA and the GMC to support the management of the medical profession in the Trust and ensure adherence to Good Medical Practice. The Statement of Compliance is to be signed and returned to NHS England by Tuesday 31st October 2025. The document should be signed by the Chair or Chief Executive of the designated body's Board.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report will be presented to the quarterly Responsible Officer's Advisory Group (ROAG) moving forward and has been discussed and approved.
Board powers to make this decision	Confirm Statement of Compliance.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Requires signature of Responsible Officer and Chairman by 31st October 2025.
Recommendations	As above
Appendices	1. Designated Body Annual Board Report 2024-25 & Statement of Compliance

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: The Rotherham NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	Amendment to Job Description of Deputy Medical Director to formally recognise the Deputy RO role including the devolved responsibilities
Comments:	A deputy RO has been appointed to ensure any conflict of interest or bias is correctly managed. The deputy RO has attended both the RO training

	and appraiser training. The deputy RO is Currently filling the role of the AMD for Appraisal and Revalidation who left the post in January 2025. Recruited for new AMD awaiting start date
Action for next year:	Ensure both the RO and Deputy RO attend relevant updates and training to maintain their knowledge

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	New process for securing future medical appraisers with appropriate financial governance. Paper sent to executive team to internally recharge Care Groups to pay appropriate share of costs to centralised fund held by MD to cover costs associated with Appraisal
Comments:	Dedicated cost centre developed with revised budgetary management processes and clear contract management for subscriptions
Action for next year:	Paper presented to the executive team to propose the creation of a centralised fund held by the Medical Director to cover the cost of Appraisal. Each Care Group will contribute to the fund according to the number of Appraisals required within that Care group

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	Appraisal and Revalidation function is aligned to Medical Workforce team to ensure a seamless transfer of medical starters and leavers. Medical Practice Information Transfer forms completed in a timely and efficient manner.
Comments:	The number of bank doctors continues to expand, accurate information is required to ensure each doctor is connected to the correct Designated Body
Action for next year:	Continue to work with Medical Workforce team regarding starters and leavers and ensuring an accurate Prescribed Connection is maintained. Liaise with Trust Bank team to ensure the list of Bank doctors remains current and where appropriate are part of the Prescribed Connection

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	Medical Appraisal Policy has recently been re-written to take into account the changes to the Good Medical Practice and to align with the impending changes to the IT platform which hosts our appraisal portfolios
Comments:	The Policy will require reviewing when the platform is changed, the changes required will purely be reference to the new IT platform and not procedural.
Action for next year	Policies which support medical appraisal and revalidation will form part of a new policy tracker which is managed through the Joint Local Negotiating Committee. Two key policies for the forthcoming year will be a revised Maintaining High Professional Standards policy and the Enhanced Support/Remediation Policy.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Y
Action from last year:	A peer review has been undertaken with Barnsley Hospital, a Trust comparable in size. The findings were positive and gave assurance that our doctors are receiving a good standard of appraisal, and the appraisers are performing well
Comments:	The feedback from the review have been shared and discussed at the Appraiser Forum meeting and Responsible Officers Advisory Group
Action for next year:	Ensure the recommendations have been implemented by all appraisers by auditing a sample of appraisals

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	The most recent Appraisal/ARCP document is requested from all new starters, whether they are locum or short term, this enables us to ensure the doctor can maintain their appraisal history. For doctors who are new to the UK a priming appraisal is offered to ensure the doctor is educated about Appraisal and Revalidation. Medical HR liaise with relevant departments to ensure all International Medical Graduates (IMG) are given a comprehensive induction and can initially work supernumerary
Comments:	Ensure all departments give suitable/timely induction.
Action for next year	Look further into supporting CPD, Governance and feedback to Locum and short term doctors as the number of such doctors are increasing .Doctors with a prescribed connection to the Trust are offered an annual appraisal and will be given information regarding complaints and SI. As part of the Appraisal IT platform doctors can request Colleague and Patient MSF. Additional work is required around MAST compliance and how this can be achieved

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	Ensure MSF and Audit include data from external work
Comments:	Pre appraisal checklists continue to be sent out to doctors 3 months prior to their appraisal month which include information about complaints, SI, reflection statements if they have been requested to attend coroner's court, and a reminder to be up to date with their mandatory Training
Action for next year:	Ensure all appraisers are aware that a letter of good standing must be added to the appraisal document of all external work paid or unpaid. Check such work is covered in MSF, QI and CPD

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	Maintain the dashboard and report findings to Responsible Officers Advisory Group
Comments:	The IT platform, L2P, logs any missed or incomplete appraisals and can be reviewed in an easy dashboard view for the Responsible Officer
Action for next year:	Review the missed appraisals to obtain themes for discussion at Responsible Officers Advisory Group and ways in which doctors can be supported in the future

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	The Policy may need to be amended when the IT platform changes to ensure accurate information is logged. The policy will be reviewed with key stakeholders including the Joint Local Negotiating Committee
Comments:	The policy will be reviewed by the appraisal team when the new IT platform is introduced
Action for next year:	Updated policy to be reviewed with key stakeholders including Joint Local Negotiating Committee

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	Appraiser recruitment remains ongoing to ensure the correct ratio is maintained
Comments:	Continue to be pro-active in the recruitment of appraisers to ensure we maintain a sufficient Appraiser group, and ensure the recruitment is proportionate to the number of doctors requiring appraisals
Action for next year:	Executive Team approval of funding structure for Appraisers. The new systems affords a greater level of consistency and fairness across each Care Group. Recruitment of new appraisers will be based on their personal qualities rather than that they are from a particular Care group

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	Continue with Appraiser Forum meetings, and sharing of information from external bodies (network events).
Comments:	Appraiser Forum agendas and minutes provide evidence of the learning points discussed. Appraisal team to check appraiser MAST compliance, especially Information Governance and Equality and Diversity
Action for next year:	Appoint new AMD for Appraisal and support them to support the appraisers. Await new instruction regarding replacement of NHS England network events

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	With the introduction of new IT software the overall sign off process should be improved. This should increase efficiency and improved alignment to information governance procedures

Comments:	Where the AMD has acted as the appraiser for a doctor, those appraisals are reviewed by the Deputy RO who will have final sign off for assurance purposes.
Action for next year:	Once new AMD appointed support them in all aspects of appraisal sign off.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	Provide assurance reports to Responsible Officer Advisory Group (ROAG) to ensure visibility of metrics, a specific confidential part of the meeting to discuss concerns pertaining to fitness to practice Revalidation is now on the dashboard presented at ROAG
Comments:	Progress reports on Revalidation recommendations Revalidation Checklist, completion dates and GMC connect data confirming timely submissions
Action for next year:	Continuance of regular ELA meetings with the GMC.Dissemination of the new MHPS Policy ensuring that all of the Designated Body Prescribed Connections are aware of their responsibilities. Adhering to GMC`s overlapping principles under Duties of a Doctor, the Trusts behaviour framework and wider Trust policies.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y

Action from last year:	Associate Medical Directors emails all doctors who have evidence missing to discuss possibility of making a deferral to give more time to collect necessary evidence. Medical appraisal and revalidation support managers to prompt doctors who are missing evidence when their checklist is created a year in advance of their revalidation date
Comments:	Revalidation checklists are routinely completed for each doctor nearing Revalidation to ensure all relevant information is available. Medical appraisal and revalidation managers ensure each doctor approaching revalidation has an electronic evidence file with shortcut links to all revalidation evidence so the AMD and RO can easily check against the checklist.
Action for next year:	With the introduction of the L2P system forward planning for MSF is much better and should reduce the number of deferrals for lack of feedback. Monitor reason for deferrals

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	There are policies in place for supporting/responding to concerns about Medical professionals
Comments:	The data pack include their appraisal month, their appraiser's name, complaints, SI, coroners request, MSF report (if they have collected within that year), and a reminder to ensure their MAST is up to date.
Action for next year:	Ensure Trust policies are up-dated with the latest guidance regarding EDI. Ensure that all policies and procedures are free from bias or discrimination, taking into account the exclusions criteria from the PPA

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y

Action from last year:	All doctors are provided with a data pack which includes complaint and Si information for the doctor to reflect on and discuss as part of their appraisal
Comments:	The above are examples of good practice as quoted in NHS England Appendix F.
Action for next year:	Review of medical and dental policies pertaining to the appraisal and revalidation function with involvement of key stakeholders.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	Consolidation of key information into one reported which is then uploaded onto the appraisal portfolio. This will also support the appraiser in exercising their role
Comments:	As detailed in 1D(i) information is shared with the doctors prior to their appraisal month which includes complaints, SI, coroner's request, MSF and a MAST reminder
Action for next year:	Ensure doctors are making good use of the information provided prior to appraisal. Appraisal and revalidation Team to review appraisal portfolios

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	The Trust has an Enhanced Support Policy in place – currently under review. The policy aligns to the MHPS
Comments:	Check with RO regarding Enhanced Support Policy or something similar

Action for next year:	Review of MHPS policy and Enhanced Support Policy with involvement of key stakeholders including the JLNC

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	Discuss at ROAG which consists of Lay and Non-Executive Director representation
Comments:	Currently use the Practitioner Performance Advice Service template, to ensure that this aligns with MHPS
Action for next year:	Audit of process in place for managing concerns about medical and dental colleagues. The audit will be aligned to the requirements outlined in the MHPS policy whilst taking into account any new national guidance in particular the GMC's Fair to Refer

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	Maintain protocols and re-audit
Comments:	An audit has been completed to check that a Transfer of Information document was sent for all new starter and received in a timely manner. Any issues to be shared with the RO

Action for next year:	The “New Starter” list issued by ESR on a monthly basis from this information GMC Connect is checked to see any previous employment to see if a TOI is required and action taken accordingly and any untoward findings reported to RO.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor’s practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Y
Action from last year:	Review of clinical governance arrangements in place for doctors subject to interventions made by the trust.
Comments:	Review MHPS policy and Fair to refer document
Action for next year:	Review of MHPS policy and Enhanced Support Policy with involvement of key stakeholders including the JLNC. Audit of process in place for managing concerns about medical and dental colleagues. The audit will be aligned to the requirements outlined in the MHPS policy whilst taking into account any new national guidance in particular the GMC’s Fair to Refer.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation’s policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	Recommendations from national reviews, reports and enquiries are disseminated through the Trust governance processes
Comments:	Review of GMC Good Medical Practice disseminated to medical colleagues and local policies and procedures reflected new regulatory changes. Relevant trust policies and procedures updated. The NHS England Improving the Working Lives of Doctors in Training reviewed at the Trust Executive Team and presented to JLNC.

Action for next year:	The NHS England recommendations associated with improving working lives of doctors in training will be reviewed via trust governance processes such as JLNC, Junior Doctor Forum and People Committee. The recommendations will also be embedded as part of the wider People Promise/People Strategy project. The Trust will also consider the recommendations outlined in the new BMA Consultant Charter. The Charter will be managed by JLNC

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Continuation of workshops through lunchtime lectures to allow for "bite-size" leadership knowledge sessions to be attended by all clinicians with subjects chosen relevant to their leadership roles
Comments:	Successful implementation of a Trust wide medical leadership and development programme which hosted a series of workshops to support clinicians entering into their first clinical leadership position
Action for next year:	Ensure that all Service Managers have an in-depth knowledge and understanding of Medical and dental Terms and Conditions, Appraisal, MSF and Job Planning

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	The recruitment team have processes in place to check all pre-employment checks as per NHS Employers Guidance
Comments:	In relation to qualification this is initially checked by the GMC and the candidate would not be able to obtain this registration without the correct qualification. The original Medical Degree from each successful candidate is required as part of the pre-employment checks

Action for next year:	Continue as per guidance and audit practices

1F – **Organisational Culture**

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	Ensuring that there is harmonisation of overriding professional standards as a doctor with the overall adherence to the Trust values and behaviour framework
Comments:	Contributing to a positive working and training environment ensuring that behaviours modelled are consistent with the principles laid out by regulatory bodies are not conflicting
Action for next year:	Ensuring that all doctors model the behaviours expected and they are free from discrimination of any kind. Work continues on the psychological and sexual safety agenda. Confidence to call out behaviours inconsistent with values, enhancing freedom to speak up opportunities/listening events.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	All policies and procedures adhere to the latest Equality and Diversity legislation. EIA available on each policy relating to A&R
Comments:	
Action for next year:	Consider how policies can be further enhanced for Trust initiatives such as veteran aware and the wider inclusion agenda

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	The Trust has a Freedom to Speak up Policy which supports and endorses the Freedom to Speak up review (2015). The Trust advertises Trust wide the members of staff signed up as freedom to speak up Guardians.
Comments:	Doctors are provided with details of complaints and SI`s which give them an opportunity to take part in reflective learning emphasising a culture of openness
Action for next year:	The Trust has appointed a new Freedom to Speak Up Guardian who has increased visibility amongst harder to reach staff groups. Doctors and dentists are aware of the new role and understand in greater detail how to access Freedom to Speak Up services

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y
Action from last year:	Documentation within appraisal portfolios Audit of quality assurance in appraisal portfolios
Comments:	Ensure that there is a mechanism embedded in sharing data about doctors to doctors to enable them to adequately prepare for appraisal Signpost to freedom to speak up guardians
Action for next year:	Ensure that Doctors and Dentists are instrumental in responding to complaints and they actively participate in the response to the patient

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Y
Action from last year:	Numbers remain very low thus unable to provide an analysis
Comments:	The RO Advisory Group continues to meet quarterly to discuss such issues. This compliments the discussions with the GMC (Employment Liaison Officer) and the Quarterly RO`s report to Board
Action for next year:	Review of action plan associated with the MWRES to gain a greater understanding of issues faced by our medical and dental colleagues including ensuring that we are able to collect the right data to be able to provide assurance that we are inclusive employer and no doctor or dentist is in receipt of less favourable treatment owing to their background.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	Ensure attendance at NHS England Network meetings and cascade information to the Appraisers at the Forum Meetings
Comments:	The number of Network meetings have reduced in frequency but the ones that are organised are readily attended by the Appraisal team
Action for next year:	Await new instructions regarding the abolition of NHS England and what will take its place to reside over Appraisal and Revalidation

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	310
Total number of appraisals completed	293
Total number of appraisals approved missed	13
Total number of unapproved missed	4
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	77
Total number of late recommendations	0
Total number of positive recommendations	70
Total number of deferrals made	7
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	6
Total number of trained case investigators	7
Total number of trained case managers	unsure
Total number of concerns received by the Responsible Officer[2]	2
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	18 months
Median duration of concerns processes closed (working days)[3]	N/A cases still open
Total number of doctors excluded/suspended during the period	1

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	80
Total number of new employment checks completed before commencement of employment	80
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
1.Finance A Business case to be presented to the exec team to endorse the financing of the Appraisal and Revalidation function, which will be held by the RO. This should ensure all Care Groups are funding their fair share/allocation of Appraisers 2. Appraisal Platform Implementation. The L2P platform has been implemented and functioning well, there have been teething issues and a number of final sign offs which has been resolved through some additional training 3.Appraiser Numbers Maintaining appraiser numbers is challenging, as there has been a 14% increase in Medical Staff, most of that number are Trust Bank doctors, who still require an appraisal as they have the Trust as their Designated Body. 4.Policies A review of all policies is underway to ensure they are relevant and fit for purpose

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Actions still outstanding
Current issues
1 Recruitment to the vacant Associate Director for Appraisal and Revalidation is awaiting on-boarding
Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1):
Ensure adequate number of appraisers facilitating a maximum of 10 appraisals each appraisal year. Ensure all appraisals are reviewed by appraisal lead to ensure consistency and quality of appraisals
Overall concluding comments (consider setting these out in the context of the organisation’s achievements, challenges and aspirations for the coming year):
Medical colleagues received high quality of appraisal as supported by the feedback received and the proud award nomination for the appraisal team. Our appraisal rate was 95%. New appraisers have been appointed and trained. External review suggested that we are providing good quality of appraisals and the changes suggested have been implemented, and will be reviewed this year. Appraisal Forum meetings have been well attended and information sharing has been taking place including an excellent update from the GMC representative on the new Good Medical Practice

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	The Rotherham NHS Foundation Trust - Board

Name:	Dr Michael Richmond
Role:	Chairman
Signed:	
Date:	

Name of the person completing this form:	Dr Jo Beahan, Medical Director
Email address:	jbeahan@nhs.net

Board of Directors
05 September 2025

The Rotherham NHS Foundation Trust

Agenda item	P146/25
Report	**Emergency Preparedness Resilience & Response**
Executive Lead	Sally Kilgariff, Chief Operating Officer
Link with the BAF	OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system D5: we will not deliver safe and excellent performance
How does this paper support Trust Values	**Ambitious**: Ensuring the Trust is delivering high quality services and a a level of compliance with EPRR core standards **Caring**: Ensuring robust emergency planning arrangements to ensure patients can be seen and cared for in all eventualities **Together**: Working collaboratively with partners to deliver services and achieve the core standards required
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report is an annual update outlining the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements and providing oversight of activities for the 2024/25 period. The EPRR core standards assurance process requires a report to be delivered to a public board stating its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements. The paper also includes a progress report against the EPRR core standards improvement plan against the standards that are not yet fully compliant. The 24/25 annual self-assessment process resulted in 40 core standards assessed as fully compliant, with the remainder partially compliant, resulting in an overall rating of non-compliant. Work continues to be undertaken by the EPRR team with services and good progress has been made ahead of this year's annual self-assessment process. Since the report was received by Finance and Performance Committee further progress has been made. Further evidence has now been reviewed by the ICB and compliance confirmed with additional standards which will move the Trust to 90% compliance and a rating of substantial compliance in the next submission. The annual assessment process this year will remain the same as last year, with the self-assessment process being undertaken in the Autumn and submission to the ICB by end of October. This will be followed by confirm and challenge sessions with final sign off by the Board of Directors prior to submission nationally.

Board powers to make this decision	The Board of Directors has delegated the oversight of the Trust's EPRR assurance to the Finance and Performance Committee, maintaining oversight of the progress of the core standards improvement plan on a quarterly basis. This annual review is presented to the Board for assurance as there is a requirement in the EPRR Core Standards for an annual report to be received by the Board of Directors.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Chief Operating Officer is the lead officer as Accountable Emergency Officer. Operational oversight of the plan is via the Trust's EPRR meeting. The plan has been discussed at the Executive Team meeting and Finance and Performance Committee who were assured on current arrangements and progress against the action plan.
Recommendations	It is recommended that the Board of Directors note the content of this report for assurance outlining the Trust's readiness and preparedness activities that have been undertaken.
Appendices	1. Core Standards Improvement Plan Tracker

1.0 Background

The Civil Contingencies Act (CCA 2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at a local level. As a category one responder, the Trust is subject to the following civil protection duties:

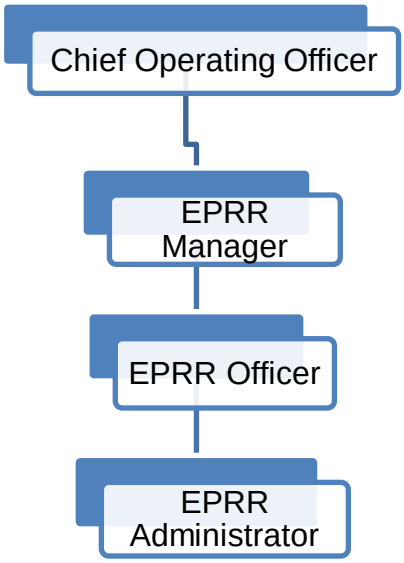
- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection maters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance coordination
- Cooperate with other local responders to enhance coordination and efficiency

The NHS Emergency Preparedness Resilience and Response (EPRR) Framework (2022)[1] describes how the NHS in England will go about its duty to be properly prepared for dealing with emergencies. The document provides the framework to help NHS Funded Organisations meet the requirements of the CCA 2004, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract. The EPRR core standards assurance process requires a report to be delivered to a public board stating its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.

This paper outlines the Trust's EPRR arrangements including resourcing, governance, risk assessment, incident response plans, a summary of incidents where command and control processes have been activated, organisational learning, training and exercising, audit and concluding with the current EPRR assurance process and update on progress against the improvement plan.

2.0 EPRR Resourcing

The Chief Operating Officer is the Trust's Accountable Emergency Officer (AEO) responsible for EPRR. The Trust's EPRR arrangements are resourced as below;



In addition to the above, the EPRR team draws upon resources from across the Trust as required to progress various work streams which is well supported.

[1] B0900_emergency-preparedness-resilience-and-response-framework.pdf (england.nhs.uk)

Whilst resourcing is currently sufficient and appropriate, a formal review will be undertaken to assess if increased demand warrants a proportionate addition to the Trust's EPRR resourcing.

3.0 Governance

Governance is delivered through the EPRR group which has representation from across the Trust, a Terms of Reference and meets on a six weekly frequency, chaired by the Director of Operations. Relevant matters, including any key issues and risks are escalated to the Chief Operating Officer. The meeting reports directly into the Executive Team Meeting, with minutes of the meeting received by that committee on a monthly basis. Throughout the year, all scheduled meetings went ahead and were quorate with the majority of members achieving the required minimum attendance requirement with the necessary escalation to the Accountable Emergency Officer for those who didn't.

4.0 Risk Assessment

The Trust manages a specific EPRR risk register, the content of which is aligned to the national risk register, South Yorkshire Local Resilience There are four organisational EPRR relevant risks recorded on the Trust register, the highest risk level of which is moderate with a risk scoring of nine. The registers are reviewed quarterly by the Trust EPRR group and informs a programme of work.

5.0 Incident Response Plans

A suite of ten emergency plans, reviewed annually is in place and available for all Trust staff to access and view online via the Hub. Hard copies of each plan are retained in the Incident Control Centre and at operational level. Plans are exercised according to an agreed schedule. Any new or existing Trust wide plans which have been significantly updated are presented to the Executive Team for approval whilst other plans reviewed are approved by the Trust EPRR group with Director level oversight.

The planning and exercising process includes collaboration with other resilience partners.

Both the Emergency Preparedness, Resilience & Response and Business Continuity Management Policy are current and compliant against respective core standards.

Each service across the Trust has their own business continuity plan. Plans are reviewed at least annually and following an incident when the plan is activated. Hard copies of plans are held with operational teams for immediate access when required. Of the 62 individual plans, 78% are in date, the remainder currently under review. The current status of business continuity plans is reviewed at each EPRR meeting with any plans passed three months being escalated to the Accountable Emergency Officer.

Response to and recovery from emergencies and business continuity incidents is managed through embedded command, control, coordination and communication (4C) process, mirroring national, regional and local arrangements.

6.0 Incidents

A number of incidents have resulted in the Trust activating its 4C process and business continuity plan over the past year which is summarised below;

June 28th - 4th July	Industrial Action – Doctors in Training
August 4th – 9th	Civil Unrest
October 9th – 15th	Operational Pressures

23rd 31st – 1st November	RCHC Loss of Water Telephony – Inbound Direct Dial Calls
November 4th 11th – 12th 26th – 28th	 Telephony –Inbound and outbound direct dial calls Reduced O2 stocks Operational Pressures
December 17th – 19th	 Operational Pressures
January 2nd – 16th 5th – 6th 28th – 29th	 Operational Pressures Adverse Weather – Snow & Ice Operational Pressures
February 28th	 Telephony – Inbound Direct Dial Calls

In addition, a number of service level business continuity incidents have occurred throughout the year, effectively managed through operational command with Director oversight.

7.0 Organisational Learning

Following each incident resulting in the activation of Trust 4C processes, a structured debrief including colleagues involved in the response and recovery phases of the incident is held with a report produced highlighting both areas of good practice and learning. Debriefs also take place following exercises. Reports are considered by the Trust EPRR group and identified owners assigned to complete approved recommendations, plans updated and learning shared. A recommendation and action tracker is maintained by the EPRR team and reviewed by the EPRR group quarterly.

8.0 Training & Exercises

Over the past 12 months the following has been delivered to colleagues across the Trust;

Training

- Decision Logging
- On Call Induction
- Major Incident Response
- Security Incident Management
- Incident Control Room Activation
- Adverse Weather Preparedness
- Principles of Health Incident Command – This course is mandatory for all colleagues performing the role of Director on call, Senior Manager on Call and the Clinical Site Operations Team.
- Business Continuity
- Chemical, Biological, Radiological, Nuclear & Hazardous Materials (CBRN/HAZMAT)
- Fuel Disruption
- Evacuation & Shelter

Exercising

- Exercise Trojan - Cyber Security
- Exercise Parlez - Major Incident Communications
- Business Continuity Incidents
- Lockdown Incidents
- Exercise Petroleum – Fuel Disruption
- Exercise Terrier & Labrador – Mass Casualty

The NHS EPRR Framework requires the Trust to complete the following:

Exercise Type	Minimum Frequency	Completed
Communication Exercise	6 monthly	18th July 2024 (out of hours) 24th September 2024 (in hours)
Table-top	Annually	10th December 2024
Live Play	3 Yearly	6 September 2023
Command Post	3 Yearly	Industrial Action throughout the reporting period
Incident Control Centre (ICC) Equipment Test	Quarterly	25th April 2024 22nd August 2024 17th December 2024 12th February 2025

9.0 Business Continuity Management

In the final quarter of 2024, a newly created Business Continuity Management policy was implemented, enhancing existing arrangements. It describes the Trust's Business Continuity Management System (BCMS), supporting the organisation's strategic aim, ensuring the Trust is resilient and capable of providing appropriate care regardless of disruptions to the delivery of service as a consequence of external or internal incidents. The policy sets out the framework for planning and responding to incidents by identifying roles, responsibilities and processes to ensure the continuity of critical services and business operations, protection of patients and staff, maintenance of the organisation's reputation and its ability to deliver the organisational strategy and objectives. A requirement to formally review the continuing suitability, adequacy and effectiveness of the BCMS is included within the policy however, given its recent introduction, this will be undertaken midway through the policy's 3 year review period cycle.

10.0 Audit

NHS England commissioned Yorkshire Ambulance Service to undertake an audit of the Trusts' preparedness to deal with a Chemical Biological Radiological Nuclear (CBRN) / Hazardous Material (HAZMAT) incident. The audit process had been updated to include specific CBRN/HAZMAT core standards included within domain 10 of the annual EPRR core standards assurance process requiring a more rigorous portfolio of evidence. The audit outcome stated the Trust is considered 'partially compliant' in being able to deal with any type of CBRN/HAZMAT incident. Several recommendations arose from the audit which the EPRR team are addressing alongside colleagues from the Urgent & Emergency Care Centre.

11.0 EPRR Assurance

All NHS organisations are required to complete an EPRR core standards annual self-assessment process of compliance, the minimum requirements commissioners and providers of NHS funded services must meet. The 2023/24 process saw the introduction of an evidence based check and challenge process led by the regional EPRR team including a significantly higher standard for compliance in comparison to previous year's processes, requiring Trusts to submit plans, policies and supporting evidence, assessed for compliance by the regional team and latterly the Integrated Care Board (ICB) which is out with of national arrangements in all but one other region who initially piloted the process. This resulted in the Trust's compliance rating reducing significantly, a position mirrored across other Trusts within the ICB footprint. Of the 62 core standards, 22 were fully compliant, 39 partially compliant and 1 non-compliant leading to

an overall assessment of non-compliant, accompanied by an improvement plan and programme of work.

Following work undertaken by the EPRR team, the 2024/25 process resulted in 40 core standards assessed by the ICB as fully compliant, the remainder partially compliant, yet despite this progress, the overall compliance rating remained as non-compliant. In the final quarter of the year, progress had been made resulting in a further 10 core standards assessed by the ICB as fully compliant, formally changing overall compliance to partial compliance. Work is ongoing to further improve the position ahead of this year's core standards annual self-assessment of compliance. The current status of this work can be read at Appendix 1.

Quarterly updates against the improvement plan are provided to the Finance and Performance Committee in addition to EPRR monthly updates within the Chief Operating Officers' report.

Sally Kilgariff
Chief Operating Officer
August 2025

Overall self assessment rating:

Ref	Domain	Standard name	Standard Detail	Self assessment RAG Sept 24	Action to be taken	Lead	Timescale	Current Rag Rating	Update
12	Duty to maintain plan	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Partially compliant	Awaiting ICB on SY wide infectious disease planning. Training & Exercising to be incorporated to work programme once complete	ICB EPRR Team	Sept 25 Sept 25	Partially Compliant	1/4/25- Work started to review existing Trust and RMBC plans. 1/7/25 - Plans reviewed evidence submitted to ICB for assessment
14	Duty to maintain plan	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Partially compliant	Awaiting SY ICB to develop county wide Mass countermeasures plan Training & Exercising to be incorporated to work programme once complete	ICB EPRR Team	Sept 25 Sept 25	Partially Compliant	1/4/25- Work started. Countermeasures described in the Trust CBRN/HAZMAT plan. Reviewing other Trust and RMBC plans. 1/7/25 - Plans reviewed evidence submitted to ICB for assessment
16	Duty to maintain plan	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Partially compliant	Develop and implement training and Exercise programme, including opportunities to test the plan with other Trusts	EPRR Team	Sep-25	Partially Compliant	1/4/25- ward based training plan under development for implementation June 25 1/7/25 - Ward based training has commenced. Plan and training programme submitted to ICB for assessment
19	Duty to maintain plan	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Partially compliant	Awaiting SY ICB to develop county wide excess death plan Training & Exercising to be incorporated to work programme once complete	ICB EPRR Team	Aug-26	Partially Compliant	1/4/25 - Not yet started. Requires ICB/LRF coordination 1/7/25 - As above. Anticipated to roll over to 25/26 work programme
21	Command and contr	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Partially compliant	Develop training and delivery plan to ensure on call managers receive training aligned to the national occupational standards, evidenced in portfolios Roll out commander portfolios	EPRR Team EPRR Team	July 25 July 25	Partially Compliant	1/4/25 - Portfolios developed. Process to be discussed at ETM ahead of roll out May 25 onwards. All commanders have been provided with details of mandatory courses. 1/7/25 - Training needs analysis completed, portfolios launched. Evidence submitted to ICB for assessment
22	Training and exercis	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Partially compliant	Develop the accessibility of Courses and availability on ESR, to include e-learning, face to face and training delivered by partners. Conduct Training needs Analysis initially for on call colleagues and then wider across the trust for all staff, working with care group colleagues.	EPRR Team EPRR Team	July 25 Jan 25	Partially Compliant	1/4/25 - TNA completed- currently being analysed prior to training programme development. 1/7/25 - TNA analysis completed and training programme agreed. Evidence submitted to ICB for assessment
24	Training and exercis	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Partially compliant	Develop the accessibility of Courses and availability on ESR, to include e-learning, face to face and training delivered by partners. Conduct Training needs Analysis initially for on call colleagues and then wider across the trust for all staff, working with care group colleagues.	EPRR Team EPRR Team	July 25 Jan 25	Partially Compliant	1/4/25 - Portfolios developed. Process to be discussed at ETM ahead of roll out May 25 onwards. All commanders have been provided with details of mandatory courses. TNA completed- currently being analysed prior to training programme development. 1/7/25 - TNA analysis completed and training programme agreed. Evidence submitted to ICB for assessment
25	Training and exercis	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Partially compliant	Develop and implement comms to promote training across the Trust Work with divisions/departments to deliver role specific training To develop EPRR induction training for all relevant staff and new joiners (Bands 1-5/6)	EPRR Team EPRR Team EPRR Team	Feb 25 July 25 Sept 25	Partially Compliant	1/4/25 - Prioritising on call training ahead of progressing this work. Lilley to roll over to 2025/26 process. 1/7/25. Work progressed and evidence submitted to ICB for assessment
46	Business Continuity	Business Impact Analysis/As	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Partially compliant	To review the Trust BIA against the NHS BC toolkit	EPRR Team	March 2026	Partially Compliant	1/4/25 - Working BIA developed. Needs refinement and consultation with care groups. 1/7/25 - Work ongoing
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Partially compliant	Follow Assurance Assessment action plan from YAS	EPRR team	Sep-25	Partially Compliant	1/4/25 - Task and finish group addressing action to move to full compliance. 1/7/25 - Task and finish group progressing actions. Regular reviews with YAS
61	Hazmat/CBRN	Equipment - Preventative Pr	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing	Partially compliant	Follow Assurance Assessment action plan from YAS	EPRR team	Sep-25	Partially Compliant	1/4/25 - Task and finish group addressing action to move to full compliance. 1/7/25 -Task and finish group progressing actions. Regular reviews with YAS
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Partially compliant	Follow Assurance Assessment action plan from YAS	EPRR team	Sep-25	Partially Compliant	1/4/25 - Task and finish group addressing actions to move to full compliance. 1/7/25 -Task and finish group progressing actions. Regular reviews with YAS

Agenda item	P147/25
Report	**Maternity and Neonatal Safety**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5-year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	High Standards for the services we deliver, aim to be outstanding, delivering excellent and safe healthcare.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	It is a national requirement for The Board of Directors to receive a monthly update on Maternity Safety, which goes through Quality Committee. This month's paper is the perinatal quality assurance score card report. This report provides a comprehensive overview of maternity and neonatal service performance at The Rotherham NHS Foundation Trust (TRFT) for June and July 2025. It highlights key metrics, safety outcomes, workforce data, patient experience, and progress against national standards and improvement initiatives. **Births and Care**: 449 babies were born across June and July, with 100% 1:1 care in labour achieved both months. **Safety Outcomes**: No Coroner Regulation 28 cases or Never Events; 30 moderate incidents recorded, nearly all downgraded after MDT review. **Perinatal Mortality**: Stillbirth rate stabilised with 1 case in July and none in June; adjusted Q1 perinatal mortality rate was 3.1/1000 births. **Workforce**: Midwifery staffing gaps reduced from 9.94 WTE to 8.62 WTE; 7.0 WTE Early Career Midwives recruited to start in October. **Training Compliance**: Newborn Life Support training at 89%; PROMPT and CTG training at 99.5%, meeting CNST Year 7 standards. **Patient Experience**: Picker survey results remain above national average for kindness and responsiveness; co-produced action plans with MNVP show impact. **Neonatal Admissions**: 14 full-term babies admitted to NNU in each month; all admissions reviewed and deemed unavoidable. **Strategic Progress**: Fully compliant with Saving Babies Lives v3; new digital patient record system approved to improve documentation and access.

Due Diligence	This paper has been prepared by the Head of Midwifery and approved by the Director of Midwifery. The report is shared through Maternity and Care Group 3 Business and Governance meetings, the Maternity and Neonatal Safety Champions and Quality Committee.
Board powers to make this decision	The Trust Board are required to have oversight on the maternity and neonatal safety work streams.
Who, What and When	Helen Dobson, Chief Nurse, is the Board Executive Lead. The Director of Midwifery or Head of Midwifery attend Quality Committee and Trust Board bi-monthly to discuss the Maternity and Neonatal Safety agenda.
Recommendations	It is recommended that the Trust Board are assured by maternity and neonatal outcome data and update provided.
Appendices	None

Perinatal Quality Assurance Scorecard



June & July 2025 Data



The Rotherham NHS Foundation Trust Maternity Services

Ambitious Caring Together

NHS The Rotherham NHS Foundation Trust

Contents

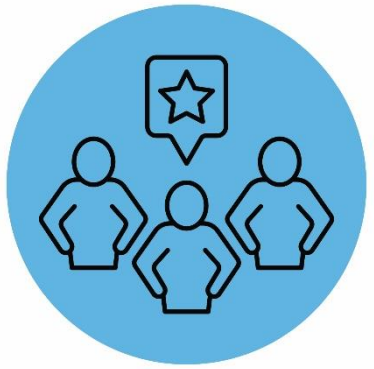

Overall Summary


Workforce


Perinatal Mortality Summary

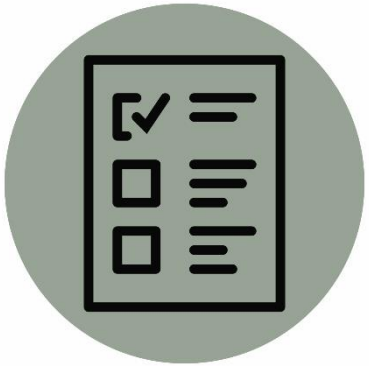

Safety


Patient Experience

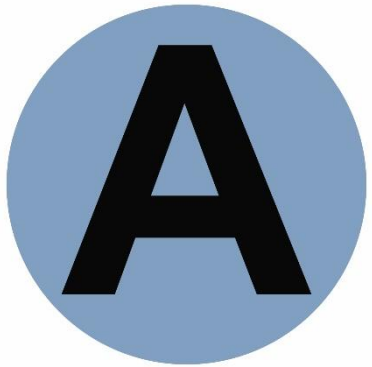

Staff Feedback


Current Issues


SPC Charts


Maternity Incentive Scheme


Saving Babies Lives v3


Attain


Preterm Birth

Month at a glance: June and July 2025

Number of Moderate DATIX Incidents in June (16) and July (14)

Number of reported Perinatal Safety DATIX Incidents in June (94) & July (90)

MNSI

0 MNSI Reportable Cases Referred

0 Coroner's Regulation 28

On track for Maternity Incentive Scheme year 7 and 3 Year Delivery Plan

89 %
MDT PROMPT % & CTG
99.5 Training %

85% Maternity & % 92.5 Neonatal staff New-born Life Support Training Compliance

Smoking at booking Q1
9.2%

Smoking at Birth Q1
6.6%

100%
1:1 Care in Labour in June and July 25

Number of 3rd and 4th Degree Tears in June (3) & July (2)

Number of Full-Term Babies Admitted to NNU in June (14) & July (14)

Incidence of Blood Loss >1500mls in June (12) & in July (5)

Safe Staffing Met 90% June& 94% July

Vacancy Rate:
Midwives: 0
Obstetric: 1 WTE

Perinatal Scorecard Summary

Overview

Quality Assurance: Robust quality assurance processes are in place, with all perinatal deaths reviewed through the PMRT and learning shared across the multidisciplinary team. Compliance with CNST Year 7 standards is being maintained, and thematic reviews are actively informing practice improvements.

Performance Monitoring: Key metrics such as 1:1 care in labour, preterm birth rates, and neonatal admissions are closely monitored and reported monthly. Performance against national targets, including Saving Babies' Lives and ATAIN, is regularly reviewed to ensure alignment with best practice and regulatory expectations.

Improvement Initiatives: Ongoing quality improvement projects include enhancing triage service delivery, thematic reviews of PPH and cord gases, and the implementation of a supernumerary shift coordinator role in neonatal care. These initiatives are supported by staff engagement and feedback mechanisms to ensure relevance and impact.

Accountability: Clear governance structures ensure accountability at all levels, with action plans developed for all safety recommendations and regular oversight by the Trust Board. MDT reviews and transparent communication with families reinforce a culture of learning and responsibility.

Resource Allocation: Funding has been secured to procure and acquire a new patient record functionality. It is anticipated that the new system will reduced the amount of time to complete documentations and improve the woman's access to her records.



Medical care (including older people's care)	29 September 2021	Requires improvement
Services for children & young people	29 September 2021	Good
Critical care	2 March 2017	Good
End of life care	14 July 2015	Good
Maternity	29 September 2021	Good
Outpatients and diagnostic imaging	14 July 2015	Good
Surgery	2 March 2017	Good
Urgent and emergency services	29 September 2021	Requires improvement

Quality & Safety

•100% 1:1 care in labour achieved both months.
•1 MNSI reportable case but stood down as normal MRI; 2 safety recommendations received in July.
•16 moderate incidents in June, 14 in July (all but one downgraded).
•No Coroner Regulation 28 cases or Never Events.
•Stillbirth rate stabilised; 1 case in July, none in June.
• x1 Neonatal death in July at 22 weeks with known anomalies.

Experience

•MSDS data shows that year on year, Picker survey results remain above national average for kindness and concerns in labour responded to.
•Co-produced action plans with MNVP show positive impact.
•Focus groups held with non-English speaking women and those from deprived areas.

Outcomes

•Preterm birth rates: 4.9% in June, 5.1% in July—below LMNS target of 6%.
•Term admissions to NNU remain above target but all considered to be unavoidable.
•3rd/4th degree tears: 3 in June, 2 in July.
•Blood loss >1500mls: 12 in June, 5 in July.
•Full-term babies admitted to NNU: 14 in both months.

Training & Learning

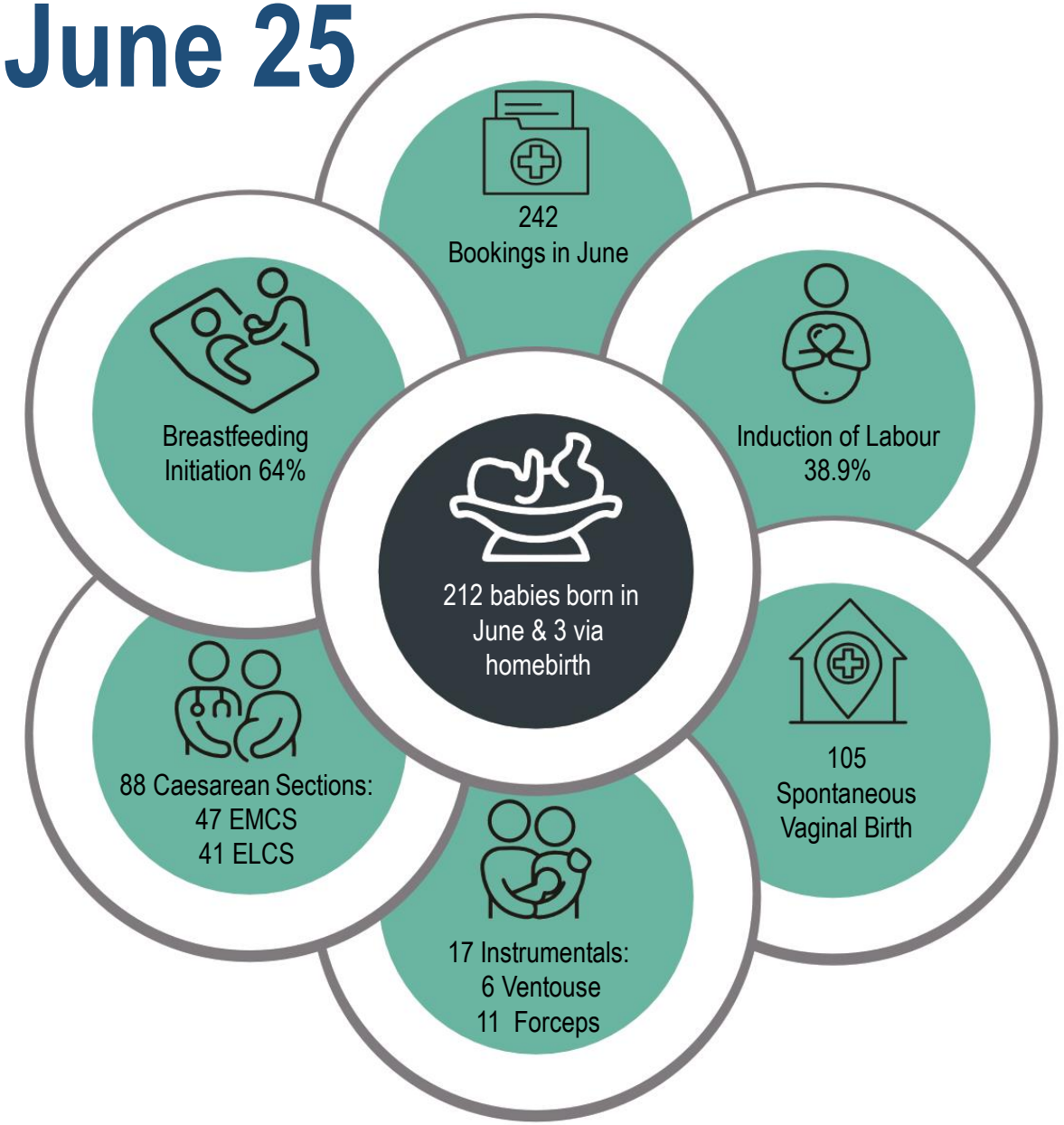
- Training is on track to meet CNST requirements in the time frame we have.
- Learning from thematic reviews continues to be informative and is shared via the safety champions meetings along with action plans.
- Focused work on NHSP midwives completing MAST is in progress.

Workforce

•No unit closures.
•Anaesthetic cover 100%.
•Red flags: 1 in June, 5 in July (all for ARM delays).
•Midwifery staffing gaps reduced from 9.94 WTE in June to 8.62 WTE in July.
•Consultant gaps persist; locum cover in place.

Overall Monthly Summary

June 25



July 25



Overall Year to Date Summary



Perinatal Mortality Summary

	2023 Total	2024 total	Cumulative 01/01/2025 - 31/05/2025	In Month: June 2025	In Month: July 2025	Information
Total Stillbirths (all)	6	9	1	0	1	Booked at BRI
Stillbirths >37 weeks	1	5	1	0	0	
Stillbirths 24-36+6 weeks	5	4	1	0	0	
Intrapartum stillbirths	-	2		0	0	
MTOP Anomaly >24 weeks	2	-		0	0	
Adjusted stillbirths	6	9	1	0	0	
Total Neo-natal deaths (NND)	4	5	1	0	0	
ENND >24 weeks up to 7 days of life	2	2		0	1	1 neonatal death @ 22/40 – known anomalies.
LNND 7-28 days	1	1		0	0	
Adjusted neo-natal deaths – all gestations (Excl MTOP)	2	2		0	0	
Total Adjusted Perinatal (24wk – 28 days)	8	11	1	**0**	**1**	
MTOP ENND	-	-		0	0	
Stillbirths elsewhere (Booked at TRFT)	-	-		0	0	
Neo-natal deaths elsewhere (outside of TRFT)	2	4	1	0	0	
Maternal deaths	1	1		0	0	
NVF <24 weeks	10	14	5	0	0	
NPMRT entered	10	14	2	0	2	
NPMRT closed	10	8	1	1	3	

In Summary

What is the local data telling us?

Local stillbirth rates (Stabilised and adjusted) have seen an increased from 2022 to 2024:

- 2021: 3.22/1000 births MBRRACE data
- 2022: 2.68 /1000 births MBRRACE data
- 2023: 2.88/1000 births MBRRACE data
- 2024: 3.66/1000 births TRFT data

ONS data indicated a 25% decrease in stillbirths in 2020, followed by a 20% rise in 2021 due to the COVID-19 pandemic. National rates were:

- 2021: 3.52/1000 births
- 2022: 3.33/1000 births
- 2023: 3.9/1000 births
- 2024 data not yet available.

What is going well?

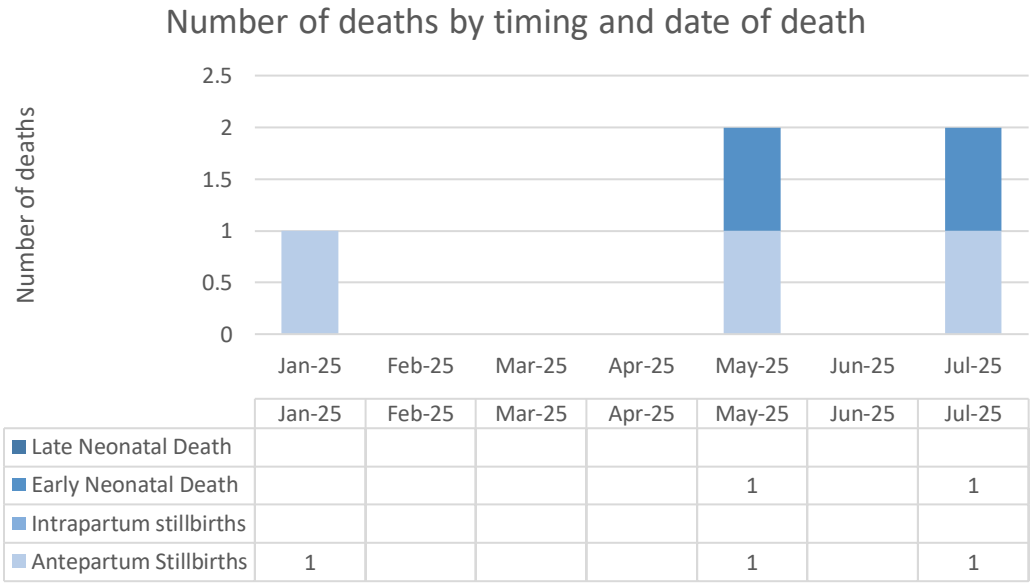
- Ongoing learning from stillbirth and neonatal death reviews is communicated through maternity MAST.
- Work has begun to look at how the families voice can be more present in the PMRT meetings.
- No themes have been found from MDT and thematic reviews at both local and LMNS levels.

Thematic review of the 2024 Stillbirths

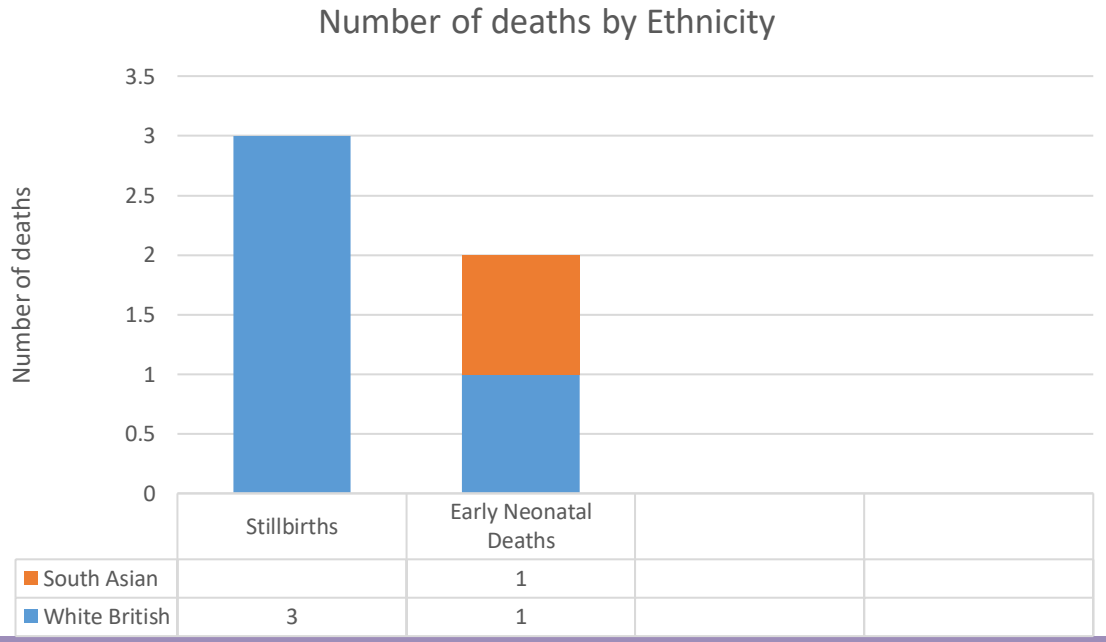
For the calendar year 2024, Rotherham Trust experienced an increase in stillbirths from 6 cases in 2023 to 9 cases in 2024.

Perinatal Mortality Summary

Year to date Summary for 2025



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Late Neonatal Death							
Early Neonatal Death					1		1
Intrapartum stillbirths							
Antepartum Stillbirths	1				1		1



	Stillbirths	Early Neonatal Deaths		
South Asian		1		
White British	3	1		

What is the local data telling us?

- There is no link with ethnicity for one particular group.
- There were 2 stillbirths below 24 weeks, 1 case, 28 to 31 weeks gestation, 1 case 32 to 36 weeks gestation and 1 case 37 to 41 weeks gestation.
- Of the 5 cases to date, 2 were thought to be placenta related and 3 had unknown cause.
- Non of the mothers were smokers.
- Only 1 mother had a raised BMI.

NB: Further analysis will be available once all reviews are completed

What will be our focus?

- To review the 2024 perinatal deaths at the TRFT annual Perinatal Learning Event that is planned for the 5th of November 2025. This will be attended by local and external experts with a view of identifying any further commonalities and themes to inform future learning.

What are our goals?

- Delivering safe care that aligns with national best practice standards.
- Achieving a decrease in stillbirth and perinatal mortality rates consistent with national targets.

Quarterly Perinatal Mortality Data - Q1 Summary

Births - 642

Q1 (2025-2026) - Perinatal Mortality all deaths (including congenital anomalies) Total Perinatal: 6.2/1000 births		
Type of Death	Number	Rate per 1000 births
Stillbirth	2	3.1
Neonatal death	2	3.1

Q1 - Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP) Adjusted Total Perinatal: 3.1/1000 births		
Type of Death	Number	Rate per 1000 births
Stillbirth	2	3.1
Neonatal death	0	0

In Summary

What do we need to focus on?

Continue to work as an MDT to reduce stillbirth rates to meet the national ambition.
Continue to learn from stillbirths and neonatal deaths and PMRT reviews and listen to families and understand how their experience can change the care moving forwards.
Sharing actions plans and learning with staff and the wider MDT for learning – LMNS and the Maternity and Neonatal Service Voices Partnership (MNVP).

Where do we want to be?

To be the best In England and regionally at meeting the national ambition of reducing stillbirths and neonatal deaths.

2023 - Local and regional stillbirth rates;

TRFT - Births 2569, Stillbirth rate **2.72/1000** birth
Barnsley – Births 2916, Stillbirth rate **2.9/1000**
Sheffield - Births 5549, Stillbirth rate **3.43/1000**
Doncaster and Bassetlaw – 4476 births. Stillbirth rate **3.04/1000**

Perinatal Mortality Summary

Maternity (Perinatal) Incentive Scheme Year 7 – 01/12/2024 – 30/11/2025

CNST Standard 1 requirements	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25
Percentage of eligible perinatal deaths reviewed using PMRT as an MDT (100%)	No cases	1 case	No cases	No cases	No case	100%	100%	100%					
Percentage of eligible perinatal deaths notified to MBRRACE-UK with 7 working days (100%)	No cases	1 case 100%	No cases	No cases	No cases	1 case 100%	0 cases	2 cases 100%					
Surveillance information completed within 1 calendar month	No cases	1 case 100%	No cases	No cases	No cases	1 case 100%	0 cases	2 cases 100%					
Percentage of parents that have had their perspective of care and any questions sough following baby's death (95%)	No Cases	1 case 100%	No cases	No cases	No cases	1 case 100%	100 %	100%					
Percentage of PMRT reviews started within 2 months (95%)	No cases	Met	No cases	No cases	No cases	100%	100%	100%					
Percentage of PMRT reports published within 6 months (60%)	No Cases	For review	No cases	No cases	No case	For review	2 cases 100%	2 cases 100%					

Finalised PMRTs – June and July 2025
June 2025
1 PMRT review closed and published
Case 1 - Graded B,A,A - The review group identified care issues which they considered would have made no difference to the outcome for the baby.
July 2025
3 PMRT reviews closed and published
Case 1 –was graded – C, A the MDT review The review group identified care issues which they considered may have made a difference to the outcome, for the baby. This case was referred to MNSI and investigated. Learning has been identified.
Case 2 – was graded A and A
Case 3 - was graded A and A
Learning and actions – actions were identified from the MNSI reviews for this trust.

In Summary

What is the data telling us?

- Families are encouraged to share their perspective /impact statement as part of the review process.

What is going well?

- No recurrent themes identified
- Families are encouraged to share their perspective as part of the review process.

What do we need to focus on?

- Continue the work around preterm birth to maintain the rate below 6.0%.
- Continue to monitor for inequalities in these outcomes based on ethnicity and deprivation.
- Establishing routine data collection on miscarriages.

What is our desired destination?

- Maintain CNST Year 7 Standard 1 to demonstrate continued learning and safety at TRFT.
- Stillbirth rates to be as low as the best European countries.
- Continue to improve family engagement in the review process.

Safety

June / July 2025

1 case met MNSI criteria for referral in June but this case was stood down as the baby had a normal MRI. 0 cases in July.

2 MNSI Safety recommendations in July from a published report.

No new PSII's declared in June or July 2025.

0 Never Events

16 Moderate Incidents were recorded for June and 14 were recorded for July 2025 (all but 1 case was downgraded following MDT review)

0 Coroner Regulation 28

MOSS DATA

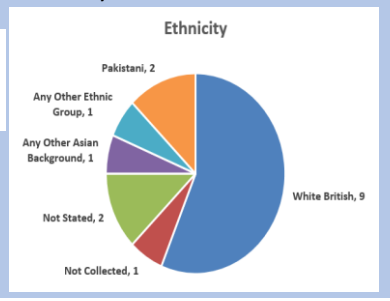
MOSS, or the Maternity Outcomes Signal System, is a digital system being developed by NHSE to monitor potential safety concerns in maternity care and support timely interventions. It is designed to improve critical mother and baby outcomes by tracking key indicators of safety standards during intrapartum care. The system is not yet fully operational but is in the pilot phase of implementation, with plans to be rolled out to all maternity services by November 2025. Any MOSS signals that are sent to TRFT will be included in this report as soon as it is available. The internal monitoring data that would accompany any signals will be included within the next report.

In Summary

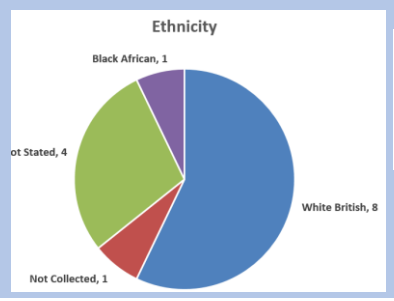
What is the data telling us?

- Moderate harms & ethnicity for June 25

- x11 MOH
- x3 3rd degree tears
- x2 shoulder dystocia



Moderate harms & ethnicity for July 25



- x5 MOH
- x2 3rd degree tears
- x1 shoulder dystocia
- x5 low cord gases
- x1 low apgars

MNSI safety recommendation

1. It is recommended that the Trust supports staff to use structured communication when planning a controlled artificial rupture of membranes. This will ensure that all relevant clinical staff are aware of when the procedure is being carried out and their roles and responsibilities in case any support or escalation is required.
2. It is recommended that the Trust works with clinicians to review and address the barriers to completing a holistic clinical assessment when a fetal heart rate is not identified, so that all risk factors and clinical options are considered in a timely manner.

What is going well? What do we need to focus on?

- Action plans are being developed and monitored via governance structures in response to the MNSI final report that has been received.
- Tri-partite meetings have been offered to the family with both maternity senior team and MNSI to ensure that any action plans developed are in line with the woman's expectations.
- Thematic reviews are ongoing for themes within the service.
- The demographic of moderate harms sustained appear to be in line with the local.
- There is one PSII case currently, the report is completed and will be shared with panel in August 25.

Where do we want to be?

- Provide full support to women and families affected by traumatic births or poor outcomes, maintaining transparency about findings and demonstrating growth.
- Foster a positive work environment where psychological safety is prioritised, allowing concerns to be voiced without fear supporting the Just Culture Principles.

Safety

Key Performance Indicator MNSI	2019	2020	2021	2022	2023	2024	2025
MNSI Referrals (Referred & Accepted)	6	3	5	1	0	2	4
Baby cooled	5	1	3	0	0	2	1
Baby cooled but no consent to investigate	0	0	0	0	0	0	1
Stillbirth (SB) /Neonatal Death (NND)	0	1 (NND)	2 (NND)	1 (SB)	0	0	3 (SB)
Stillbirth / Neonatal Death but no consent to investigate	0	0	0	0	0	0	0
Maternal death	1	1	0	0	0	0	0
Maternal deaths but no consent to investigate	0	0	0	0	0	1	0
MNSI Total Safety Recommendations	2	6	9	1	0	2	8

What insights does the data provide?

- The series of stillbirth incidents that took place at TRFT were the primary focus of MNSI's investigations this year.
- The unit was given 2 safety recommendations in July, giving a total of 8 safety recommendations in 2025.

What is going well?

- TRFT continues to collaborate closely with families connected to MNSI cases.
- Every family is offered support by the Maternity Independent Advocate to assist them throughout their investigative process.
- Completed reports are distributed through clinical effectiveness and Safety Champions.
- No further cases have been referred to MNSI for the past 2 months.

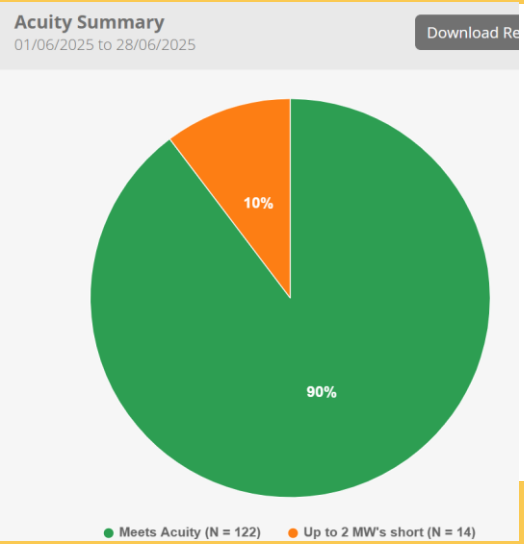
What do we need to focus on?

- That all recommendations and final reports have SMART action plans.
- Continue to share draft reports with staff and families.
- Create 'Lightening Learning' newsletters to share any final reports with staff for learning.
- Ensure all action plans are completed in a timely manner.

Where do we want to be?

- Strive for zero MNSI Safety Recommendations as part of a culture focused on improvement and learning but learn from the ones we may receive.
- Provide full support to women and families affected by traumatic births or poor outcomes, maintaining transparency about findings and demonstrating growth.

Workforce

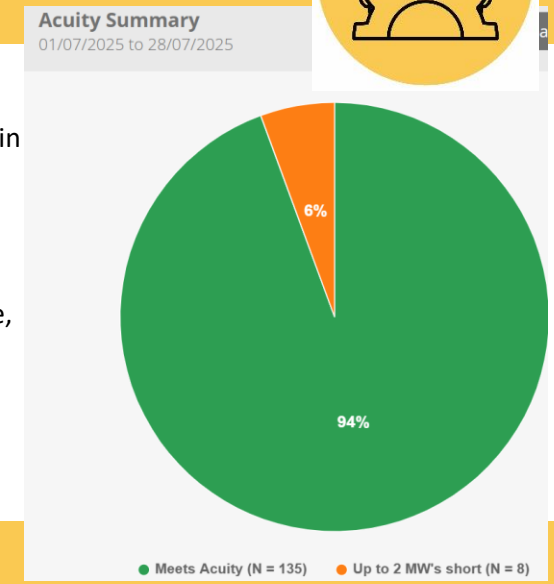


Midwifery Staffing:. The Maternity service has successfully recruited 7.0 WTE Early Career Midwives, set to commence in October 2025, to help manage turnover and fill gaps in the rota due to maternity leave, which aren't accounted for by the 21% uplift at TRFT. NHS Bank usage is carefully monitored with regular roster meetings to maintain grip and control of spending.

Medical Staffing: An ongoing 1 WTE Consultant gap has not been recruited to due to a lack of skilled staff. A further 1 WTE gap is expected for Q2 of 2025. The care group is currently exploring Locum cover. In June, 17 Dr's shifts required cover for ST1/2 and ST3 to ST7, a further 39 shifts required cover for Consultant gaps. July, 30 shifts were filled with locum Dr's for ST1/2 and ST3/7. 50 shifts required Consultant level locum cover for July. Reasons included annual leave, study, sickness, strike cover and additional work.

June 2025 data

July 2025 data



In Summary

What is the data telling us?

- Staffing achieved 100% one-to-one care in labour during both months.
- No community midwives were called into the unit for escalation out of hours in June or July.
- Our pastoral support midwives are preparing to welcome 7.0 WTE early career midwives in Sept/Oct.
- We had 1 red flag in June and 5 in July, all of which were for a delay in women being offered Artificial Rupture of Membranes (ARM). This occurs during high acuity periods, as women are awaiting transfer to the labour ward for 1 to 1 care.

What do we need to focus on?

- In June, service gaps calculated at 9.94 WTE, decreasing to 8.62 WTE in July due to maternity leave and long-term sickness. NHS professionals are utilised to fill these gaps, with roster challenge meetings overseeing Bank usage.
- Continue to audit triage services and staffing to monitor improvements.
- Continue to support the ward teams to input accurately the correct levels of acuity in the tool.
- Continue to have 4 midwives on the ward area to meet the high acuity demands seen in this area – this will improve the women's experience and also discharge processes for women.

What is going well?

- No red flags were used to escalate that Consultants did not attend when required as per the RCOG guidance for obstetric emergencies.
- No red flags were used to escalate that a Consultant ward round did not take place twice daily on labour ward.
- There is close monitoring of NHS P usage each month – only shifts above the 21% uplift are released.
- The unit did not close in the month of June or July 2025.
- Anaesthetic cover for labour ward was rostered in 100% of the time in both months.
- NNU nursing staffing met the Qualitied in Speciality (QIS) BAPM requirements in both months.
- Supernummary labour ward co-ordinator status was maintained in 100% of times for both months.

Where do we want to be?

- To cover all gaps via substantive staff with minimal Bank usage to cover last minute sickness.
- Maintain low sickness and absence levels
- Continue to have 100% for all CNST year 7 staffing requirements.

Mandatory training- TRFT

MATERNITY DASHBOARD DATA End of July 25 Total Compliance	Obstetric Consultants	Obstetric Registrars (ST3-7)	Obstetric Trainees (ST1-2)	Midwives (All bands)	NHSP Midwives	Clinical Support staff	Obs Anaes
Module 1: SBL (Total taught module compliance only. % worked out by % for each module element added together divided by 5 SBL elements) not including: e-learning VBA/GAP or SFH compliance	100% (face to face taught content)	98% taught face to face content	100% of relevant taught content	96%	84%	82%	N/A
Module 2: FS Study Day	100%	100%	100% career SHO	98%		N/A	
Module 3: PROMPT (% of staff that has attended full day within last 12months)	100%	100%	100%	96%	75%	81%	71%
Module 6: NLS *SCBU staff and paediatric staff reported on separately	N/A	N/A	N/A	94%	75%	82%	N/A
Total attendance to Midwifery Update Day (combination of TRUST requirements and module 4/5 content)	N/A	N/A	N/A	91%	N/A	N/A	N/A
Core Competency Day (Modules 1/4/5/6)	100%	100%	100%	94%	75%	82%	N/A

In Summary

What does this data indicate? Traffic light system of attendance to mandatory training for MIS 7 Standard 8 demonstrates that number of staff meeting the requirements is good for most staffing groups.

What is going well?

Fetal surveillance compliance and attendance is very good and this reflects the safety recommendations to ensure all staff working on Labour Ward are up to date and have passed the in-house fetal surveillance Study day test which is a national recommendation.

What do we need to focus on?

Targeted for PROMPT attendance is clinical support staff, NHSP regular midwives (we only have x 3 regular NHSP midwives- so this is in fact only one staff member to increase figures to 100% compliance) and Obs roster anaesthetists. Clinical Educator Midwife is working with leads to ensure all anaesthetists booked onto PROMPT for full day before end of MIS 7 Reporting period.

Where do we want to be?

Sustain 90% compliance or above for most of the year in all of the reportable subjects.

Neonatal Nursing Workforce

At present, 76.6% of the nursing workforce are Qualified in Speciality Trained (QIS) training, which meets the BAPM Qualified in Specialty (QIS) standards necessary for safe care and the MIS year 7 standard. The roster skill mix includes 5 registered nurses and a minimum of 3 staff per shift who are QIS, some shifts have 4 QIS staff. Compliance against this standard is monitored by the ODN as part of quarterly workforce reports. The accompanying table displays workforce data submitted to the ODN for Q1 25/26. The unit has established a supernumerary shift co-ordinator role from 1st April 2025 utilising the current establishment, the clinical team have engaged well and have highlighted the importance of the role in providing support and leadership to the nursing team. We continue to maintain QIS above the 70% compliance and have a 2 yearly training plan to ensure we remain QIS compliant.

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 39.46, of which 27.62 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	29.30	29.68	30.79	-1.49	-1.11
Total reg nurses	27.10	27.48	26.80	0.30	0.68
Total QIS	27.10	21.04	18.76	8.34	2.28
Total non-QIS	0.00	6.44	8.04	-8.04	-1.60
Total non-reg	2.20	2.20	3.99	-1.79	-1.79
Reg nurses as % nursing staff	92.5%	92.6%	87.0%		
QIS as % reg nurses	100.0%	76.6%	70.0%		

In Summary

What is the data telling us?

- The service is currently inline with the BAPM QIS standard, which we anticipate to continue, however compliance may decrease due to retirement and recruitment but will remain over 70%.
- In July the shift co-ordinator fell to 62.9% due to staff sickness and increased ITU acuity – 27 shifts had no co-ordinator.
- We didn't meet the 'nursing staff required to meet activity at average 80% occupancy'. This is because, although over recruited, the tool is built on the expected standard of 25% uplift.

What do we need to focus on?

- Reviewing induction package for all new staff
- Reviewing training package for staff returning from maternity leave
- Support training plan to ensure all staff rotate through QIS pathway over next 2 years.

What is going well?

- Continuation of the shift co-ordinator role.
- 3 new Band 6 QIS staff in post.
- 1 Band 6 QIS to vacancy
- 1 temporary B6 clinical educator to support QIS.
- Appointment of clinical educator/governance post.

Where do we want to be?

- Supernumerary coordinator well embedded
- Maintain above 70% QIS compliance or above
- BFI accreditation to stage 2/3 – require funded post to support Neonatal BFI accreditation
- Funded post to support Bereavement care.
- Badgernet Data analyst to support data cleansing.

Neonates at a glance: June 2025



What is going well?

Appointment of Clinical educator/governance lead

Appointment of other B6 posts to ensure each shift has appropriate QIS skill mix and supernumerary coordinators.

Where do we want to be?

Full BFI accreditation to support breast feeding and NNAP compliance.

Badgernet data analyst post to ensure all reporting NNAP data is valid and reliable.

What is the data telling us?

90% compliance for NLS which meets Safety action 8 CNST.

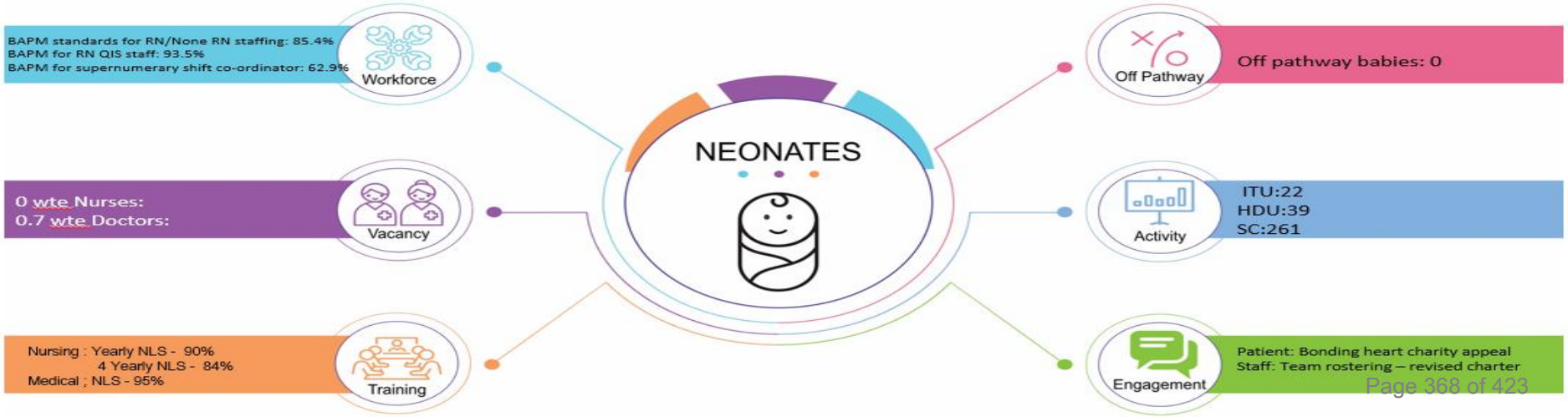
62% compliance for shift coordinator due to sickness and high acuity.

What do we need to focus on?

Support staff training plan for all non QIS staff to achieve full QIS over next 2 years.

Review ways that the NNU roster can support supernumerary coordinator in periods of high acuity/staff sickness.

Neonates at a glance: July 2025



Neonates: June and July 2025



Neonates		June 2025	July 2025
Workforce:	BAPM standards for RN/None RN staffing:	100%	85.4%
	BAPM for RN QIS staff:	98.3%	93.5%
	BAPM for supernumerary shift co-ordinator:	86.6%	62.9%
Vacancy	Nurses:	0 WTE	0 WTE
	Doctors:	0.7 WTE	0.7 WTE
Training		Nursing : 90% (yearly NLS) 84% (4 yearly NLS) Medical: 95%	Nursing: 90% (yearly NLS) 84% (4 yearly NLS) Medical: 95%
Off-Pathway		0%	0%
Activity	ITU:	4	22
	HDU:	74	39
	SC:	167	261
Engagement	Patient:	Coffee Morning NNU	Bonding heart appeal
	Staff:	Shift co-ordinator role	Team rostering – revised staff charter

Patient Experience

Patient experience is crucial for the quality of maternity care, making patient feedback a priority at TRFT. A recent Kings Fund paper noted that "organisations with the most developed approaches to feedback have adopted a wide variety of tools, tailored to local needs." (The Kings Fund, 2023). Given this, senior leaders in maternity and neonatal services believe it's vital to allocate adequate time and resources for feedback activities, especially under service pressure.

Response to concerns during labour and birth			Trust data		National data	
2022	78.1	77.6	Higher	77.2	Higher	
2021	89.2	80.7	Higher	78.7	Higher	
2019	85.9	87.3	Lower	84.4	Higher	
2018	77.8	78.1	Lower	81.9	Lower	
2017	65.8	80.5	Lower	81.3	Lower	
2015	78.4	81.2	Lower	81.4	Lower	

Kindness during postnatal hospital care			Trust data		National data	
2022	77.0	70.5	Higher	70.6	Higher	
2021	81.9	75.8	Higher	71.0	Higher	
2019	74.5	72.2	Higher	75.6	Lower	
2018	74.8	73.6	Higher	74.0	Higher	
2017	71.2	73.7	Lower	73.8	Lower	
2015	71.5	71.7	Lower	70.2	Higher	

In Summary

What is the data telling us?

- The above Maternity Safety Data Sheet (MSDS) published nationally, highlights where a Trust is on it's safety journey over recent years. The above tables show where TRFT is in response to women's feedback from the Picker survey.
- The above information demonstrates that positive response rates have maintained over the last three years and have been higher than the national average for a positive result.

What do we need to focus on?

- Continue to work with the MNVP and listen to the feedback and respond positively to the information gathered i.e. recent focus groups have taken place with women who do not speak English and the partners of women from the most deprived areas.
- We are co-producing an action plan for the most recent Picker survey results with the MNVP chair to continue to learn from the feedback.

What is going well?

- Results from service user Picker Survey's have maintained positive response rates for the questions around concerns in labour and kindness in care.
- The last three years of results have mostly been above the national positive response rate.
- Co-produced action plans with the MNVP from previous years have demonstrated positive change on service user feedback in future years.

Where do we want to be?

- To be in the top 10 % of highest performing maternity units in the UK where women give outstanding feedback about the care they have received.
- Co-produce all services with the MNVP and listen to all the voices of women and families who use TRFT maternity and NNU services.
- Triangulate all data to proactively respond to any themes or commonalities where concerns begin to arise.

Listening to Staff & Feedback

Midwives' confidence in organisations response to concerns about unsafe clinical practice		Local data		National data	
2022	71.2	52.5	Higher	53.2	Higher
2021	79.3	46.7	Higher	48.0	Higher
2020	72.0	69.2	Higher	60.1	Higher
2019	53.8	65.2	Lower	61.7	Lower
2018	63.9	61.6	Higher	61.7	Higher
2017	54.1	59.8	Lower	61.2	Lower

Midwives' recommendation of the service					
2022	81.3	76.3	Higher	65.3	Higher
2021	79.3	64.4	Higher	64.3	Higher
2020	81.3	79.2	Higher	78.1	Higher
2019	65.4	79.1	Lower	76.9	Lower
2018	73.0	74.6	Lower	76.2	Lower
2017	52.6	69.1	Lower	74.9	Lower
2016	61.1	63.5	Lower	73.0	Lower
2015	48.5	54.1	Lower	74.6	Lower

2024 survey shows that 84% recommended the service and 87% felt that the Trust would act on unsafe practice.



Safety Champions Annual Newsletter
How we have used your feedback to improve safety in 2025



Helen Dobson
Chief Nurse

In 2025 so far we have met with teams from the Community, Neonatal, Labour Ward, Wharncliffe and Greenoaks.



Rumit Shah
Non-Executive Director

Following your feedback we have;

- Following feedback around the environment in Triage and labour ward, there is to be 1 million pounds available for improvements in 2025.
- Following concerns around the quality of the interpreting services, a new contract with a new company has been commenced.
- Following feedback of the water quality on the NNU, we are working with the estates team to try and bring a solution.
- We have heard your concerns around theatre capacity and we are working to understand the data and how we can move forwards with improvement plans.

In Summary

What is the data telling us?

- Safety Champions walk around continue to give staff an opportunity to share their thoughts and feelings around working within the NNU and Maternity. Staff report that they feel confident to speak out around any potential issues that they face whilst at work.

What is going well?

- Data released within the Maternity Safety Data Sheet (MSDS), shows a trend for staff within the service increasingly reporting positively for the two questions around safety and recommending TRFT as a place to work. In the las three years reported TRFT were higher than national.

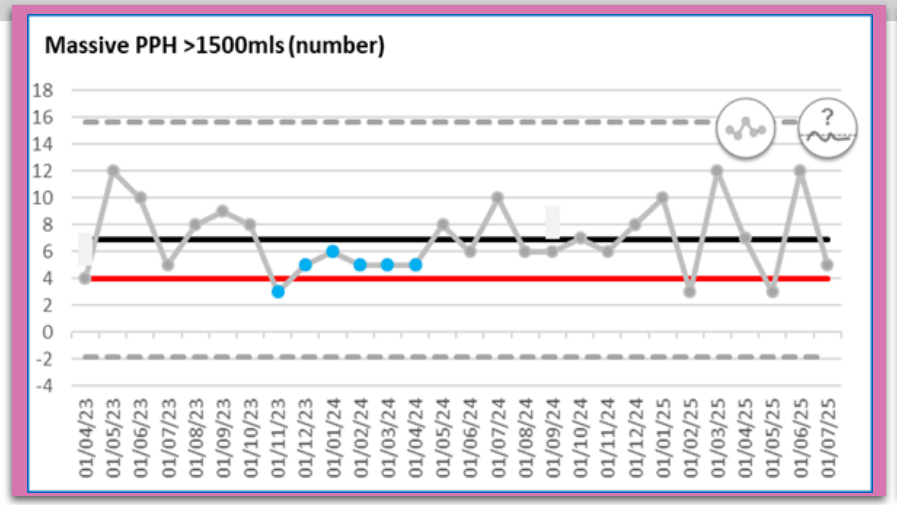
What do we need to focus on?

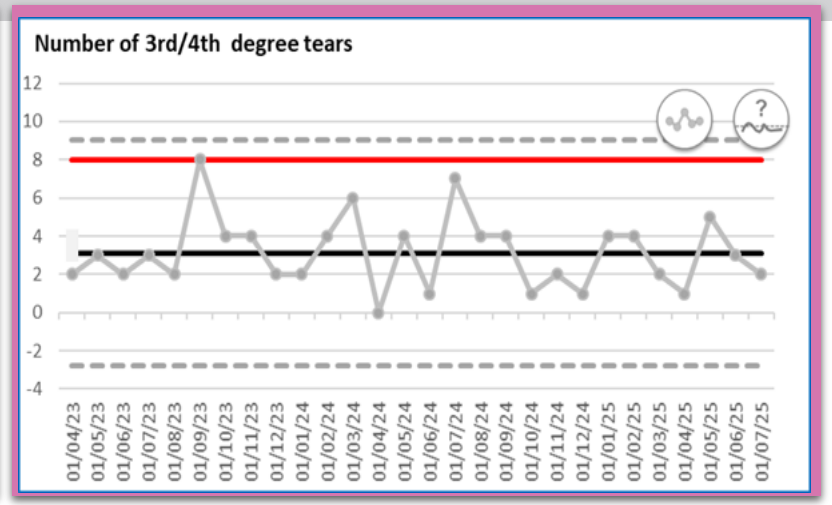
- Continuing to not only listen to the teams in the various areas but to ensure that feedback is given back around any actions taken from the walk rounds.

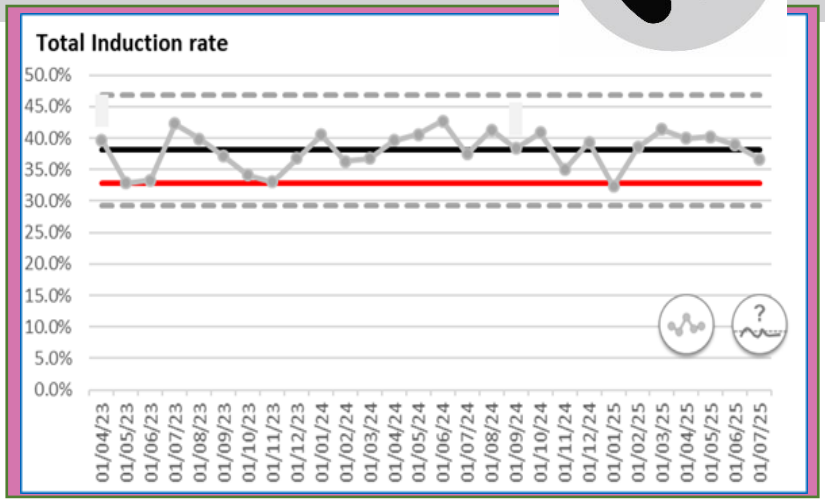
Where do we want to be?

Continue to improve staff survey scores and continue to make TRFT a great place to work where staff feel safe, supported valued and listened to.

SPC charts



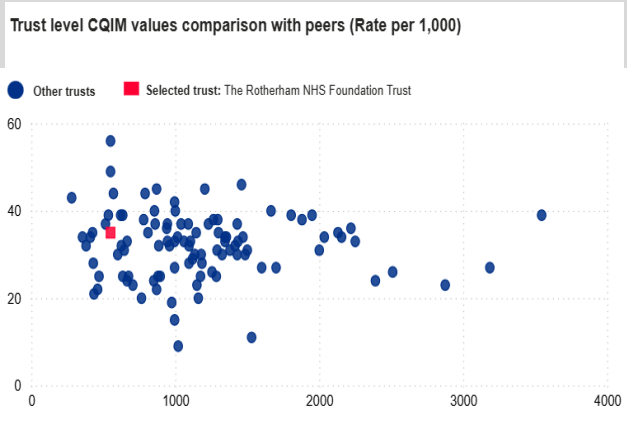




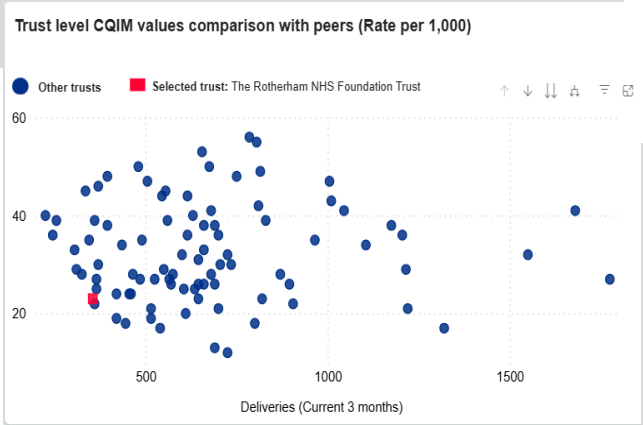
In Summary

What is the data telling us?

- The two charts below represent where TRFT rates for post partum haemorrhage (PPH) and 3rd and 4th degree tears are in comparison to other Trusts.
- The red dot is TRFT and shows the event per 1000 births.
- Induction of labour rates remain around national average.



TRFT position for PPH



TRFT position for 3rd and 4th degree tears

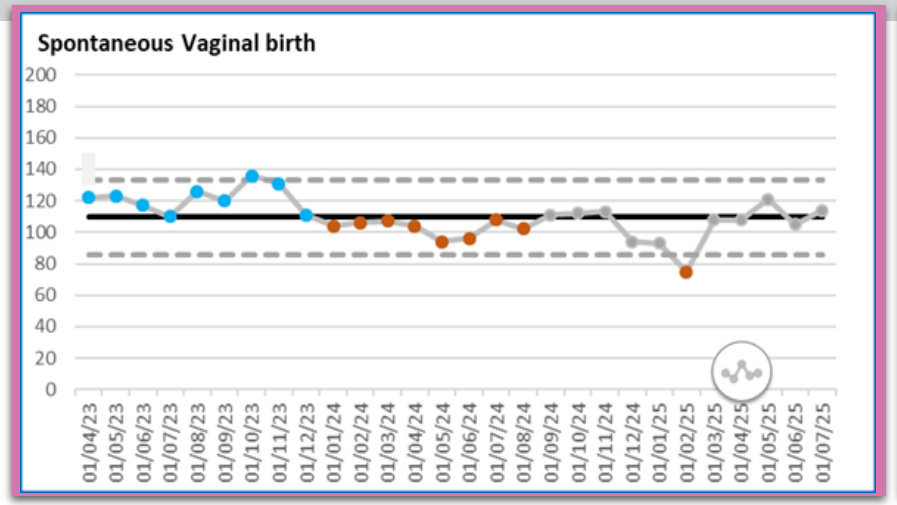
What's going well & What should we concentrate on?

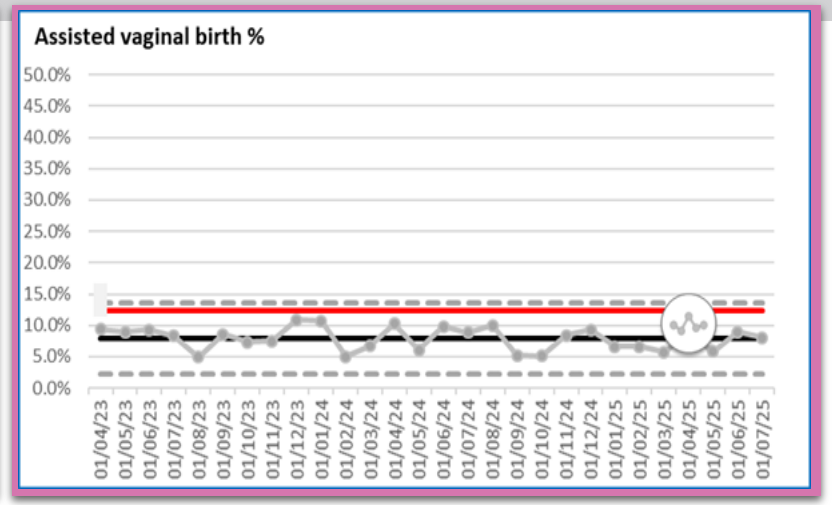
- Continue to support women to make an informed choice around induction of labour and that women fully understand the process. Induction of labour antenatal education classes continues to have positive feedback.
- Continue to learn from the ongoing PPH thematic review and to reach out to the Trusts who have very low PPH rates.
- Ensure that the pelvic health service is fully supported to give ongoing care to women who have suffered a vaginal tear.

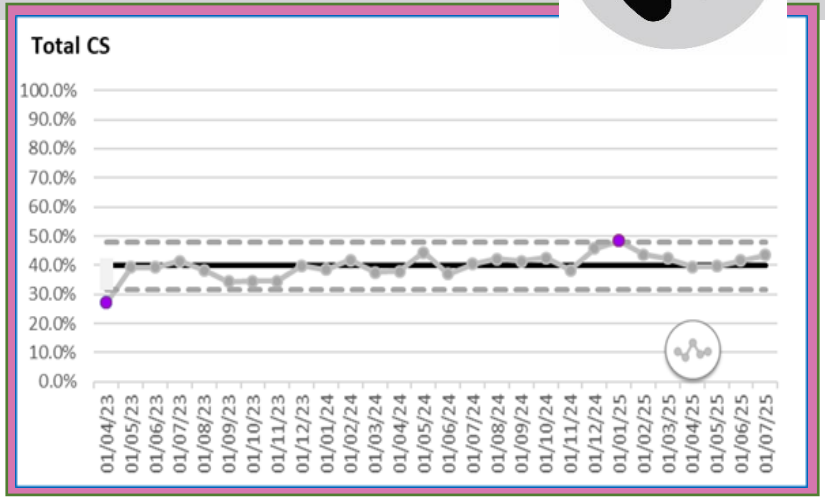
Where do we want to be?

- To be one of the safest maternity units in the country , women are fully informed to make a choice that is right for them and when unintended harm occurs, the service will continue to support a compassionate, transparent and honest approach to investigating harm providing support for families and the staff involved.

SPC charts



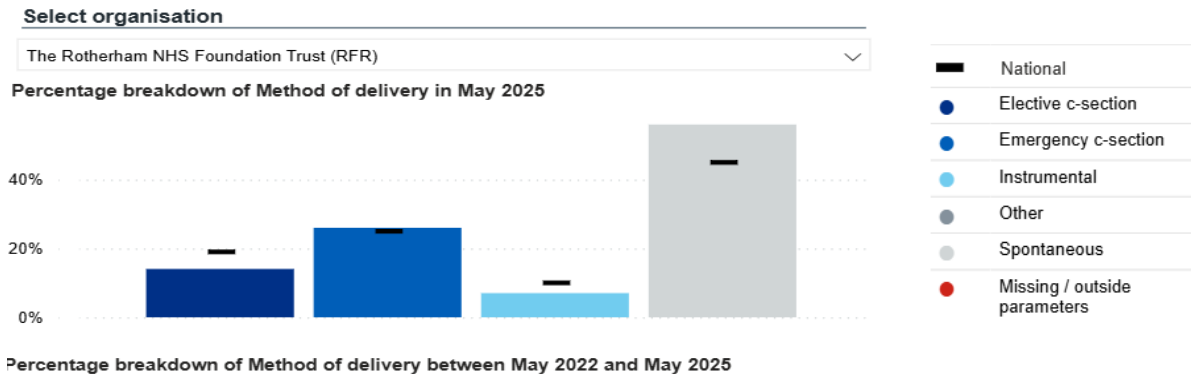




In Summary

What is the data telling us?

- The MSDS data below highlights that 56% of women had a spontaneous vaginal births as an average since May 2022.
- Looking at the same data set but for assisted births (forceps and ventouse births), TRFT have a rolling average of 7%
- The elective c- section rate is just below the national average



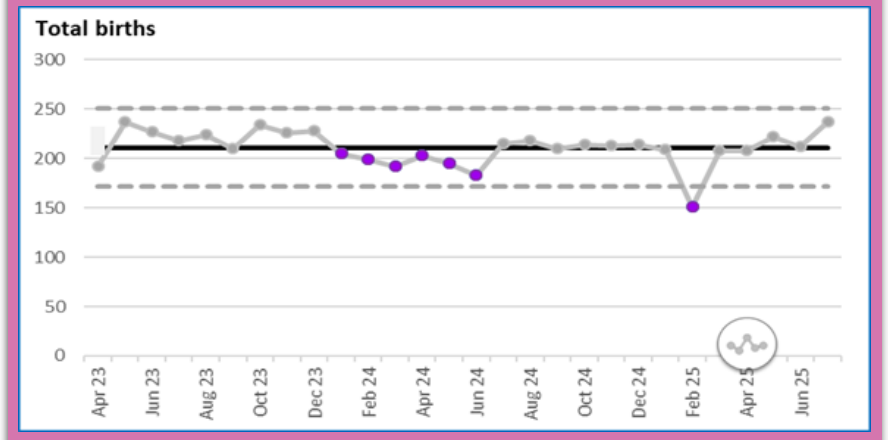
What's going well & What should we concentrate on?

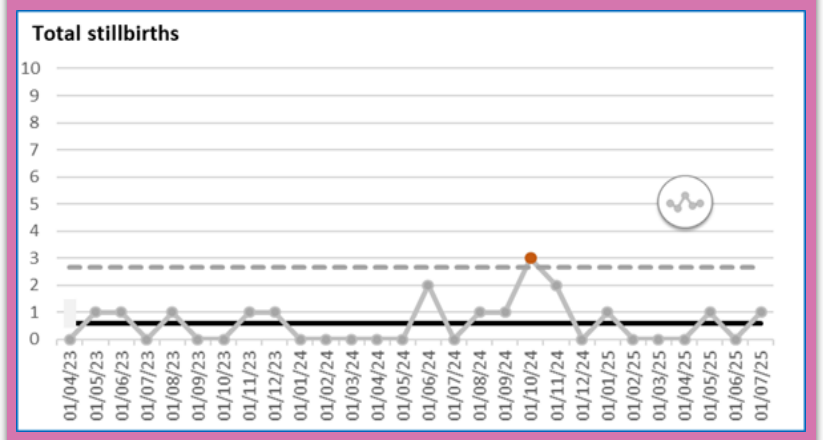
- The data does not show us anything concerning.
- After triangulating other data sources such as complaints and concerns and the legal score card with the above graphs, none of the three data sets feature as a theme or commonality.

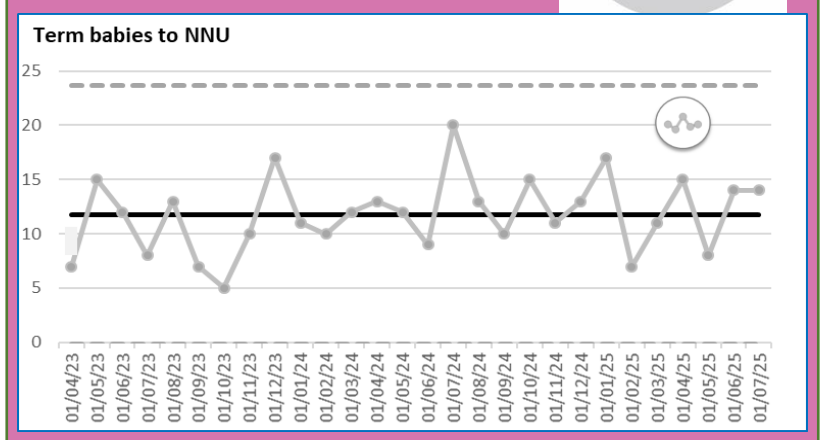
Where do we want to be?

- Support women's choice and continue to share information with women to make an informed choice of birth options.
- Ensure that we are aware of any themes or commonalities that may present as a problem from the triangulated data.

SPC charts







In Summary

What is the data telling us?

- Our rolling birth rate is maintaining on average to what we would expect at approximately 2500 birth.
- Stillbirth rates have stabilised with 1 case in the period of June and July.
- ATAIN (Term admissions to the NNU continue to be a challenge (see slide 25 for more).

What is going well?

- Birth rates remain stable.
- Stillbirth rates have stabilised, however, we aim to continue to the work to achieve the national ambition for reducing still birth and neonatal deaths.
- The team working on the ATAIN QI project is being shared within the system for wider learning.

What should we concentrate on?

- Maintaining a positive picker survey score so women and families wish to continue to birth in our unit and feel safe in our care.
- Continue to PMRT surveillance and associated QI work around stillbirths and neonatal deaths.
- Continue the ATAIN work that aims to learn from any term admissions.

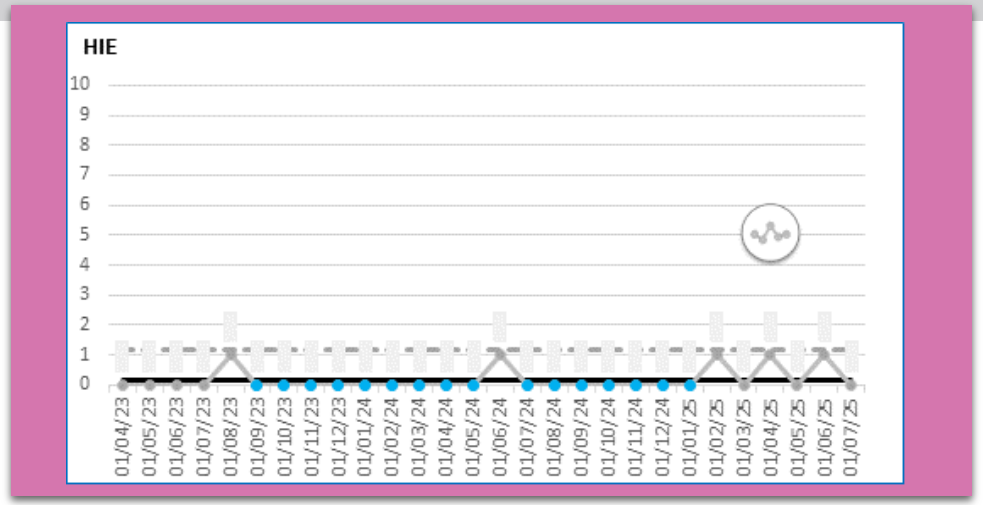
Where do we want to be?

- Be in the top 10 % in England for patient feedback via Picker.
- Learn from any stillbirths to continue to reduce perinatal death rates.
- Reduce any avoidable term admissions to the NNU.

SPC charts

Mild HIE (Stage 1):
Babies with mild HIE often show some behavioral changes like being overly alert, irritable, or having sleep disturbances. They may also have trouble feeding. Most babies with mild HIE recover fully with supportive care.

Moderate HIE (Stage 2):
Moderate HIE involves more pronounced symptoms, such as lethargy, muscle limpness, poor reflexes, and brief pauses in breathing (apnea). Seizures are also common in the first 24 hours.



Severe HIE (Stage 3):
Severe HIE is characterized by the most significant brain injury, with symptoms like delayed seizures, stupor or coma, and irregular breathing patterns. Some babies with severe HIE may also experience organ damage.

The severity of HIE is determined by factors like the duration of oxygen deprivation, the baby's gestational age, and the extent of brain damage. Mild HIE is often treated with monitoring and supportive care, while moderate to severe HIE may require interventions like therapeutic hypothermia (cooling).

2025 data In Summary

What is the data telling us?

- In February there was one case of a baby born with HIE level 2, the baby was transferred for cooling and an MNSI report has been received with 2 safety recommendations (see safety slide No 11).
- In March there was one case of a baby born with HIE level 1, this was referred to MNSI as per process however the mother did not give consent for the investigation to take place. All internal reviews found care to be appropriate.
- In June a baby was transferred out for cooling but had a normal MRI – MNSI concluded that this case did not meet the criteria for investigation and was therefore investigated locally.

What should we concentrate on?

- Monitor for any commonalities with any HIE cases. In 2 of the cases there has been some difficulties in using the (cerebral functioning monitoring) CFAM equipment on the NNU once the baby has been transferred there from labour ward. The NNU lead has developed an action plan which will be shared at the Safety Champions meeting.

What is going well?

- An in depth MDT review of any case where HIE is suspected is undertaken.
- Support is given to any family who has a baby transferred out and or has a HIE diagnosis is supported and offered the Maternity and Neonatal Independent Advocate.
- Learning from any case is shared with the wider teams.

Where do we want to be?

- To have low numbers of HIE and avoidable harm.
- When a HIE case does occur that the women and families and staff involved feel supported and that any learning is shared with the wider teams to improve care.

Maternity Incentive Scheme : Year 7



Safety Action 1:
Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard? **On track to achieve**



Safety Action 2:
: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? **On track to achieve**



Safety Action 3:
Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies? **On track to achieve**



Safety Action 4:
Can you demonstrate an effective system of clinical workforce planning to the required standard? **On track to achieve**



Safety Action 5:
Can you demonstrate an effective system of midwifery workforce planning to the required standard? **On track to achieve**



Safety Action 6:
Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? **On track to achieve**



Safety Action 7:
Listen to women, parents and families using maternity and neonatal services and coproduce services with users. **On track to achieve**



Safety Action 8:
Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training? **On track to achieve – escalations have been made to ensure that Anaesthetic colleagues can attend training.**



Safety Action 9:
Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues? **On track to achieve**



Safety Action 10:
Have you reported 100% of qualifying cases to Maternity and New-born Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025. **On track to achieve**

Saving Babies Lives v3 (Quarter 4 review)

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	99%	Fully implemented	100%	CNST Met

- At the June 2025 Local Maternity and Neonatal System (LMNS) assurance visit for the implementation of Saving Babies Lives V3 (SBLV3), the unit was assessed as fully compliant with all 6 elements.
- All ongoing audits for each element were assessed along with the QI work which has ran alongside many of the 6 elements. Positive feedback has been received for being the first unit in the system to achieve this level of compliance.
- Next steps – some slight modifications have been made to the SBLV3, on going audits will now be required to be in line with the new guidance.

Three-year delivery plan quarterly oversight

Q1 2025-2026

The Rotherham NHS Foundation Trust outlier summary: comparison to national result / benchmark

	Total measures	Negative outliers	Positive outliers
Total	36	4	12
Listening to and working with women and families with compassion	12	1	5
Growing, retaining and supporting our workforce	10		4
Developing and sustaining a culture of safety, learning and support	11	2	3
Standards and structures that underpin safer, more personalised, and more equitable care	1	1	

T1c:Being listened to during antenatal check-ups	95.2%
T1e:Involvement in decisions during labour and birth	83.9%
T1g:Adequacy of information or explanations during postnatal ho	70.3%
T1i:Being listened to during postnatal care	84.2%
T1ni:Baby Friendly Accreditation - Maternity	100.0%
T1nii:Baby Friendly Accreditation - Neonatal	0.0%
T2ai:Midwives' satisfaction with recognition for good work	56.3%
T2bi:Midwives' satisfaction with work being valued by your organ	50.0%
T2hi:Midwife Turnover Rate	3.7%
T2ii:Midwife Sickness Absence Rate	2.6%
T3aii:Obs & Gynae experience of learning culture	100.0%
T3bi:Midwives' confidence in organisations response to concerns	80.2%
T3ci:Midwives' recommendation of the service	95.1%
T3dii:Recommendation of the training post - Obstetrics and Gyna	25.0%
T3h:Quality of shift handovers for trainee doctors	66.7%
T4aiii:Stillbirth Rate (Stabilised) (MBRRACE)	2.9
T4biii:Neonatal Mortality Rate (Stabilised) (MBRRACE)	1.0
T4eii:Preterm Birth Rate (MSDS)	9.3%

Theme families 1: Listening and working with families

- LMNS resources around the possible NNU journey that women may experience are to be shown on the Greenoaks TV.
- The Trust has agreed for Maternity to procure a new patient record functionality that will give digital access to women of their records.

Theme 2: Growing, retaining and supporting the workforce

- Staff have been encouraged to apply for the Florence Nightingale leadership programme.
- The Director of Midwifery has been working with the other System Directors to forecast future workforce requirements and service provision with a focus on cost benefit analysis.

Theme 3: Developing and sustaining a culture of safety, learning and support

- An action plan is being developed by the medical team to improve the trainee GMC survey result.
- MNVP chair is working with the Maternity in-patient Matron to look for commonalities within any complaints or concerns.

Theme 4: Standards and structures to underpin safe, more personalised and equitable care

- SBLV3 fully compliant following the June 2025 assurance visit from the LMMS.
- Business case has now been agreed for a new EPR system for maternity and neonatal services reducing time spend on documentation and improve safeguarding.
- Audits ongoing to monitor the NEWTT2 and MOEW compliance.

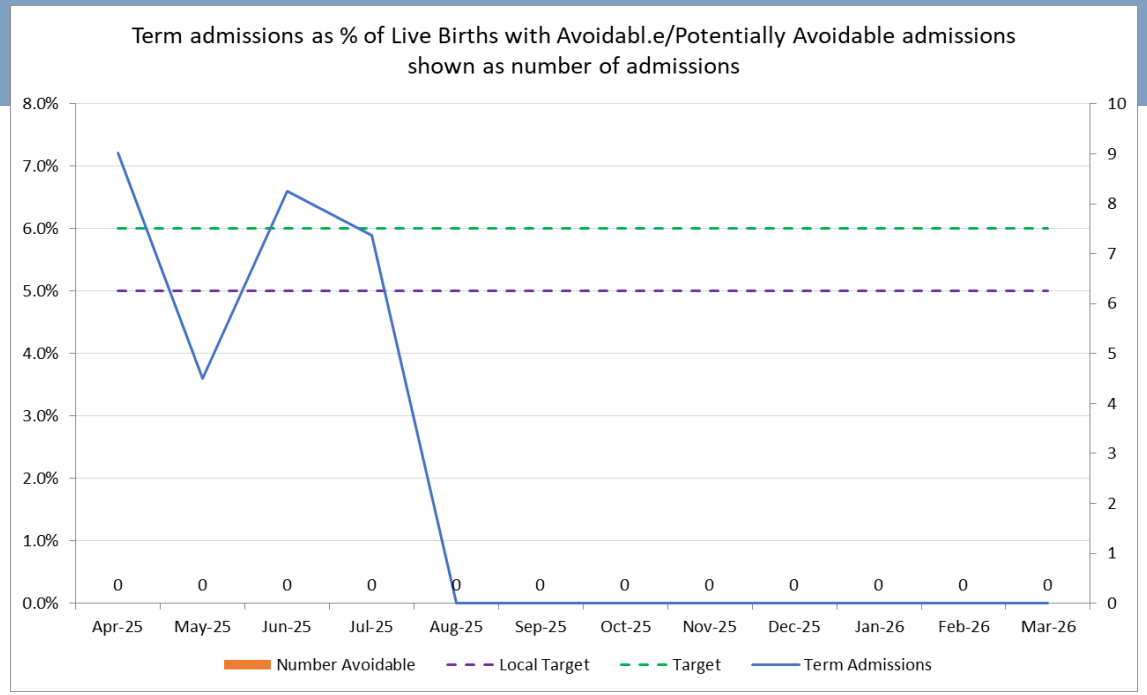
Outlier issues

Baby Friendly accreditation for NNU	Work ongoing to progress the NNU to full BFI	
Pre term births above 6%, the data above is a 6 month rolling tracker.	June data shows 4.9% and July was 5.1% - QI work continues with the new Pre-term lead Midwife in post (see slide 25)	
Recommendation of the training post Ob's & Gynae and handovers	Response rates for this GMC survey are lower than in previous years. The College Tutor at TRFT is working with the wider team to develop an action plan and undertake listening events.	



Escalation	
In progress	
Completed	

ATAIN



South Yorkshire and Bassetlaw
Local Maternity System
Transforming your maternity services together

SYB ATAIN - QI Dashboard V5.0

Unit/Trust: Rotherham

Completed by:

Month	Live Births All Gestations	All Inborn Admissions (excl transfers)	Inborn TERM admissions (37/40)	Term Admissions as % of Live Births	5% Local Ambition	6% National Target	Avoidable Admissions (Enter Below)	% Avoidable Admissions
Apr-25	208	29	15	7.2%	5.0%	6.0%	0	0.0%
May-25	222	17	8	3.6%	5.0%	6.0%	0	0.0%
Jun-25	212	19	14	6.6%	5.0%	6.0%	0	0.0%
Jul-25	236	26	14	5.9%	5.0%	6.0%	0	0.0%

In Summary

What is the data telling us?

- In June and July 2025, Term admissions were above our system target of 5%.
- Following review of all the cases via an MDT meeting, all cases were found to be unavoidable.
- None of the cases could have been cared for on a transitional care area.

What is going well?

- Only one baby in this time frame was discharged within from the NNU within 1 day. This we feel gives further assurance that all babies had an appropriate admission,

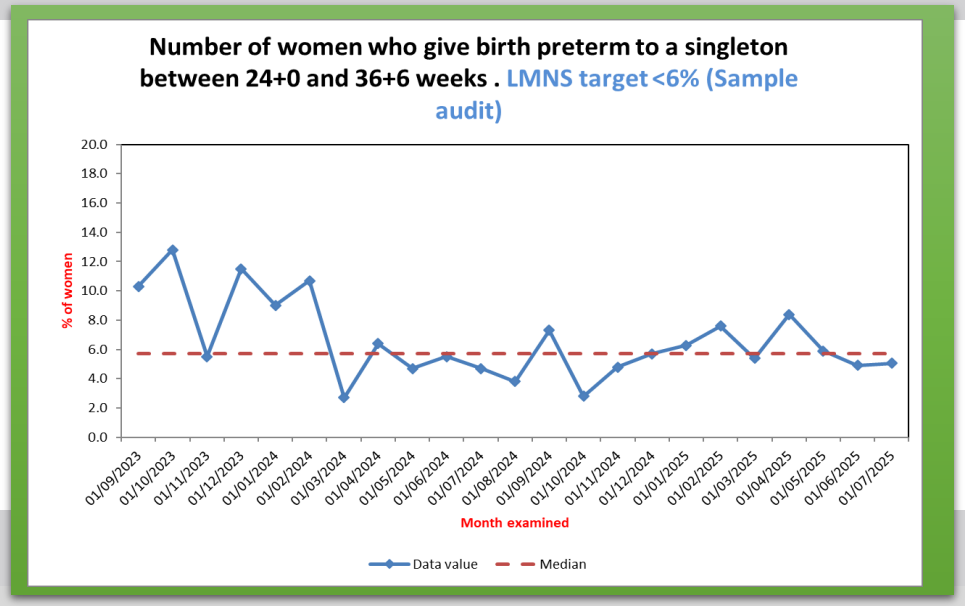
What do we need to focus on?

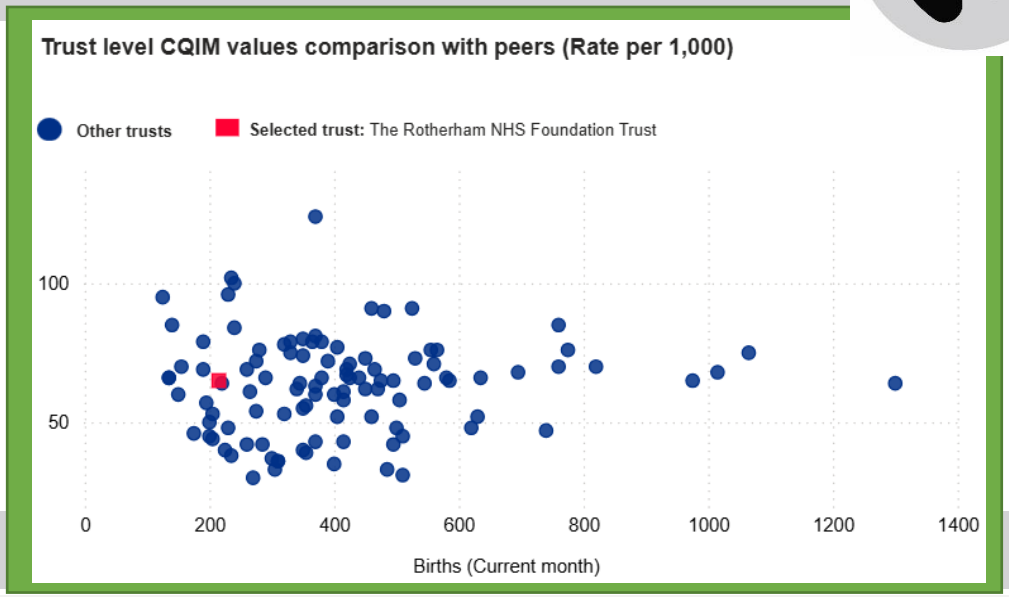
- Continue to work on the QI work, (AMAT registered) and share all learning within the system.
- This work contributes to the CNST Standard 3 – Full compliance demonstrates that we are a unit that learns from term admissions and influences safety within maternity services.

Where do we want to be?

- Reach a Term Admission Rate of ≤5%
- Continue to learn from any avoidable term admissions to the NNU.

Preterm Birth





In Summary

What is the data telling us?

- That the TRFT pre-term rate has been 4.9% in June and 5.1% In July 2025. This remains below the Local Maternity and Neonatal System (LMNS) target set of 6%. The average Preterm rate since the start of 2025 is 6.2%. (See graph to the left)
- The updated data for the Fetal optimisation metrics has not been updated for June or July at the time of writing the report.
- Data from the MSDS shows our position against other Trusts for pre-term births per 1000 births. (see graph to the right)

What should we concentrate on?

- New Pre-term Birth Midwife to provide continuity of care to these patients in clinic.
- Ensuring special indicators are added to their records and audited.
- Provide more detailed information on signs and symptoms preterm labour to mothers.
- Teaching now on MAST monthly about preterm – what we are doing to reduce preterm rates/prevention/management.

What is going well?

Whilst the ODN data is yet to be published, internal monthly audit data remains positive;

- In June and July, 100% of women on the pre-term pathway had been given information on pre-term birth.
- In June and July, 100% of women who attended with signs or symptoms of pre-term birth were assessed using the correct test (fFN/Quipp).
- In June and July 100% of women who attended with possible pre term labour spoke to a neonatologist.
- In Q1 no babies were born 'off pathway' (i.e. Babies born below 27 weeks born at Rotherham as transferred out appropriately).

Where do we want to be?

- We want to continue to reduce pre-term births at TRFT and when a pre-term birth does occur, give 100% of optimising care to babies which will reduce morality and morbidity.
- Maintain off pathway KPI's ensuring that all women are offered the opportunity to birth their babies in the right place.

Current Issues and Summary

Staffing and Acuity: Labour ward and NNU met staffing standards. Supernumerary coordinator role maintained. Consultant gaps remain a challenge; locum cover used.
•**Neonatal Staffing:**. BAPM compliance: RN staffing 100% (June), 85.4% (July); QIS 98.3% (June), 93.5% (July). Shift coordinator compliance dropped to 62.9% in July due to sickness.
•**Safety and Incident Reporting**: No new PSII cases. Continued thematic reviews and family engagement. PMRT reviews closed and published with learning shared.
•**Patient Experience**: Positive feedback sustained across Picker surveys. MNVP collaboration ongoing to improve service responsiveness.
•**Training Compliance**: On target to meet year 7 Maternity incentive scheme (MIS)
•**Perinatal Mortality** Adjusted perinatal mortality rate Q1: 3.1/1000 births. Continued focus on reducing stillbirths and neonatal deaths.
Governance and Learning: CNST Year 7 standards on track., Action plans developed and monitored. Learning shared via newsletters and MDT reviews.

In Summary

What is the data telling us?

Staffing levels have remained stable, with 100% 1:1 care in labour and no unit closures.
Stillbirth rates have stabilised, with one case in July and none in June.
Neonatal admissions and preterm birth rates are being closely monitored, with term admissions above target but deemed unavoidable.
Patient feedback continues to be positive, with Picker survey results above national average.
Safety incidents are being reviewed and actioned, with no new PSII cases or Coroner Regulation 28 reports.

What do we need to focus on?

Continue to reduce avoidable term admissions to the NNU through ATAIN QI work.
Address Consultant workforce gaps and reduce reliance on locum cover.
Maintain and improve shift coordinator compliance in neonatal care during periods of high acuity.
Strengthen family engagement in PMRT reviews and ensure learning is shared across the MDT.
Sustain momentum on governance actions and ensure SMART plans are completed in a timely manner.

What is going well?

100% 1:1 care in labour achieved across both months.
Neonatal and maternity staffing met BAPM and CNST standards.
Positive feedback from service users sustained over three years.
Safety recommendations from MNSI are being actioned and monitored.
Preterm birth rates remain below LMNS targets, with strong compliance to care pathways.

Where do we want to be?

- Be one of the safest maternity and neonatal unit in the country, with the lowest rates of avoidable harm.
- Achieve full BFI accreditation and maintain high National Neonatal Audit programme ((NNAP) compliance.
- Ensure all families feel heard and supported through transparent review processes.
- Maintain staffing levels through substantive recruitment and reduce reliance on bank and locum cover.
- Continue to lead regionally in compliance with Saving Babies' Lives and MIS standards.

Board of Directors' Meeting
05TH September 2025

Agenda item	**P148/25**
Report	**Senior Information Risk Owner (SIRO) Annual Information Governance Report**
Executive Lead	Bob Kirton, Senior Information Risk Owner, Managing Director
Link with the BAF	B7
Purpose	Decision ☐ To note √ Approval ☐ For information ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report documents the Trust's compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the Freedom of Information Act 2000, Data Protection Act 2018 and the General Data Protection Regulations for the period 1 April 2024 – 31 March 2025. The current status of the Trust's annual Data Security and Protection Toolkit (DSPT) submission is also provided for the period 1 July 2024 – 30 June 2025. Key points to note from the report are: 1. The DSPT underwent a radical change for 2024/25 and now includes the Cyber Assurance Framework (CAF). The Trust was required to provide evidence of compliance against a total of 47 Outcomes which consists of 197 Best Practice Indicators (BPI's). 2. The internal audit review of the DSPTK/CAF, which is required annually, was carried out against 12 Outcomes (8 Mandatory and 4 chosen by the Trust) across all 5 Objectives, covering 64 Best Practice Indicators (BPI's) on the Toolkit. 3. The Trust has performed well against the mandatory IG Training compliance. The target for compliance this year was 85% (set by the Trust, as we also had to include specialist training KPI's) and the Trust achieved 90%. 4. FOI requests have decreased 3% when compared with the previous year. Response rates from staff remained constant and this is reflected by the mandatory

	compliance of responses being sent within 20 working days, achieving **91%** compliance.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Trust's Information Governance Committee is chaired by the SIRO, meets on a regular basis and receives updates on all key information governance areas included within the Annual Report.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	The Board is asked to note this report.
Appendices	None

Introduction

1. The SIRO role has responsibility and accountability for the effective, efficient and compliant management of the Trust's information assets.

2. Data Security and Protection Toolkit (DSPT/CAF)

2.1 This is the performance tool produced by NHS England. The Toolkit covers areas of IG, IT and Cyber Security and forms part of CQC inspections within the Well Led Key Lines of Enquiry.

2.2 The Trust has provided evidence against all 197 mandatory Best Practice Indicators (BPI's). The submission is yet to be confirmed as satisfactory by NHS England.

The levels, set by NHSE on the DSPT/CAF are, 'Achieved', 'Partially Achieved' and 'Not Achieved'. These are the levels expected of the Trust and whilst the Trust was able to 'Overachieve' against some BPI's, any over-achievement is not being rated this year.

The levels are broken down into:

Achieved (A) – 74
Partially Achieved (P/A) – 99
Not Achieved (N/A) - 24

Each of the BPI's (including the Not Achieved) required an additional 'Statement', as well as the documented evidence, to support the evidence submitted.

Year on Year, it is known that the N/A's and P/A's will become 'P/A's' and 'A' requirements, but as this will require investment in infrastructure/software and resource, the raise of the level of achievement will be decided at a national level, with consultation.

2.3 An internal audit is carried out annually on the Trust's Data Security and Protection Toolkit (DSPT/CAF) submission.

The internal audit review of the DSPTK/CAF, was carried out against 12 Outcomes (8 Mandatory and 4 chosen by the Trust) across all 5 Objectives, covering 64 Best Practice Indicators (BPI's) on the Toolkit. Of the 64 BPI's checked, only 2 items were selected for minor strengthening but overall, the Trust was awarded an assurance level of '**High Confidence**' with a '**Low Risk**' level (**RAG rated Green across all Outcomes**).

The full audit report is provided. (**RFT 2526 01 DSPT Final Report.PDF**)

3.0 The UK General Data Protection Regulations (UK GDPR) Implementation Plan

3.1 The UK General Data Protection Regulations (UK GDPR) Implementation Plan continues to be reported on at the IG Committee (IGC) meeting.

Current Status of the UK GDPR Implementation Plan:

A new Bill has received Royal Ascent (June 19 2025), and this is called the 'Data Use and Access Act' 2025 (DUAA).

The new 'Act' introduces a number of 'changes/updates' to the UK GDPR and these will be slowly introduced by the ICO (Information Commissioner's Office) over the period 2025/26.

The Plan will be updated as these changes are introduced, along with notification of changes affecting Trust Policies, SOP's and Privacy Notices.

It is expected that this will involve a number of departments making changes to their procedures, where 'Personal Identifiable Information' (PII) is used, even where this has been pseudonymised.

4.0 Information Governance Risks

4.1 The Trust currently has the following number of 'information governance' risks on its register (this does not include cyber security risks):

- "Approved risks" – 4 risks. These consist of 2 at a score of 9, 1 at a score of 12 and 1 at a score of 20.
- "Risks under control / managed risks" – 11 risks. These consist of 1 at a score of 3, 1 at a score of 4 and 9 at a score of 6.
- "New Risk" - 2 risks. These consist of 1 at a score of 3 and 1 at a score of 6.

Where a risk is shown as **'Approved'**, this has been before the Risk Committee and been accepted. These risks are still open and being progressed.

'Risks under control' are approved risks that the Trust cannot currently influence regarding a resolve or are progressing to conclusion and may ultimately be closed.

A **'New risk'** is a risk that has yet to be accepted by the Risk Committee

5.0 Information Governance Incidents

5.1 The Trust uses two definitions on Datix for Incidents, which are Information Governance and Confidentiality. Incidents can be assigned to either of these for the attention of the IG Team.

5.2 For the period April 2024 – March 2025 a total of 427 reports mentioning one of the definitions were recorded. 142 incidents were recorded as being Information Governance with 285 being recorded under Confidentiality. This is a decrease on the previous year (449).

5.3 All reports are considered for investigation by the IG Team with the most serious incidents followed up and some leading to full investigation. Some of the more serious incidents may involve the HR Team. Serious incidents involving data breaches will also be reported to the Information Commissioner's Office via the online Serious Incident Reporting tool.

5.4 The IG Team has developed a Data Security and Protection Incidents (DSPI) Standard Operating Procedure for senior staff.

6.0 Serious Incidents Requiring Investigation (SIRI)

6.1 The organisation is required to report on any Serious Incidents (SIRI's) within 72hrs of being notified of the incident. These are notified to the Information Commissioner's Office (ICO) or NHS Digital using the reporting tool on the Data Security and Protection Toolkit.

6.2 For the year 2024/25, the DPO has assessed 10 serious breaches with action taken as follows:

Incident 36602 – 11/04/2024
This was deemed not reportable to the Information Commissioner's Office by the reporting tool. Investigated internally.

Incident 36765 – 23/04/2024
This was deemed not reportable to the Information Commissioner's Office by the reporting tool. Investigated internally

Incident 36821 – 26/04/2024
This was deemed reportable and investigated by the ICO.
The ICO considered the Trust was taking the matter seriously and concluded that no further action was necessary.

Incident 37212 – 23/05/2024
This was deemed not reportable to the Information Commissioner's Office by the reporting tool. Investigated internally.

Incident 38377 – 29/07/2024
This was deemed not reportable to the Information Commissioner's Office by the reporting tool. Investigated internally.

Incident 38486 – 02/08/2024
This was deemed not reportable to the Information Commissioner's Office by the reporting tool. Investigated internally.

Incident 39321 – 30/09/2024
This was deemed not reportable to the Information Commissioner's Office by the reporting tool. Investigated internally.

Incident 40264 – 06/12/2024
This was deemed not reportable to the Information Commissioner's Office by the reporting tool. Investigated internally.

Incident 41332 – 26/02/2025
This was deemed reportable and investigated by the ICO.
The ICO considered the Trust was taking the matter seriously and closed the case, offering the Trust additional advice.

Incident 41652 – 19/03/2025
This was deemed reportable and is currently under investigation by the ICO.

7.0 Freedom of Information (FOI) requests

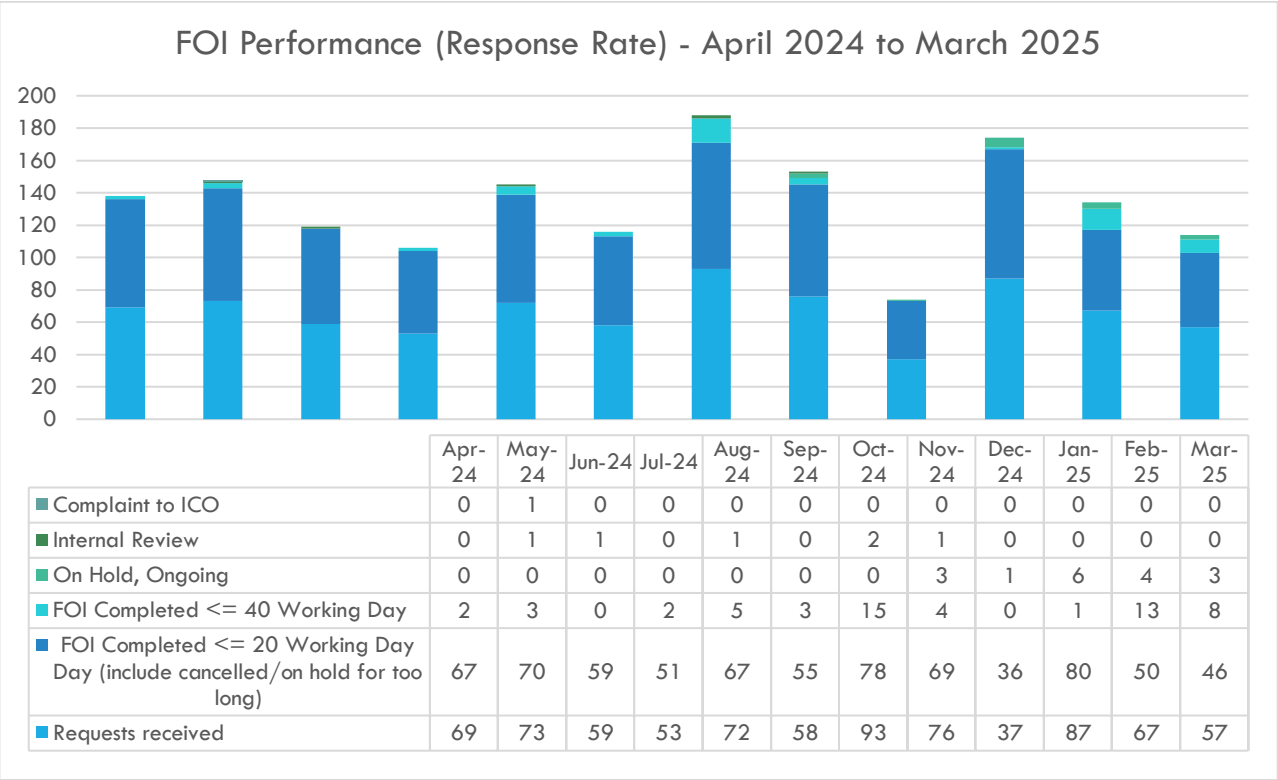
7.1 Details of the number of FOIs received, per month, are provided for the period 2020 through to 2025 in the table below. One FOI may contain several questions. The numbers below provide the number of FOIs received, not the number of questions / requests received.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021-2022	69	53	49	50	43	44	30	50	49	44	50	53	584
2022-2023	51	43	57	60	61	48	49	70	55	79	54	61	688
2023-2024	55	55	66	83	65	61	86	74	43	95	76	68	827
2024-2025	69	73	59	53	72	58	93	76	37	87	67	57	801

7.2 FOI requests were slightly lower than the previous year, reducing by 26.

October 2024 was the busiest month for the FOI with the highest FOI request received being 93, this is because of the staff accommodation closure.

FOI performance was very good with 91% of FOI's responded within the 20-day limit.



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Complaint to ICO	0	1	0	0	0	0	0	0	0	0	0	0
Internal Review	0	1	1	0	1	0	2	1	0	0	0	0
On Hold, Ongoing	0	0	0	0	0	0	0	3	1	6	4	3
FOI Completed <= 40 Working Day	2	3	0	2	5	3	15	4	0	1	13	8
FOI Completed <= 20 Working Day Day (include cancelled/on hold for too long)	67	70	59	51	67	55	78	69	36	80	50	46
Requests received	69	73	59	53	72	58	93	76	37	87	67	57

7.3 There are 6 FOI Internal Review and 1 Complaint to the ICO in this financial year.

7.4 The FOI Tracker is continue to be modified for better reporting.

8.0 Subject Access Requests (SARs) including Access to Health Records for Deceased individuals (AHRA)

8.1 The SAR team sits under the Patient Access Service. A Subject Access Request is made by a living individual for access to information held about them, by the organisation while Access to Health Records is request for information about deceased individuals. Most SARs/AHRAs are received from service users, but they have also been received from staff and others.

8.2 The tables below show the number of (SARs/AHRAs) made under Data Protection legislation/Access to Health Records Act, which were received by the Trust for 2024/25.

Month	Requests	Breach
Apr-24	190	1
May-24	187	1
Jun-24	143	1
Jul-24	195	94
Aug-24	183	168
Sep-24	172	88
Oct-24	188	42
Nov-24	156	14
Dec-24	111	10
Jan-25	209	0
Feb-25	169	1
Mar-25	177	3

9.0 Requests for personal information from Law Enforcement Agencies.

9.1 The IG Team and SARs Team continue to support South Yorkshire Police, and other law enforcement agencies for requests for confidential and personal information relating to victims of crime and those suspected of committing those crimes.

9.2 During the period April 2024 – March 2025, the following were received by the IG Team:

- Police requests (CID49s, CID104s, misc.): 44

During the period April 2024 – March 2025, the following were received by the SARS Team:

- Police requests (CID49s, CID104s, misc.): 294
- National Crime Agency requests: 8

9.3 All requests are reviewed for consent and those without (and some with) are reviewed by the Team involved and the Caldicott Guardian or SIRO with occasional advice being sought from the Data Protection Officer. Whilst every effort is made to assist in investigations, the release of information has to be proportionate and justifiable.

10.0 Data Flow Mapping

10.1 The Trust now has 158 information asset registers across the organisation.

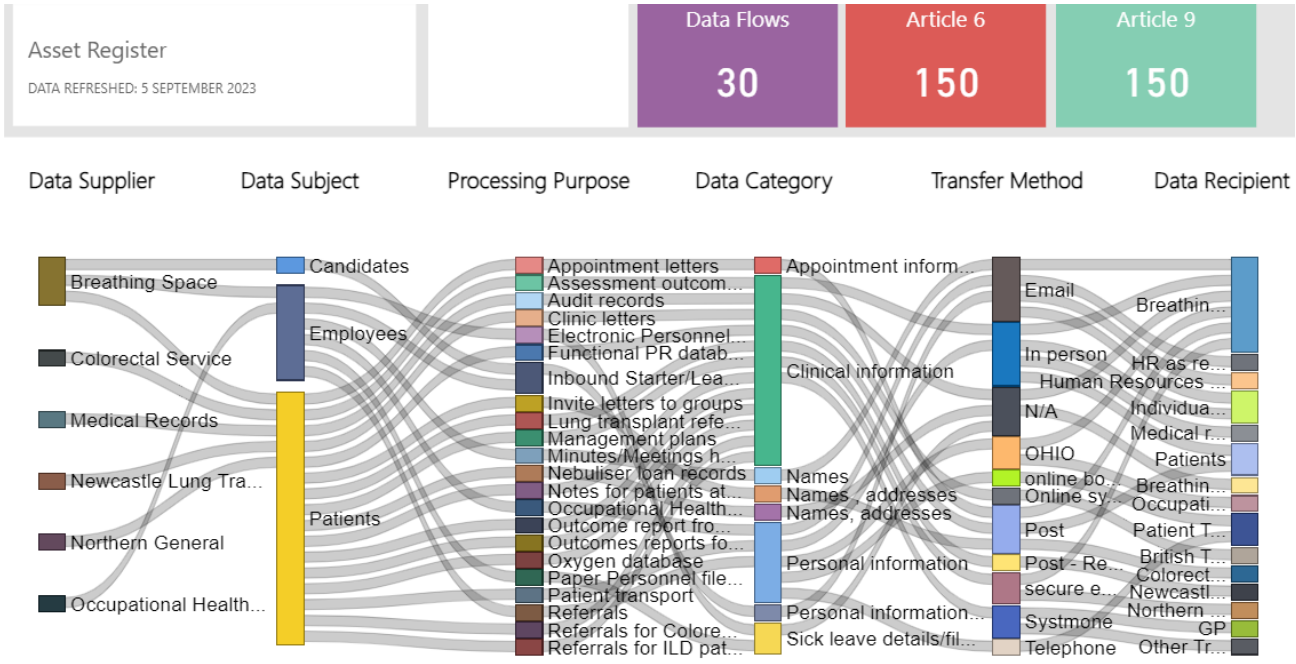
	Grand Total
Care Group 1	23
Care Group 2	28
Care Group 3	37
Care Group 4	26
Corporate	44
Grand Total	158

	Reviewed in the last 12 Months	Not Reviewed in the last 12 months	Grand Total
Care Group 1	23		23
Care Group 2	22	6	28
Care Group 3	33	4	37
Care Group 4	24	2	26
Corporate	35	9	44
Grand Total	137	21	158

10.2 The data flow mapping tool, developed in Power Bi, a Microsoft® toolset, provides a visual overview of data flows in the organisation, based on the information provided within the asset registers. The way the information is gathered and displayed is currently under review and discussions are underway with Health Informatics colleagues regarding a replacement system which will also include risk.

The tool also enables the IG and Health Informatics teams to quickly view how data is being transferred and whether this can be improved for example, where paper trails may exist, making them digital.

Current Power Bi output showing a single service data flows.



10.3 Where no change has taken place, this must be indicated on the register as a 'date checked'. Staff changes and service re-organising does have an impact on registers being maintained staff are reminded to change the asset ownership as required.

11.0 Conclusion

11.1 The internal audit is carried out annually by 360 Assurance and has been undertaken ahead of the submission date for the Data Security and Protection Toolkit (DSPT) which is now 30 June year on year. For this year, evidence provided against 197 BPI's were assessed across 47 Outcomes, and 2 low risk items were selected for strengthening.

The Trust was again awarded ‘Substantial Assurance’ by the auditors against all 12 audited Outcomes (64 BPI’s).

11.2

The IG Training requirement changed this year, the new training threshold is now based on each organisation. The Trust set a new target of 85% compliance this year as we also had to include specialist training KPI’s. The Trust achieved 90% IG Training compliance this financial year.

11.3 FOI requests substantially increased in the year rising to 827. Response rates from staff internally improved and compliance with the mandatory 20 working day response back to requestors is at 94%. The FOI Tracker is constantly being modified to improve reporting.

Bob Kirton
Managing Director/Senior Information Risks Owner

Public Board of Directors
5 September 2025

The Rotherham NHS Foundation Trust

Agenda item	P149/25
Report	**Safeguarding and Vulnerabilities Team Annual Report**
Executive Lead	Helen Dobson, Chief Nurse and Executive Lead for Safeguarding
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	This paper supports the Trust in being ambitious to continually improve the quality of safeguarding practice through the delivery of robust safeguarding arrangements. At the core of safeguarding activity is the importance of giving the best possible care to patients, with safeguarding embedded throughout all care that is delivered. The safeguarding team provides care and support to staff who have been exposed to difficult situations alongside advice and support on the management and progress of safeguarding presentations. For safeguarding to be successful and impactful, it requires partnership working, and this report highlights the strength of the Rotherham Safeguarding Partnerships and the contribution that TRFT makes to the safeguarding system.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Annual Report provides a summary of the safeguarding activity undertaken across the Trust, and wider Safeguarding Partnerships during this annual period of 2024-25. This report provides assurance that all statutory duties have been undertaken in accordance with legislation and regulatory requirements. • Compliance with all safeguarding standards met and agreed by ICB • 360 assurance auditors review of safeguarding policy, procedures and governance provided significant assurance • Quality Improvement work completed jointly with digital health colleagues to improve the referral from UECC to MASH by creating a digital solution embedded within Meditech. This has halved the time it now takes to make that referral. The report demonstrates the significant work undertaken in partnership across Rotherham, with TRFT leading a number of work-streams

	including the Childhood Neglect work and the Safeguarding Adult Review work. Of note to highlight to the Board, but not included in this report, is that the safeguarding simulation training highlighted in last year's annual report has been shortlisted in the HSJ patient safety integrated working category.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Annual Report presented to Operational Safeguarding Group May 2025 Annual Report presented to Safeguarding Committee June 2025 Annual Report presented to Quality Committee July 2025
Board powers to make this decision	NHSE Safeguarding Assurance The Children Act (1989) and (2004) Section 11 compliance The Care Act (2014) compliance
Who, What and When (what action is required, who is the lead and when should it be completed?)	No actions required
Recommendations	It is recommended that the Board accept this paper as providing assurance that TRFT are appropriately discharging their safeguarding duties in line with legislative and contractual obligations. The report highlights significant work across all work-streams to continuously improve, and deliver high quality safeguarding actions which should be celebrated.
Appendices	Safeguarding Annual Report 2024-25



Safeguarding & Vulnerabilities Team Annual Report 2024-2025



Ambitious Caring Together



Foreword

As the Executive Lead for Safeguarding, it is my pleasure to introduce The Rotherham NHS Foundation Trust Annual Safeguarding & Vulnerabilities Report for 2024-25. This has provided an opportunity of reflection to review the safeguarding work undertaken across the Trust this year and whilst this agenda continues to be challenging, there is a lot to celebrate and be proud of with the safeguarding work undertaken across the Trust, and by the achievements and progress made by the Safeguarding systems across Rotherham and South Yorkshire. TRFT has continued in its commitment to ensuring that we help all residents of Rotherham live lives free from abuse and neglect.

Safeguarding can be complex and emotive work, and to safeguard effectively requires all agencies to work together in a collaborative and supportive way to develop seamless and effective safeguarding plans. This last year has seen a number of key initiatives across the borough, and we would like to thank our safeguarding partners from across Rotherham for working with us to safeguard the people of Rotherham.

This report provides assurance to the Trust Board, our regulators, our patients and their families and our partner agencies that everyone working at The Rotherham NHS Foundation Trust see safeguarding as part of their core business, and that we recognise that safeguarding children, young people and adults is a shared responsibility, with the need for effective joint working between partner agencies and professionals, so that vulnerable groups in society are protected from harm. We all have a role to play in ensuring our patients and their families receive outstanding care.

Helen Dobson
Chief Nurse and Executive Director for Safeguarding

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1 Introduction

Welcome to the TRFT 2024-25 Annual Safeguarding & Vulnerabilities Report. The purpose of this report is to provide a declaration of assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, adults and families who come into contact with our services. This report encompasses all areas of the safeguarding & vulnerability agenda including:

- Safeguarding Adults and Children
- Domestic and Sexual Violence and Abuse
- Mental Capacity and Deprivation of Liberty Safeguards (DoLS)
- Prevent
- Mental Health
- Child Death
- Learning Disability
- Autism
- Dementia

The national safeguarding agenda continues to evolve as we learn from research, data analysis and serious incidents. The Safeguarding Team is an active participant in national and local safeguarding forums to ensure that TRFT and Rotherham consider the impact of learning and update and deliver best practice in safeguarding. The TRFT safeguarding team works closely with the care groups to embed any learning and takes a continuous improvement approach to safeguarding practice.

The Safeguarding Team continues to provide a range of support options to clinical areas to ensure a Think Family ethos is embedded, and that we work together to respond to emerging themes. We recognise that supporting staff to ensure all patients and service users are protected is pivotal in ensuring safe and effective safeguarding for all age groups, and that policies and procedures are inclusive.

2 Safeguarding Policy and Statutory Guidance

Safeguarding is governed by a plethora of legislation, policy and guidance. Non-exhaustive lists are below. The local policies and procedures we have in place at TRFT are reflective of these.

Local Policies and procedures are in place that support staff to understand their actions and duties around the legislation and guidance that is in place. As policies are reviewed, where appropriate, an all age approach is being taken to support staff in responding to their concerns. The following policies have been updated this year.

- Safeguarding Policy (all age)
- Domestic Abuse
- Safeguarding Supervision
- Mental Health Act
- Prevent (radicalisation)
- Missing Patient Plan

Legislation that impacts on Safeguarding:

- Human Rights Act 1998
- The Children Act 1989, revised 2004
- The Care Act 2014
- Care Quality Commission Health and Social Care Act 2008
- The Sexual Offences Act 2003
- Serious Crime Act 2015
- The Mental Health Act 1983 and 2007
- The Mental Capacity Act 2005
- The Modern Slavery Act 2015
- The Domestic Abuse Act 2021
- The Terrorism Act 2000
- The Equality Act 2010
- FGM Act 2003

Policy & Guidance that impacts on Safeguarding:

- Serious Violence Strategy 2018
- Health and Social Care Act 2022
- Deprivation of Liberty Safeguards 2007
- Working Together to Safeguard Children 2023
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff: Fourth edition: January 2019
- Adult Safeguarding: Roles and Competencies for Health Care Staff (2024)
- United Convention on the Rights of the Child 1989
- Looked after Children: roles and competencies of healthcare staff December 2020

3 Safeguarding Governance and Accountability

The Chief Nurse is the Board Executive lead for safeguarding and is accountable for safeguarding across the organisation.

The Chief Nurse is supported by the Deputy Chief Nurse, the Head of Safeguarding, and the Safeguarding and Vulnerabilities Team who provide leadership at all levels, both within TRFT and across the Rotherham Safeguarding Partnerships to underpin the objectives of the safeguarding partnerships.

Safeguarding Governance is fully embedded within the governance structure at every level of the organisation, with representation from the safeguarding and vulnerabilities team attending the local care group meetings, and with external partners from across the borough attending the safeguarding committee to ensure there is true collaboration and appreciation for the safeguarding work we do together. Having our partners present provides an additional layer of scrutiny and challenge, and ensures TRFT are held to account for their actions.



4 External Governance and Accountability

4.1 NHSE Appreciative Enquiry

During Quarters 1 and 2, NHS England completed an Appreciative Inquiry into safeguarding adult practices at TRFT. This involved interviews with key staff, observation and review of governance process and policy, and focus groups with staff from across the Trust. The final report has not yet been received, but feedback provided to the leadership team at the time highlighted the positive safeguarding leadership, and that the care group leadership team consider the safeguarding team as integral to their teams with strong relationships to ensure safeguarding is a part of all decisions. The report will be shared with Trust Board once received.

4.2 Safeguarding Standards Assurance

As part of providing assurance to the Integrated Care Board (ICB), TRFT has conducted the safeguarding self-assessment assurance document, with all areas assessed as 'Blue-Embedded in practice', or 'Green-fully compliant with continuous improvement'. No additional information was required from the ICB who agreed with the self–assessment ratings.

Domain	Blue/ Embedded assurance	Green/ compliant assurance
Safeguarding assurance & accountability (16)	14 domains	2 domains
Learning & practice Improvement (10)	12 domains	2 domains
Partnership working (6)	5 domains	1 domains
Embedding safeguarding (7)	5 domains	2 domains
Wider Safeguarding agenda (12)	9 domains	3 domains

4.3 360 Assurance Audit

360 Assurance conducted an objective and unbiased review into the effectiveness and controls in place in relation to safeguarding practice. The outcome found significant assurance across the safeguarding framework, with sound governance, risk management and controls in place. The findings included:

- Clear leadership and staffing in place
- Governance structure to support safeguarding
- Clear use of actions and evidence of these being progressed and completed

Three low risk areas were identified to strengthen practice, which have all been completed:

- Medical representation at the UECC safeguarding huddles to be strengthened
- Report format for safeguarding operational meeting to be consistent
- External partner representation at safeguarding committee and its role in identifying items for escalation to Quality Committee could be more explicit.

Joint Safeguarding Board Assurance

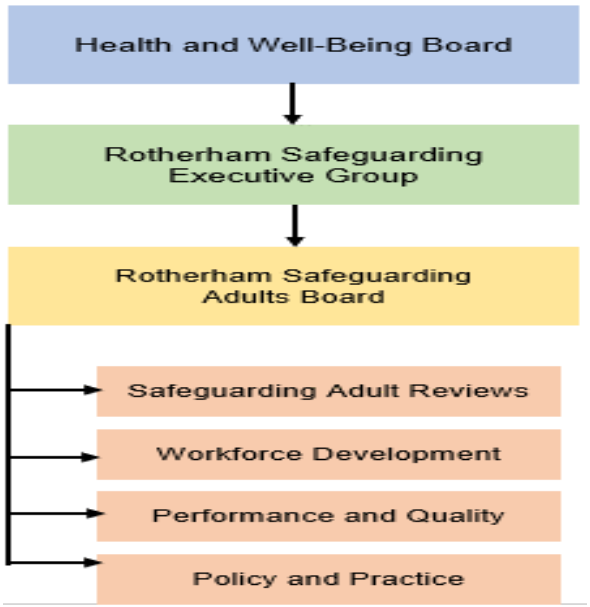
TRFT are consistent and effective partners, appropriately represented at all levels across all of the Safeguarding Partnerships, with the Trusts Safeguarding Team proactively working with, and influencing the work-streams to enhance integrated working and develop policy and strategies to strengthen processes that ensure that individuals are safeguarded from abuse and harm, and ensuring that early intervention is available for everyone who needs it. The Trust participated in the joint assurance day, showcasing evidence of the work undertaken by the Trust that contributes to the work of the partnerships, and demonstrated many pieces of work completed jointly by the Trust and partners including Rotherham Metropolitan Borough Council, and South Yorkshire Police. The Trust were thanked by South Yorkshire Fire and Rescue for providing supportive supervision



"The presentation given was very clear regarding how TRFT colleagues share learning across both the adults and children's partnerships. The close working relationships with both adult and children's colleagues support a positive and effective think family approach within TRFT. "

Feedback from the Independent Chair RSAB/RSCP

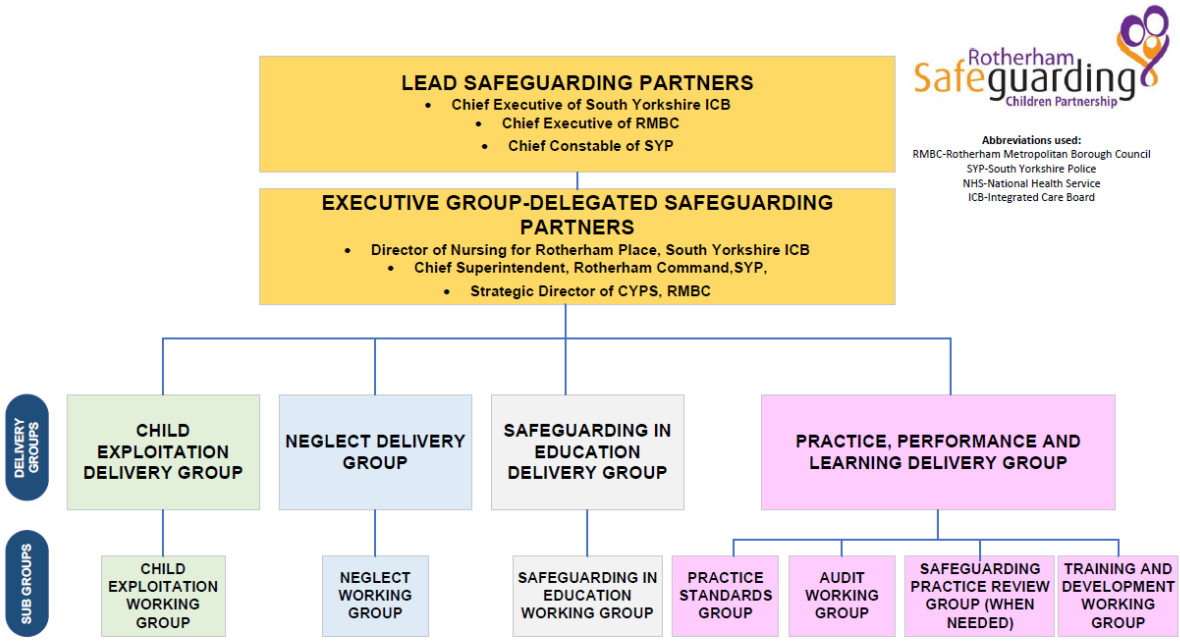
4.4 Rotherham Safeguarding Adult Board (RSAB)



- TRFT are represented at all levels of the RSAB and pro-actively support the work of the Board to safeguard adults across the borough.
- TRFT Head of Safeguarding co-chair the SAR sub-group, which is responsible for reviewing significant incidents and commissioning Safeguarding Adult Reviews (SARs) and ensuring the action plans are completed, with changes implemented to improve the safeguarding practice across the borough. The SAR sub-group works closely with the Domestic Abuse lead for the Safer Rotherham Partnership to ensure oversight and learning from significant incidents of domestic abuse.
- Following ministerial advice, the SAR sub-group will now consider all deaths of homeless people to assess if they meet the criteria for a SAR. There have been no deaths in Rotherham relating to a homeless person, but the group has engaged with the homeless and rough sleeping teams in Rotherham, including an education session that was delivered by The Board Manager and TRFT Head of Safeguarding.
- A new Thresholds guidance document has been produced which aims to inform decision making when considering a referral to adult safeguarding.

"TRFT have been a key member of Rotherham's Safeguarding Adult's Board since its inception. Colleagues have contributed significantly to the Board and its subgroups, in particular the Safeguarding Adult Review subgroup and Policy & practice subgroup which are co- chaired by the Trust. We have continued to strengthen our safeguarding partnership arrangements in response to our 2023 peer challenge, and the Trust has been a key partner, integral in delivering our three year strategy and action plan.
Many Thanks to all at TRFT for their support of the work of the Safeguarding Adult Board."
Moira Wilson
Independent Chair
Rotherham Safeguarding Adult Board.

4.5 Rotherham Safeguarding Children Partnership (RSCP)



TRFT have remained a consistent and reliable partner of the RSCP, working with partner agencies to improve our collective response to safeguarding children and young people. There continues to be a significant amount of work across the partnership to continuously improve safeguarding practices. The governance chart sub groups as shown in the chart, and additional focused working groups for targeted pieces of work. To ensure the best use of the specialist resource, the safeguarding team are working with the ICB and RDaSH safeguarding teams to strengthen the health voice and reduce duplication where opportunities allow.

- TRFT are represented at all levels of the Partnership with the ICB representing health partners at the executive, as directed by Working Together to Safeguard Children (2023).
- TRFT Head of Safeguarding chairs the Neglect Delivery Group. Its ambition is to eliminate childhood neglect in the borough. During Safeguarding Awareness Week in November 2024, the Neglect Strategy was formally launched at the New York Stadium, with agencies and individuals being asked to ‘pledge’ how they would help tackle neglect.
- TRFT are an active member of the Child Exploitation Delivery Group and the new risk assessment tool developed by this group has been implemented across the Trust. The safeguarding team have delivered short education sessions known as ‘stop the shift’ on harm outside of the home to ensure that staff are kept up to date with emerging indicators of harm outside of the home.
- The audit group undertakes multiagency audits to provide assurance that the ‘safeguarding system’ is working effectively. Audits this year have reviewed Children Missing from Education, Neglect, Harm Outside of the Home and Early Help.
- A new Harm outside of the Home pathway has been launched, with further training and awareness of this planned for Q1 of 2025/26.

"TRFT continue to be a consistent and reliable partner around the Rotherham Safeguarding Children Partnership (RSCP). They actively contribute to discussions and decisions, offering constructive challenge at key parts within the process and partnership.

Representatives from TRFT support the partnership and lead on one of the key dedicated sub-groups, as well as assisting on other groups, and relevant task and finish groups. They are an active partner in the wider partnership arena and provide good reassurance across the health professionals. During the last year TRFT has supported driving the priorities and embedding working across the partnership, specifically around the neglect priority. This was very evident during the safeguarding awareness week.

Thank you to all at TRFT for your continued support."

Darren Downs
Independent Chair & Scrutineer
Rotherham Safeguarding Children Partnership

4.6 Safer Rotherham Partnership (SRP)

TRFT are a consistent member of the SRP, with members of the safeguarding team regular contributors at the Multi agency risk assessment conference (MARAC) for high risk domestic abuse, with TRFT working with partners from across health to establish a pathway for medical assessment for suspected non-fatal strangulation.

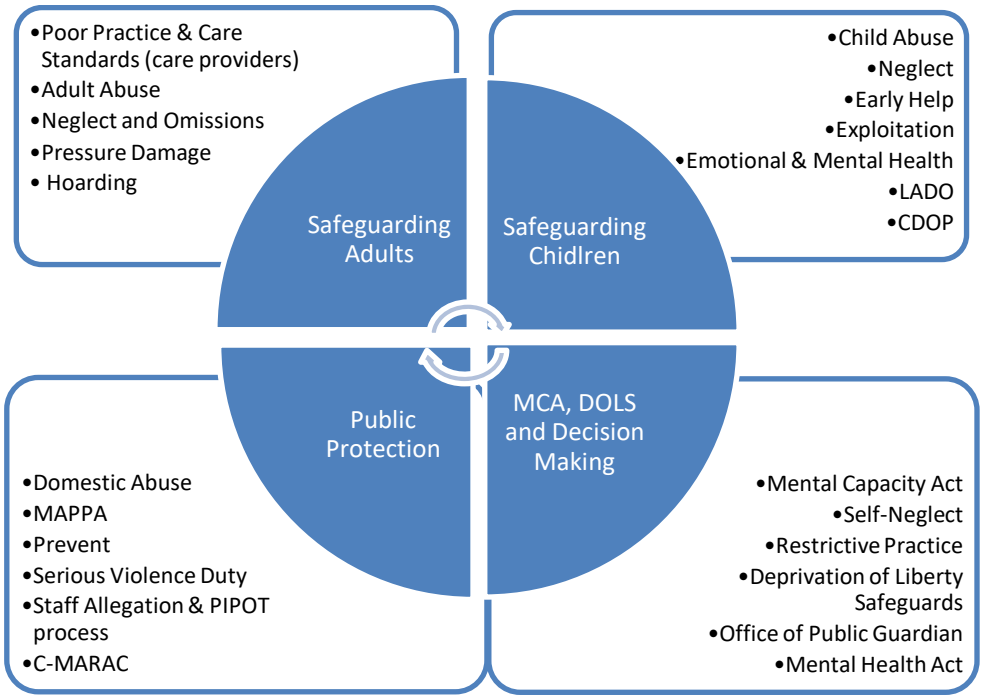
Key areas include:

- Contributed to Domestic Homicide Review work
- Regular attendance and participation at Chanel panel
- Attendance and contribution to Domestic and Sexual Abuse Core Priority Group.
- Community MARAC is a multiagency meeting where individuals with multiple complexities are discussed and plans put in place to help them stay safe. This has increased from fortnightly to weekly during this period.
- Drug and Alcohol Related Death (DARD) panel, which looks to learn lessons from these deaths.
- Contribute to the Serious Violence Duty Action plan
- As part of the serious crime duty work, TRFT have implemented a pathway with South Yorkshire Police when there are concerns of drink spiking.

Learning from Domestic Homicide Reviews has taken place across TRFT.

5 Current Position of TRFT Safeguarding and Vulnerabilities Team

As the year ends, the team is fully resourced, with development work ongoing to ensure a Think Family Safeguarding approach is implemented across safeguarding. The chart below highlights the key areas of work that the team lead on or support with. The Trust has been working in partnership with Dementia UK, and as the year ends we are thrilled to have appointed a new Admiral Nurse who will work with the Trust leadership team to embed best dementia practice across the Trust.



- TRFT are compliant with all statutory and regulatory requirements.
- All staff have access to the Trust policies and procedures which have been updated to reflect current research and guidance, are evidence based and take account of new legislation. They are aligned to the Rotherham multi-agency safeguarding procedures.
- The safeguarding team has coordinated and delivered a robust audit programme across the clinical services, which shows improvement in safeguarding practices.
- Safeguarding begins with robust recruitment, with all new recruitments within the Trust, meeting the DBS standards and are appropriately vetted by references.

6 Safeguarding Adult Incidents, Referrals and Trends:

	Q1 23/24	Q2	Q3	Q4	Q1 24/25	Q2	Q3	Q4
Number of referrals to Adult Safeguarding	162	155	205	258	198	188	205	191

Safeguarding adult referrals have remained consistent this year, with referrals being made from all areas of the Trust. The main themes identified by the Trust relate to neglect or self- neglect. The quality and performance sub-group of the RSAB reviews the referrals and TRFT are highlighted as having a good conversion to enquiry rate, indicating that the staff have good knowledge and awareness of safeguarding.

7 Safeguarding Children Incidents, Referrals and Trends

	Q1 2023/24	Q2	Q3	Q4	Q1 2024/25	Q2	Q3	Q4
Number of referrals to children's social care	360	311	325	373	431	409	323	361

There have been 1331 child social care referrals, for children living in Rotherham. Safeguarding children referrals have remained within expected levels, with most of the referrals coming from the Urgent and Emergency Care Centre, where in a typical month they make approximately 100 referrals. The Trust have identified a range of concerns relating to abuse or neglect of children, but the main reasons for referral are concerns due to the adults with dependent children presenting with emotional wellbeing concerns impacting on children and children presenting in crisis with emotional wellbeing concerns. UECC staff are not only recognising and identifying acute safeguarding concerns, they are consistently thinking of differing levels of need including early help and interventions applying the think family approach has increased the referrals for complex and vulnerable threshold when patients are presenting.

The quality referrals evidences increased competency and compliance over the past 12 months where staff are responding to safeguarding concerns across all levels of need. This includes identifying harm outside the home, risks and improved response to adults that present with mental health, substance misuse, domestic abuse and physical disability that impacts on family life and dependent children. The strengthened systems and processes for documentation supports the implementation of electronic Safeguarding huddles in departmental areas which have been evidenced in audit as the safety net allowing patients to be reviewed within 24 hour period and any additional safeguarding actions agreed collectively are completed.

This year, the safeguarding team have led on a quality improvement project working with UECC nursing and medical staff, RMBC Service lead and IT applications specialists to launch the direct referral for non-urgent children's social care referrals from the patient record. There is evidence of improved good quality referrals with a streamlined service as staff can focus on the documentation of concerns as opposed to navigating a more complex IT system to submit a referral. The referral submitted will also automatically trigger a paediatric liaison referral, avoiding duplication of information. Time taken to submit the referral have been reduced significantly.

Raising awareness of the practice resolution process has given staff more confidence to have respectful professional challenge and escalation where required to resolve situations promptly. The safeguarding team have supported staff throughout the year with practice resolution, working closely with social care partners to ensure both risks and protective factors are clearly understood. Where there are safeguarding concerns,

a discharge planning meeting takes place before discharge to ensure that robust safety plans are in place.

7.1 Paediatric Liaison (PLN)

Paediatric Liaison ensure that information is shared between agencies relating to the patient's hospital attendance. They act as a crucial bridge between hospital and community services, ensuring seamless communication between services. The Paediatric Liaison Nurses provide support to the in-patient areas where there are 16 and 17 year olds, and assist with the safeguarding checks and discharge processes.

Patient Impact Story

A 17 year old looked after child attended UECC by ambulance, experiencing mental health crisis. The young person shared some concerns regarding his placement and stated he did not want to go back. He had been in the UECC department for an extended period.

Paediatric liaison supported UECC staff to liaise with out of area social care to try and facilitate a safe discharge.

Information was shared with the looked after children's nursing team and PLN supported in arranging a professionals meeting after discharge to discuss the attendance and made a plan to support if he re-attended UECC.

The paediatric Liaison Nurses discharge the role of the key worker for child death. They liaise with many professionals as part of the key worker role, including UECC staff, GP, Coroner's Office, Police, Social Care, Early Help, Paediatrics, Mortuary staff both here and at Sheffield Children's Hospitals, and the consultants. The key workers are passionate in providing the voice of parents/carers at any professionals' meetings held. During this year they have worked with the Trust Charity and secured funding for bereavement support for those families who experience unexpected child bereavement. This is being delivered by Bluebell Wood, who already provide a service for those who experience an anticipated child bereavement.

8 Safeguarding Supervision

Supervision is the cornerstone to embedding safeguarding practice and learning from incidents, it also supports staff emotional resilience in processing the emotive elements of incidents. Outcomes are not always easy for staff to accept, examples include adults making unwise and risky decisions regarding relationships, or declining interventions that would help them live safer.

Group supervision continues to be delivered by the safeguarding team for all Trust areas who require this compliance, with a mixture of face to face and Teams meetings. Moving forward, we hope to phase out the Teams sessions as face to face provides much richer discussions and improved opportunities for engagement.

Supervision is available to all staff, with many requesting adhoc sessions to discuss incidents or situations they have been involved in.

Supervision compliance remains below expected levels of compliance, with local leaders working on actions to improve compliance.

Group Supervision Trust Wide ESR data	69 %
1:1 Supervision Trust Wide ESR data	89%

9 Maternity Specific Activity

Female Genital Mutilation (FGM)

The risk assessment has been reviewed and updated to reflect local and national approaches.

There have been 56 contacts for FGM into safeguarding. These are flagged on the national spine as well as local records to highlight the potential risk.

Around 50 unborn babies with vulnerabilities are identified each month as requiring additional early help or social care input and support. There were 27 newborn babies that required the Local Authority to seek an Interim Care Order at birth during 24-25.

The PAUSE project, which supported mothers whose children were not in their care due to social care intervention, has now ended due to funding. This may impact on services as the support they provided covered a range of accessing health specific services, and may lead to more pregnancies where the Local Authority will need to seek legal advice.

10 MASH Activity

TRFT are represented in the Multi Agency safeguarding Hub (MASH). They provide health information and analysis to support decision making for multiagency information safeguarding enquiries (MAIS). The health representative provides information to the Multiagency domestic abuse (MADA) meetings where there are children. The MASH continues to be a busy, faced paced environment with information being required promptly to inform decision making.

	Total No MAIS	MADA Meetings	MASH Meetings	Strategy Meetings
April 2024	148	55	25	3
May 2024	146	28	15	8
June 2024	144	36	14	3
July 2024	130	28	13	5
August 2024	131	40	17	0
September 2024	121	29	8	0
October 2024	160	26	14	1
November 2024	132	34	8	0
December 2024	119	32	8	1
January 2025	144	21	10	1
February 2025	126	22	8	0
March 2025	149	20	10	0
Total	**1650**	**371**	**150**	**22**

11 Domestic and Sexual Abuse & Violence

What is MARAC?
The multiagency risk assessment conference (MARAC) is a multi -agency meeting that discusses high-risk domestic abuse cases, for adult victims and young people aged 16+. Actions are taken to reduce the risk of survivors/victims of abuse and disrupt perpetrator behaviour.

What is DASH & HARK?
Domestic Abuse, Stalking, Harassment & Honor based Violence (DASH) is an assessment tool used to help professionals assess the level of risk in situations of domestic abuse.

Humiliation, Afraid, Rape, KICK (HARK) is a screening tool used in UECC to assist in identifying domestic abuse/intimate partner violence.

These are shared with the safeguarding team to confirm appropriate referrals have been made

What is Non-fatal strangulation?

Section 70 of the Domestic Abuse Act specifies that non-fatal strangulation is a specific crime. Safe Lives found that those who have experienced non-fatal strangulation are 8 times more likely to be killed than someone who has not experienced NFS.

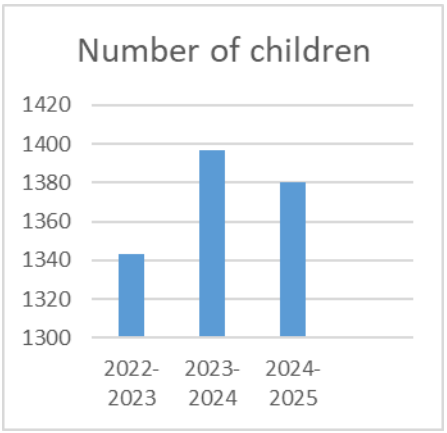
The safeguarding team represent TRFT at MARAC (Multi-Agency Risk Assessment Conference) meetings. Meeting frequency has increased in Rotherham this year, with one taking place most weeks. Over the last year, the safeguarding team have supported 10 members of staff who were discussed at MARAC, working sensitively with the individual and their line manager to ensure work is a safe and supportive place. The safeguarding team continue to raise awareness of the support and safety measures that TRFT can implement to protect staff in the workplace.

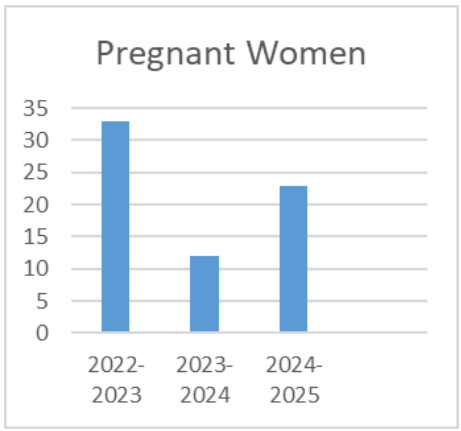
MARAC representatives are crucial to the success of MARAC, bringing relevant risk information held by their organisation, sharing that information appropriately and collaborating with other representatives to create action plans to reduce risk and increase safety for families.

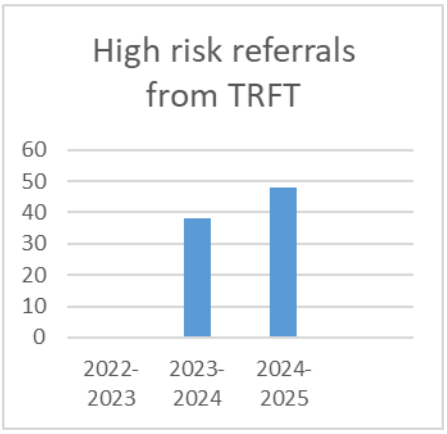
MARAC is a process through which agencies create coordinated action plans to reduce the risk of serious physical harm and homicide. At the heart of the MARAC, process is the working assumption that no single agency or individual can see the complete picture of risk, but all may have insights that are crucial to improving safety.

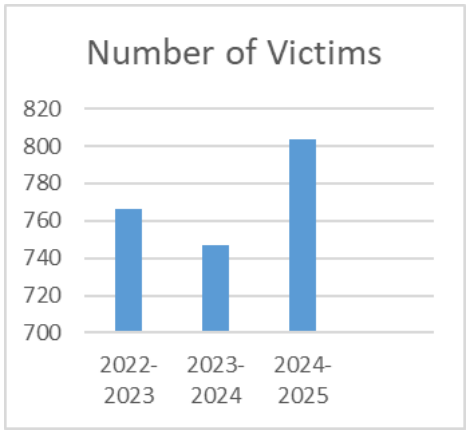
11.1 MARAC Data

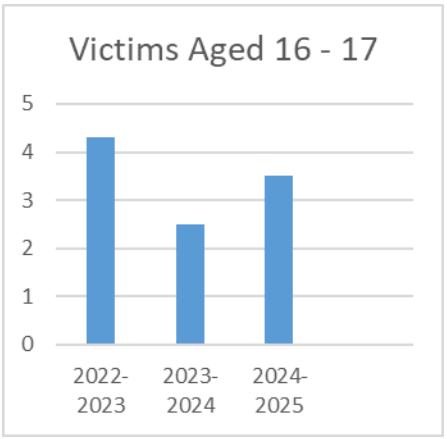
The charts below show a general increase in the number of incidents, with over 800 victims discussed in this high risk arena, with TRFT making almost 50 referrals this year.

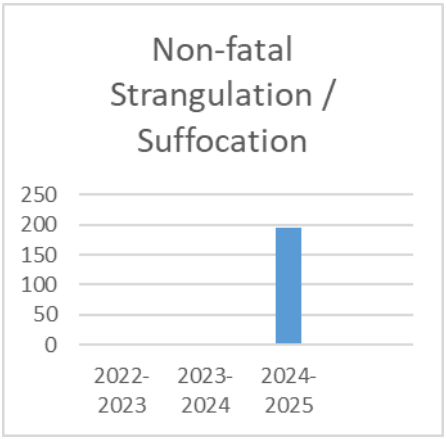












The charts show the number of cases where non-fatal strangulation is a feature. The safeguarding team have promoted and raised awareness of the Patient Information Leaflet “Information for victims of Strangulation” and QR Code with our partner agencies at MARAC so that all agencies ensure this is shared with their staff and with victims.

11.2 The Sexual Safety Charter

Working with the People Team, the Trust formally launched the sexual safety charter via the Team Brief. Working with partners across the Trust, the safeguarding team developed a new allegation policy which ensure a consistent and transparent approach to the management of any allegations are considered from a safeguarding angle. The Sexual Safety Charters seeks to ensure that there is a safe and supportive culture at TRTF, and that staff who raise concerns are appropriately supported. The Trust

Communications team have supported with designing posters and sharing messages throughout the year to ensure momentum is maintained.

The leadership team from across the organisation have had training on recognising and responding to incidents of sexual safety and or harassment, and safe bystander interventions. This is included in Trust 'Big Welcome' induction to ensure that new staff are aware of the support available.

Where staff are living with or impacted by domestic abuse, the safeguarding team work closely with Security, The People Team and clinical leaders to support individuals in a sensitive way. The safeguarding team, where appropriate will liaise with other agencies for example; Police, Social Care and Hopian.



As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

These commitments will apply to everyone in our organisation equally.

12 Adult Safeguarding Caused Enquiries

TRFT received 19 enquiries throughout 2024/2025 regarding the care that TRFT services provided. The main themes were in respect of discharge arrangements and communication of which there were 7. The remaining 12 enquiries were concerning a combination of basic care provision, drug error or medication issues. All enquiries closed to Safeguarding after initial enquiry. It is notable that only one enquiry was in relation to pressure damage. This is believed to be due to the changes in Safeguarding processes, TRFT governance and the Threshold Guidance document.

All S42 caused enquiries are reported on datix, and learning from these investigations continues to be shared through local Governance meetings. This change in process and transparency has had a positive effect on the timely return of investigations.

13 Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS)

What is a Deprivation of Liberty?
Deprivation of Liberty Safeguards are put in place to ensure that individuals over 18 who lack mental capacity to make their own decisions, who are not free to leave, and who are under continuous supervision and control receive appropriate care and treatment, and that any restrictions are the least restrictive option available.



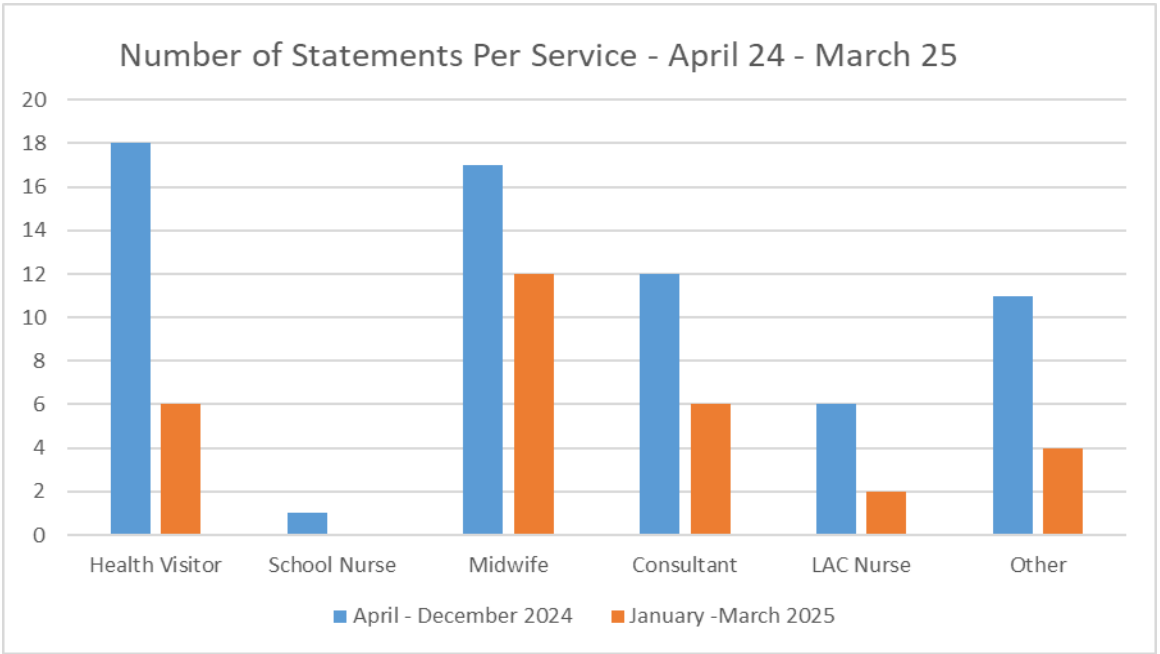
	Q1 2023/24	Q2	Q3	Q4	Q1 2024/25	Q2	Q3	Q4
Number of DoLS applications	122	98	124	133	111	121	126	160

The safeguarding team have completed an audit of the DOLS process which highlighted areas for improvement, which the team are working with ward leaders to improve. A repeat audit will take place in 2025/26 to monitor the improvements.

All DOLS applications are reviewed by the safeguarding team to ensure that appropriate mental Capacity Assessments have been completed.

TRFT has been a respondent in one application to the Court of Protection during, and has sought legal advice on a small number of patients where this was being considered a possibility.

14 Court and Legal Statements



The safeguarding team quality assure all legal statements and during this year, have continued to work in partnership with the Trust solicitor. 95 legal statements have been completed during this year.

Where staff are called to provide witness evidence in person within proceedings, either in family court or crown court, the safeguarding team coordinate with the Trust legal Solicitor a court preparation meeting and have attended court to support staff. The Safeguarding team have supported TRFT practitioners this year in preparing for court. The safeguarding team have liaised closely with police witness team to ensure efficiency the process whilst keeping staff informed and updated with progressions.

15 Child Exploitation

The Trust employs a child exploitation nurse who is co-located with the EVOLVE team. Their role is to:

- Work with children and young people who are exploited either sexually and/or criminally
- Offering health assessments and support with identified outstanding health needs
- Offering health assessment to every young person who has been referred to the youth justice service
- Tailored support to each young person to ensure identified health needs are met
- Working as part of a multi-agency team which includes social care, police, early help, CAMHS, Roads, youth justice, education
- Sharing of information relevant to the risk of exploitation

The caseloads change each month as young people are added to youth justice programmes, or are identified as being at risk or/ experiencing exploitation, but a typical months data:

- 55 young people on the Evolve (child exploitation) caseload.
- 49 young people on the youth justice caseload- this is a very fluid caseload as they remain with the service for a minimum of 12 weeks and up to a year, depending on the orders issues from court. The majority on the caseload are on for a 12 week period.
- MACE meetings are held weekly with TRFT representation at each meeting.

The safeguarding team works closely with the child exploitation nurse, and provides support and supervision for complex situations.

16 Child Death Review Service

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. As a Trust, we pride ourselves on delivery a high standard of care and support for bereaved parents and families. The role of the Keyworker has been fundamental for us achieving our aim of offering timely, appropriate and compassionate support to all bereaved parents. This role is integrated into the Paediatric Liaison role and has worked well, providing availability of the service as recommended in the Child Death Review Statutory Guidance 2018.

The keyworker is the “voice of the parent” at all professional meetings. The work of the keyworker has proved insightful into the worries, fears and issues parents hold onto following the unexpected death of their infant or child. The service continues to be available Monday to Friday, 9am – 4.30pm. Standards are in place for the keyworker role to ensure that there is consistency of delivery.

The TRFT CDR Lead Nurse Sharon Pagdin retired in December 2024. Her hard work and dedication to driving change, developing arrangements when a child dies and improving recognition of the needs of the bereaved has been greatly valued and will be much missed. There was no gap in service as TRFT appointed in a timely way, allowing a significant handover period to ensure a seamless transfer.

The CDR Service has now taken on the role of CDOP manager and administrator on a temporary basis initially. This will be reviewed and is expected to become permanent in 2025/2026.

Review and analysis of all children who have died and resident in Rotherham

In 2024/2025, Rotherham recorded twenty child deaths in total, six more than the previous year and slightly above average (seventeen). As of April 2025, there are currently twenty-two active cases progressing through the child death review process. Six of these cases date back over a year as Coronial inquests, specialist pathology report, criminal investigation and capacity within Rotherham Safeguarding Children Partnership administrative arrangements delay the review process. The Trust has liaised with the partner agencies and worked extensively in partnership to address the issues identified. Exceptional CDOPs have taken place during 2024 to reduce the backlog, which will continue to be monitored through Rotherham CDOP.

Three deaths were not considered part of the Rotherham CDOP process. Two cases were transferred to Sheffield and one case was noted to be a stillbirth, therefore not required to be considered in CDOP.

Number of Rotherham child deaths on a financial yearly basis from 2016 onward.

2024/25	2023/24	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17
20	14	17	23	11	13	22	20	15

Rotherham Child Deaths 1st April 24 – 31st March 25

Expected deaths	Q1	Q2	Q3	Q4	Unexpected deaths	Q1	Q2	Q3	Q4
Child resident in Rotherham	4	2	4	1	Child Resident in Rotherham	3	3	0	3
Died out of area	2	1	1	1	Died out of area	1	1	0	1
JAR						2	3	0	2

Joint Agency Response (JAR)

The Trust has co-ordinated and chaired seven JAR meetings. One case, although unexpected, did not require a JAR meeting as the baby was born at 20 week's gestation while the JAR for the remaining case was held in the 25/26 period.

The meetings have continued to be held via teams and as a result are well attended, with excellent engagement from health, police, social care and education. All meetings have been held within the required timescale. The JAR meeting frequently receives feedback from attendees highlighting the meeting has not only been beneficial in putting a multi-agency plan of support in place for bereaved families but is also supportive and empathetic to professionals involved in care of the child/family.

Coroner's Officers are invited to all JAR meetings and meeting minutes of JARs and CDRMs are shared with the Coroner, in line with statutory guidance.

Child Death Review Meeting (CDRM)

The CDRM occurs for all child deaths, irrespective of a death being expected or unexpected. To avoid duplication of services a CDRM may take place in existing meetings or as a stand-alone meeting. The Trust is responsible for coordinating and chairing CDRMs and gathering information from external Trusts where a child may have died. Not all external Trusts are as developed as our Trust in their Child Death Review services and obtaining such information has, at times, been problematic, contributing to unnecessary delay in Rotherham cases being presented at Rotherham CDOP.

A pathologist has attended all Child Death Review meetings (CDRM) when a post-mortem has been performed. This has received positive feedback from pathology services and their contribution at the CDRM has been of value. The CDRMs for all child deaths have worked effectively in terms of attendance and participation.

The Lead Nurse for Child Death Review has followed a pathway to gather appropriate information and an escalation pathway to address concerns where information is not shared in a timely manner.

> While specific child mortality data for Rotherham is not detailed in the NCMD 2023–2024 report, regional and national trends suggest that factors such as socioeconomic deprivation and ethnic disparities likely influence child health outcomes in the area. Efforts by local health services to monitor and address these issues are crucial in improving child health and reducing mortality rates.

Data released by NCMD spanned from 1 April 2019 to 31 March 2024 and across South Yorkshire highlighted that most infant, neonatal and child deaths occurred within the highest level of social deprivation, and the least deaths were seen within the lowest levels of social deprivation. Regionally, children in the most deprived areas had death rates more than twice those in the least deprived areas.
While national child mortality rates have seen a slight decrease, disparities persist, particularly in regions like Yorkshire and the Humber. Rotherham, along with our neighbouring towns and cities, faces challenges related to socioeconomic deprivation

that impact child health outcomes. Addressing these issues requires targeted interventions and policy changes focused on health equity and socioeconomic improvements.

The Rotherham CDOP's proactive approach in reviewing various categories of deaths and planning for future reviews indicates a commitment to understanding and addressing mortality factors within its service area.

TRFT Achievements

1. TRFT CDR service has supported RMBC to reduce the number of cases awaiting review at CDOP.
2. Direct contact and liaison with the National Child Mortality Database Programme has continued to prove valuable in supporting the child death review service to remain compliant with CDR statutory guidance e.g., a grading system used to identify modifiable factors; reporting a death occurring overseas.
3. Consolidation of an effective pathway for sharing learning from CDOP within TRFT and the wider partnership continues and has been well received.
4. Key professionals in the Trust CDR team are members of the association of Child Death Review Professionals, keeping the Trust current and forward thinking in national child death policy, procedure and learning.

5. TRFT has secured charitable funding to support bereaved parents and families and offer ongoing support, provided by Bluebell Wood Hospice.

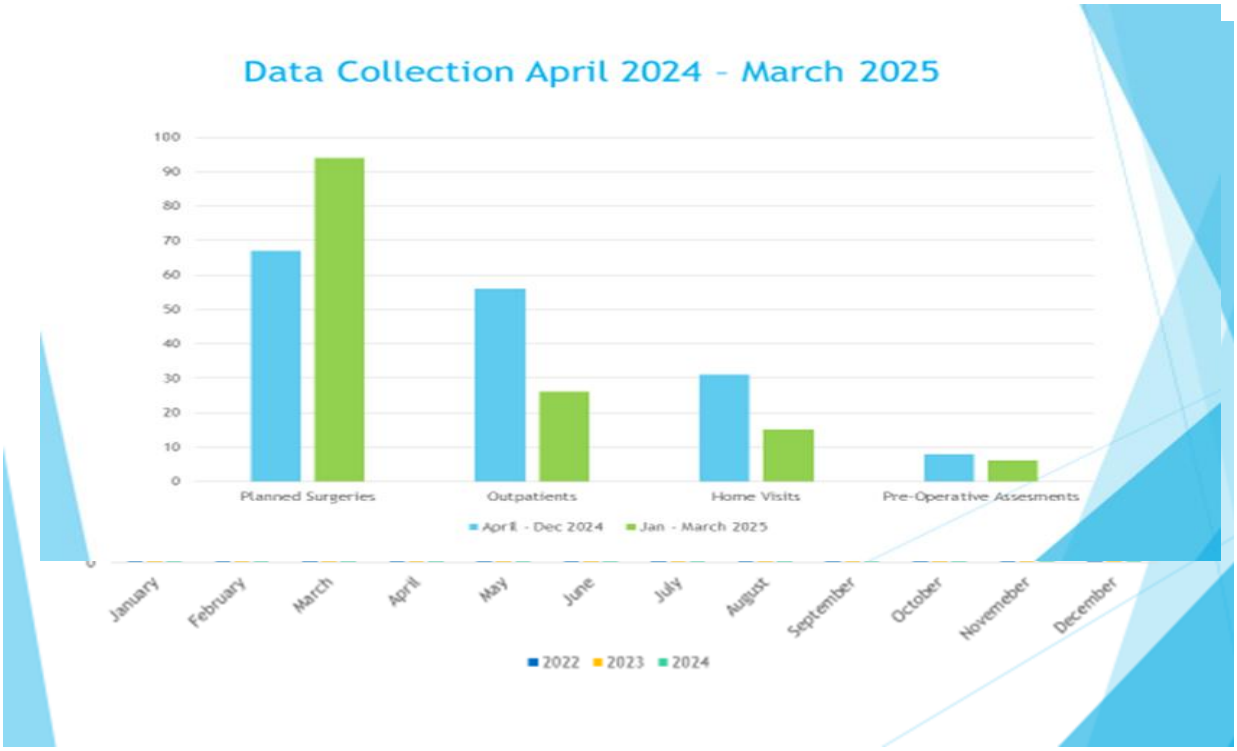
What are our plans for 2025-2026?

- Embedding within the TRFT CDR service the role of CDOP manager and CDOP admin.
- Embedding of the 'Child and neonatal death following a life-limiting condition' SOP.
- Review the impact of bereavement support for families/carers following the death of a child resident in Rotherham.
- Lead Nurse Child Death Review will continue to contribute to the TRFT self-assessment in relation to Bereavement Care Standards and identify actions for TRFT.

17 Learning Disability and Autism Team

The Learning disability and Autism team provide support to both Children and Adults, across an all-age spectrum with a Learning disability or who are Autistic.

- The team saw an **increase of 70%** in the numbers of inpatients seen from 2023-24 into 2024-25
- Planned surgery pathway involvement of the team has also **increased by 70%** during this period, with some positive feedback from all involved.
- Due to team capacity and operational priorities, there has been a reduction in home visits during Q4, but this area of support will resume as staffing returns to normal levels.
- The team continues to support and review patients who have additional needs, but no formal diagnosis.



The team continue to support planned admissions through the surgical pathways, utilising the non-medical prescribing skills within the team. For some people with a learning disability and / or autism, coming through the Trust is the only option for them to receive much needed physical health investigations and or treatment. This work also includes the Trust Community dental pathways, which include both children and adults.

The team has a number of resources to help the patient journey within our Trust. This includes the use of light therapy equipment, which is found in the form of bubble tubes within UECC (Urgent and Emergency Care Centre) to our smaller pieces of light therapy equipment on the main wards and departments. Recently we have been lucky enough to have further editions to this which have been funded by our hospital charity, in the form of sensory bags. These include weighted lap blankets, noise cancelling headphones and fidget/distraction toys.



Throughout the Trust and the community facilities, we have an ever-growing body of

Learning disability and Autism champions, a role which is about empowering staff members and teams to reflect on the care they give to this patient group and the tools to improve their patient experience. The team has also been lucky enough to be granted pin badges to highlight our Learning disability and Autism Champions. We hope to present these at a Learning Disability and Autism Champion event later in the year.

Patient Story

Recently the team worked with a patient who has a severe learning disability and some psychological wellbeing issues. They presented as extremely anxious around coming to hospital and had been unable to attend several of her mammogram appointments. This patient had a previous mastectomy; hence follow-up mammogram appointments were of high importance to them. We referred to and worked with the psychologists within the specialist community Trust, ensuring the patient had a social story explaining what would happen on the day they came to hospital.

The team did lots of pre-appointment work, reiterated the social story, training the staff team in working in a consistent way with the desensitisation programme.

We prescribed a pre-med prior to leaving home for the appointment, which her care team administered. On the day, we organised a quieter entry route into the hospital and supported the patient to the appointment, giving verbal and physical reassurance throughout.

After a history of three failed mammogram appointments, this patient was finally able to tolerate the scan. After the appointment to further embed the positive experience, a large slice of cake and a coffee was enjoyed!

The Learning Disability team have helped with several of my patients. They have supported me with the consultations, processing tests and in particular with patients requiring a General Anaesthetic. The care and professionalism provided by the LD/A team has been excellent. This made my involvement as a Surgeon a lot easier and wholesome.
Continue with the good work.
Thank you
Continue with the good work.

Awards and Feedback

The team were very proud to have been shortlisted in the 2024 Nursing Time awards for their work supporting people with a learning disability.



"My son had elected surgery at Rotherham Hospital, he has autism and learning difficulties. The Learning Disability Nurse visited at home to complete his hospital passport. I honestly can't praise them enough, they were second to none, so kind and understanding. A huge giant thank you has to go to this team, as I do not believe the surgery would have happened without their planning, understanding and continued support.
We were home safe at about lunchtime and all had gone as planned, absolutely fabulous. Thank you to you all"

18 Prevent

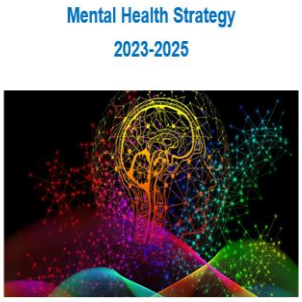
What is the Prevent Duty?
The Prevent Duty was introduced through the Counter Terrorism Strategy and Security Act 2015 and the Duty required health bodies, local authorities, higher education institutions, prisons, probation and the police to consider the need to Safeguard people from being drawn into terrorism.



TRFT use the e-learning for health Preventing Radicalisation training. All staff and volunteers working in the NHS are required to have an understanding of the risk factors for those vulnerable to exploitation for radicalisation.

TRFT are represented at Channel, and share information into the meeting as required. There have been no missed opportunities identified for TRFT this year.

19 Mental Health



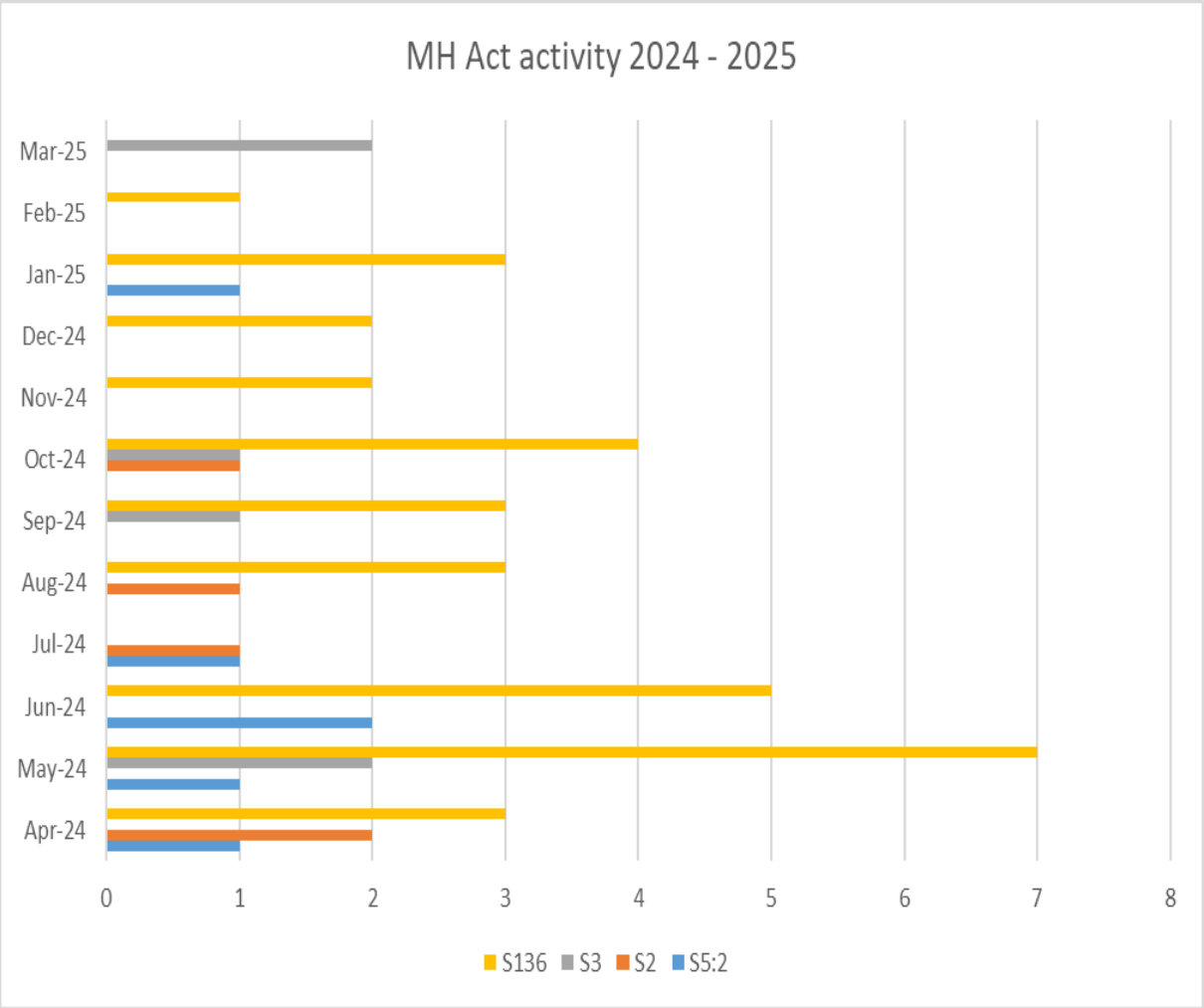
The safeguarding team represent TRFT at the Operational and Strategic Suicide Prevention Groups, which are managed through Public Health. There has been significant progress made across TRFT in relation to supporting individuals with Mental Health concerns. Monthly meetings with the Mental Health Act team at RDaSH are in place that reviews individuals who have been subject to the Mental Health Act at TRFT.

A supportive approach to de-escalation and restrictive care has started to be rolled out, with an external training provider commissioned to deliver training in safe restrictive care methods. The Trust have successfully trained over 100 staff which enables a better experience for the patient, as they can receive care from the team who are delivering their care, rather than the use of agency staff.

Section 136 of the Mental Health Act

The chart below shows mental health activity across the Trust, with 33 patients detained under Section 136 in UECC during this annual period (compared to 30 in 2023-24). All individuals who attended UECC whilst detained required physical healthcare.

There has been 6 individuals where the use of the holding power section 5.2 was implemented. The safeguarding team have worked with the Mental Health Liaison Team to deliver training and raise awareness of section 5.2, and how this may assist with the assessment and management of some patients.



20 Training

The safeguarding team continues to deliver training as a key part of the role.

The Think Family training is delivered twice a month. The sessions is based on real safeguarding situations and is case study based. The day always evaluates very positively.

For this annual period TRFT clinical staff have achieved (Trust Wide data):

Adult SG Level 2	91%
Adults SG level 3	100%*
Children SG level 2	85%
Children SG level 3	87%
Basic Prevent Awareness	92%
Preventing Radicalisation	93%
Safeguarding Team Level 4	100%
Dementia	99%
Oliver McGowan E-learning	81%
Oliver McGowan Tier 2	25%

Oliver McGowan training is now in its second year, with a plan in place to get all staff trained during the 3 year period. In line with the guidance, all sessions are delivered by people with lived experience of Autism and a Learning Disability. The sessions are always fully booked and are evaluating positively.

Non-clinical staff achieved:

Adult SG level 1	88%
Children SG level 1	85%

21 Risk Management

There has been considerable progress on safeguarding risks, with 1 remaining in place at this time.

Medical Workforce non-compliance with Safeguarding MaST

This risk is Trust wide and relates to the medical workforce where there is poor compliance across all Care Groups, with exception of community.

Targeted communications to medical workforce from the Medical Director have been sent, and signposting for staff to access the correct training and MaST compliance will form part of pre-appraisal and appraisal conversations.

Compliance at the end of this annual period has significantly improved, and this will be monitored and it is hoped the risk can be reduced and then closed during this period.

22 Conclusion

This has been another challenging year across the NHS, and TRFT has remained compliant in discharging all contractual and statutory safeguarding duties. The level of safeguarding activity demonstrates that safeguarding practice is embedded across clinical practice, and whilst we practice a continual improvement approach to embed learning and best practice, we are proud of how staff have continued to be professionally curious where they have concerns. The Safeguarding Team has made positive progress with the objectives this year, and have lead, and supported a number of work-streams across the system, continuing to be a consistent and reliable partner to the safeguarding partnerships in Rotherham.

23 Glossary of Terms

CDOP	-	Child Death Overview Panel
CDR	-	Child Death Review
CE	-	Child Exploitation
DASH	-	Domestic Abuse, Stalking, Harassment and Honour-based violence Assessment Tool
DHR	-	Domestic Homicide Review
DOLS	-	Deprivation of Liberty Safeguards
ESR	-	Electronic Staff Record
FGM	-	Female Genital Mutilation
HARK	-	Harassment, Attack, Rape, Kick
IDVA	-	Independent Domestic Violence Advisor
ISVA	-	Independent Sexual Violence Advisor
ISH	-	Integrated Sexual Health
LAC	-	Looked After Children
LADO	-	Local Authority Designated Officer
LPS	-	Liberty Protection Safeguards
MADA	-	Multiagency Domestic Abuse meeting
MARAC	-	Multiagency risk assessment conference
MASH	-	Multiagency Safeguarding Hub
MCA	-	Mental Capacity Act
MHA	-	Mental Health Act
PIPOT	-	Person in Position of Trust
RSAB	-	Rotherham Safeguarding Adult Board
RSCP	-	Rotherham Safeguarding Children Partnership
SAR	-	Safeguarding Adult Reviews
SARC	-	Sexual Assault Referral Centre
SCPR	-	Safeguarding Child Practice Reviews
SUDIC	-	Sudden Unexpected Death in Childhood
UECC	-	Urgent and Emergency Care Centre

	PUBLIC TRUST BOARD MEETINGS		2025 Jan	March		May	June	July	Sept	Nov	2026 Jan	March
			9	7		2		4	5	7	9	6
			M10	M12		M2	Annual Acc.s	M4	M6	M8	M10	M12
	PROCEDURAL ITEMS											
	Welcome and Apologies	Chair	●	●		●	●	●	●	●	●	●
	Quoracy Check	Chair	●	●		●	●	●	●	●	●	●
	Declaration of Conflicts of Interest	Chair	●	●		●	●	●	●	●	●	●
	Minutes of the previous Meeting	Chair	●	●		●		●	●	●	●	●
	Matters arising (not covered elsewhere on the agenda)	Chair	●	●		●		●	●	●	●	●
	Action Log											
	OVERVIEW & CONTEXT											
	Board Committee Chairs Reports QC, FPC, ARC, P&CC	NEDs	●	●		●		●	●	●	●	●
	Chairman's Report	Chair	●	●		●		●	●	●	●	●
	Chief Executive's Report	CEO	●	●		●		●	●	●	●	●
	CULTURE											
	Patient Story	CN		●				●		●		●
	Staff Story	DoP	●			●			●		●	
	Annual Staff Survey	DoP		●								
	Staff Survey Action Plans	DoP				●						
	Freedom to Speak Up Quarterly Report	CN		●		●				●		●
	Freedom to Speak Up Annual Report	CN				●						
	Gender Pay Gap Report and Action Plan	DoP		●								●
	Integrated EDI Plan - WRES, WDES, PSED	DoP								●		
	Patient Experience and Inclusion Annual Report	CN						●				
	End of Life Annual Report	DCN						●				
	Medical Education Quality Report	MD	●								●	
	STRATEGY & PLANNING											
	TRFT Five Year Strategy 6 month Review	CEO				●				●		
	Operational Plan: 6 Month Review	DCEO				●				●		
	Annual Operational Planning Guidance	COO									●	
	Winter Plan	COO							●			
	Estates Strategy	DoEF	●dfd									
	Fire Safety Strategy	DoEF		●		●			●			
	Digital Strategy	DoHI								●		
	Quality Strategy	CN						●				●
	SYSTEM WORKING											
	SYB ICS and ICP report	DCEO	●	●		●		●	●	●	●	●
	SYB ICS CEO Report (included as part of CEO report)	CEO	●	●		●		●	●	●	●	●
	Partnership Working	MD				●			●			
	SYB ICS - Wider Needs of Rotherham Community	Public Health		●					●			
	PERFORMANCE											
	Integrated Performance Report:	COO	●	●		●		●	●	●	●	●
	Safe Staffing & Establishment (6 monthly)	CN	●					●			●	
	Finance Report	DoF	●	●		●		●	●	●	●	●
	Summary of review on Laboratory safety prior to TUPE of staff	MD		●								
	ASSURANCE FRAMEWORK											
	Board Assurance Framework	DoCA	●	●		●		●	●	●	●	●
	Corporate Risk Register	DoCA	●	●		●		●	●	●	●	●
	Annual Review of risk appetite	DoCA							●			
	Health and Safety Annual Report	DoE									●	
	Quality Assurance Quarterly Report	CN		●		●			●	●		●
	SIRO Annual Report	DCEO							●			
	Safeguarding Annual Report	CN							●			
	POLICIES											
	Health and Safety Policy (review date August 2026)	DoE										
	Freedom to Speak Up Policy (Updated when National Policy available)	CN										
	Management of Complaints and Concerns Policy (review due 2025)	CN										
	Procurement Policy (due for renewal February 2026)	DoF										
	Risk Management Policy (due April 2026)	DoCA										
	REGULATORY AND STATUTORY REPORTING											
	Annual Report and Audited Accounts	DoF					●					
	Audit & Risk Committee Annual Report	Com Chair					●					
	People & Culture Committee Annual Report	Com Chair					●					
	Finance and Performance Committee Annual Report	Com Chair					●					
	Quality Committee Annual Report	Com Chair					●					

	Nomination and Remuneration Committee Annual Report	Com Chair					•					
	Annual Quality Accounts	CN					•					
	Maternity & Neonatal Safety Report	CN	•	•		•		•	•	•	•	•
	Data Security and Protection Toolkit Recommendation Report	SIRO						•				
	Quarterly Report from the Responsible Officer Report (Validation)	MD	•			•			•		•	
	ANNUAL Responsible Officer report (Validation)	MD							•			
	Quarterly Report from the Guardian of Safe Working	MD	•			•				•	•	•
	ANNUAL Report from the Guardian of Safe Working	MD				•						
	Mortality & Learning from Deaths Quarterly Report	MD		•		•		•		•	•	
	Mortality & Learning from Deaths Annual Report	MD								•		
	Emergency preparedness, resilience and response (EPRR) assurance process sign off/Annual Report	COO							•			
	Controlled Drugs Annual Report	MD		•								•
	NHSE Self-Assessment for Placement Providers	MD									•	
	BOARD GOVERNANCE											
	Register of Sealing (bi-annual review)	DoCA		•					•			•
	Register of Interests (bi-annual review)	DoCA		•					•			•
	Review of Board Feedback	DoCA									•	
	Board Committee ToRs - Audit & Risk Committee	DoCA								•		
	Board Committee ToRs - FPC, QC, PC	DoCA				•						
	Review of Standing Financial Instructions	DoF								•		
	Review of Scheme of Delegation	DoF								•		
	Review of Standing Orders	DoCA								•		
	Going Concern	DoF		•								•
	Segmental Reporting	DoF		•								•
	Accounting Policies	DoF		•								•
	Review of Matters Reserved to the Board (ad hoc)	DoCA										
	Constitution	DoCA										
	Annual (re)appointment of Senior Independent Director	Chair							•			
	Annual (re)appointment of Board Vice Chair	Chair							•			
	Annual Board Meeting dates - approval	DoCA							•			
	Fit and Proper Person	DoCA							•			
	Escalations from Governors	Chair							•	•	•	•
	Annual Planner	Chair	•	•		•		•	•	•	•	•
	Board feedback		RS	SH		SC		AM	EP	KM	JRa	MT
	NED Review of complaints files (Quarterly)		RS			SC		KM		JB	HW	