# HEALTH SELECT COMMISSION
## Thursday 27 March 2025

Present:- Councillor Keenan (in the Chair); Councillors Yasseen, Bennett-Sylvester, Clarke, Garnett, Havard, Rashid, Tarmey and Thorp.

Apologies for absence:- Apologies were received from Baum-Dixon, Duncan, Ismail and Mr R Parkin.

The webcast of the Council Meeting can be viewed at:-
https://rotherham.public-i.tv/core/portal/home

## 50. MINUTES OF THE PREVIOUS MEETING HELD ON 23 JANUARY 2025

**Resolved:-**

That the minutes of the meeting held on 23 January 2025 were approved as a true and correct record of the proceedings.

## 51. DECLARATIONS OF INTEREST

The following declarations of interest were made:-

| Member | Agenda Item | Interest Type | Nature of Interest |
|---|---|---|---|
| Councillor Garnett | Agenda Item 6 and 7 | Personal Interest | Employment at TRFT |

## 52. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the public or the press.

## 53. EXCLUSION OF THE PRESS AND PUBLIC

There were no items on the agenda that required the exclusion of the press or members of the public.

## 54. TRFT SAME DAY EMERGENCY CARE CENTRE DEVELOPMENT

The Chair welcomed the Managing Director, Bob Kirton and the Chief Operating Officer, Sally Kilgariff, TRFT to the meeting and invited them to introduce the presentation.

The Managing Director, TRFT explained that they had recently taken up the role previously occupied by Michael Wright who had regularly attended the Commission's meetings, having undertaken the same role

previously at Barnsley. They were now in their third month of getting to know and understand the Trust and were working closely with partners through the Health and Wellbeing Board, Place Partnership and Rotherham Together Partnership.

The Managing Director, TRFT outlined their intention to set out the plans for the Same Day Emergency Care (SDEC) Centre, which was essentially an extension of the Urgent and Emergency Care Centre (UECC) at the hospital.

They explained that the UECC was set up in 2017 and had proved very successful. The opportunity was presented to obtain some national funding through NHS England following a rigorous process that concluded in December 2024, which was pursues by the Trust with the support of the Board due to increased attendance at the UECC.

The Managing Director, TRFT explained that TRFT felt it was important to engage with the Health Select Commission at an early stage to offer an opportunity to influence the development of the SDEC in a way that reflected the needs of Rotherham people.

They described that the SDEC represented a £7 million investment through the national Additional Capacity Targeted Investment Fund (ACTIF), which aimed to increase urgent emergency care capacity and same day emergency care capacity within departments and the associated benefits to patient flow.

The Managing Director, TRFT summarised the practical purpose of the SDEC, and explained that when a patient presented at an emergency department, health professionals often knew what the patient needed but struggled to deliver the care required within the available space. The SDEC provided the additional space needed to deliver care in one location, which reduced the need for costly and time-consuming admission which did not always deliver optimal patient experience. Ultimately, its purpose was to support Urgent and Emergency Care demand, improve timely access and patient outcomes.

The SDEC implementation had also offered the opportunity to unlock additional benefits which addressed issues elsewhere within the Trust such as pre-op assessment, sexual health and the fracture clinic.

The Managing Director, TRFT explained that the Trust had had to move at pace to secure the capital, considerations around workforce and clinical models were simultaneous workstreams. They explained that staff engagement was undertaken, patient engagement and public engagement which took place the day prior to the Health Select Commission meeting. They outlined some of the areas of discussion from the public engagement event including accessibility for people with neurodiverse needs and dementia, the toilet facilities and kitchen facilities etc.

The Managing Director, TRFT explained that the aim was for the SDEC to open in June 2025, whilst the overall project comprised of a number of phases. The Chief Operating Officer, TRFT distributed and described a site plan which saw movement of a number of services and clinics to different locations across the hospital site, with the planned moves intended to improve overall patient flow. The example of the relocated fracture clinic, which delivered co-location with the orthopaedic clinics and wards and provided a dedicated facility across inpatient, elective, non-elective and outpatient areas with dedicated x-ray facilities, was cited. Sexual Health was also cited as an area of growing demand where relocation offered the welcome opportunity for growth and expansion. The final example referred to was the pre-op assessment facility which was relocated adjacent to day surgery, optimising patient flow and the patient pathway. This was to be augmented by a dedicated drop-off area and reflected a tangible improvement for patients in terms of accessibility.

It was acknowledged that some disruption to services was expected whilst services were relocated, with some aspects of care already having moved to temporary location, however efforts were made to minimise the impact of any disruption and the benefits anticipated justified the level of disruption experienced for both staff and patients.

The Managing Director, TRFT explained that there was robust governance around the SDEC development, with progress updates reported regularly through the Trust's internal governance structures. They provided an overview of the proposed layout of the SDEC, linked this to existing capacity pressures experienced within the UECC which were particularly evident at times of volume attendance and explained the positive impact this delivered to patient flow.

They emphasised that the Trust was keen to work with the public to refine the remit of the SDEC and maximise its impact. This involved an element of engagement to ensure patients understood the offer within SDEC and that the UECC wasn't always the first port of call.

The Chief Operating Officer, TRFT added that the Trust were working closely with community colleagues and teams, and the ambulance service to ensure appropriate referral pathways existed which aimed to minimise unnecessary attendances.

The Chair thanked the officers for the presentation and invited questions and comments.

Councillor Bennett Sylvester wanted to understand whether the relocation of the Sexual Health clinic would impact on the Diabetes centre.

It was confirmed that it did not and there would be no change.

Councillor Bennett-Sylvester also queried whether the SDEC development was expected to relieve pressure on the Acute Medical Unit (AMU) and Acute Surgical Unit (ASU) which anecdotal evidence reflected did not deliver a positive patient experience and represented a 'bottleneck' in terms of patient flow and treatment.

The Managing Director, TRFT commented that in many cases, people believed that Accident and Emergency, or UECC in TRFT's case was the greatest pinch point, but AMU and ASU were also highly pressurised as the reception points for all in-patients. They described those areas as rewarding but challenging places to work.

They added that the principle of the SDEC was that it was for people that didn't need full admission as an alternative route, and explained that people often thought of physicians working in emergency care as one big team but there was a distinct difference between emergency care physicians and acute care physicians. In that sense, the SDEC represented a space where those clinicians and physicians could work side by side on agreed pathways and meant that patients could be assessed in that area rather than taken into the AMU.

Councillor Clarke commented that a common concern raised through Councillors surgeries was hospital parking. Increased attendance, and increased patient flow inevitably meant an increased number of vehicles, and as such they queried whether the Trust were investing in the car parking or park and ride schemes.

The Managing Director, TRFT acknowledged that hospital parking was challenging in any setting. The Trust had implemented automatic number plate recognition to parking facilities to simplify the process, and alongside that had increased the number of parking spaces, but accepted that there was more work to do and no easy solutions. To their knowledge, park and ride facilities had not been considered specifically, but parking more generally was very much on the agenda.

Councillor Havard wanted to understand whether the SDEC would make it easier for patients with reoccurring issues to access ongoing treatment rather than having to go through complicated assessment processes each time. They cited a personal example to illustrate the barriers presented to accessing ongoing care.

The Managing Director, TRFT advised that as a general principle, the NHS was good at providing emergency care, but aftercare was the area where it struggled as a service. The purpose of the SDEC was to offer a clear pathway, predominantly concerned with medical issues such as deep vein thrombosis (DVT) to begin with, extended over time to address precisely those issues; direct access to the service at point of delivery rather than repeated triage and assessment.

Councillor Havard queried whether GPs were appraised of hospital care a patient had received so that they were mindful of this in the event that patients needed additional support in the period of time shortly after receiving treatment at hospital.

The Managing Director, TRFT confirmed that GPs were always advised of the hospital's interactions with patients, but acknowledged that through digital communication channels there were sometimes issues.

The Assistant Director of Transformation, South Yorkshire ICB added that there was a significant piece of work underway to make information sharing and communication more effective and patient centred. This work recognised differing approaches across different pathways and aimed to deliver a greater degree of consistency.

Councillor Thorp commented on the terminology used and the confusion changes to terminology can cause for patients and others accessing services and queried whether there would be sufficient clear signage to provide appropriate directions around the hospital estate.

The Managing Director, TRFT expressed the view that consistent messaging was key, but the Trust was working with staff and volunteers to ensure that patients and visitors were supported on site.

The Chief Operating Officer, TRFT added that the Trust were also exploring doing something different with signage and potentially upgrading to digital signage which was easier to update.

Councillor Thorp noted the SDEC's clear intent to deliver improvements in terms of patient flow and outcomes, but queried how TRFT proposed to measure success.

The Managing Director, TRFT confirmed that the level of funding secured necessitated comprehensive monitoring and evaluation throughout. The premise was a different approach to delivering services in the face of increased demand and stagnant budgets, with the expectation that services operated more efficiently and in less overtly pressurised environments. In order to demonstrated that, the Trust were expected to implement checks and balances around take-up and outcomes, patient experience and staff satisfaction.

The Chief Operating Officer, TRFT added that the Trust had to be clear when they submitted the funding bid what improvements would be made across a number of metrics, with focus on the 4-hour emergency care standard. The SDEC bid was based on an out of hours fracture clinic pilot which garnered positive results. The SDEC bid was modelled on those principles.

Councillor Thorp queried the relatively small waiting area detailed on the SDEC plans and that whilst there was a proposed dedicated drop off zone

for the pre-op assessment centre relocated to the rear of the hospital estate, no indication was given that the needs of those arriving on public transport had been considered.

The Managing Director, TRFT reflected that testing out the proposals and the potential shortcomings was the purpose of the engagement activities that were undertaken, and added that TRFT were working through identified issues and concerns, such as the one highlighted by Councillor Thorp, to develop solutions.

The Chief Operating Officer, TRFT expressed the view that Councillor Thorp had raised a valid point which required further exploration. With respect to the waiting area the Trust had modelled the numbers of patients coming through against waiting times and factored in the expectation that patients would be seen more quickly and would not accumulate in the waiting area. Some patients were expected to stream into existing the existing UECC waiting area or Paediatric waiting area. The overarching intent was to have different waiting areas for different categories of patients based on evidence that reflected that helped patients understand their place within and reduced friction around differing waiting periods for different types of care or clinicians and physicians.

The Managing Director, TRFT noted that it was amazing that the team had worked so quickly to put the bid together, but emphasised that the proposals shared in the agenda pack were the best first attempt and there was the opportunity to be flexible with the space based on feedback received.

The Chair queried the reference made to making better use of existing resources. They wanted to know whether that meant there were no additional staff resources to support the SDEC, and if so whether that would adversely impact other hospital services.

The Chief Operating Officer, TRFT explained that all of the services that were being brought together under the SDEC umbrella were functional elsewhere within the hospital and the intention was to create space and capacity through co-location, collaboration and efficient pathways. Significant investment in staffing within the service areas that comprised the SDEC had already been made, such as the increased UECC workforce in terms of Doctors, Clinical Fellows, Nursing and Reception staff. Further recruitment was planned as needed.

Councillor Yasseen applauded the effort that went into securing the SDEC investment capital. They commented that it would have been helpful if the information provided in the agenda pack had provided some basic data concerning the drivers for the SDEC development such as the increased levels of attendance at the UECC, perhaps illustrating Rotherham's comparative position to other Accident and Emergency environments to allow the Commission to consider the impact over time.

The Managing Director, TRFT advised that the drivers of emergency care attendance were an extremely complex area, and one which had dominated conversations within and beyond the Trust. Increased attendance was the national trend within Accident and Emergency Departments and Rotherham was no exception to this. Some drivers were due to epidemiology, population health, co-morbidities and health inequalities, the latter of which were perhaps felt more acutely in Rotherham than in other areas. It was also noted that there was increased incidence of working age patients due to the perception that hospitals were a faster route to accessing care than primary care services.

The Chief Operating Officer, TRFT added that the Trust were engaged in collaborative work with Healthwatch Rotherham around understanding attendance behaviours. Growth was seen in both walk-in and ambulance attendance, and it was felt important to understand the finer detail. It was suggested that it may be appropriate to share those findings with the Health Select Commission once that work was complete.

Councillor Yasseen echoed Councillor Clarke's comments relating to parking at the hospital, and added that they didn't feel that the Trust always understood its role as part of a wider residential community, with a significant proportion of the impact of increased attendance around access and parking being borne by the hospital's residential neighbours, where permit boundaries were imposed sequentially when parking concerns were displaced from one location to another. They wanted to know how the Trust intended to respond to that element of their community responsibility.

The Managing Director, TRFT explained that the Trust understood the concerns around parking and accepted that it was a big issue and one that they were happy to work to resolve.

Councillor Bennett-Sylvester commented that, relevant to discussions around car parking, having attended the Badsley Moore Lane site recently, they were aware of a number of vacant or disused units and queried whether the possibility of relocating certain services there to alleviate pressures on the main hospital site had been considered.

The Managing Director, TRFT confirmed that this was discussed and outlined a Barnsley project that had successfully relocated a community diagnostics centre which reduced visits to the main hospital site by approximately 60,000 annually. They agreed that there was scope to consider alternate solutions to service accessibility and conversations were being taken forward regarding the overall estates strategy, particularly with respect to community delivery.

The Chief Operating Officer, TRFT added that the Trust had already moved quite a few services into the breathing space facility and accepted the benefits around parking and accessibility. The Trust were considering

further services that could be offered from that site, mainly diagnostic services, and were considering further funding bids to extend services at that location.

The Chair wanted to understand how the SDEC development aligned with the findings and recommendations in the Darzi report and whether investment in hospital-based delivery of NHS serviced best served the needs of Rotherham residents in the long term.

The Managing Director, TRFT confirmed that Same Day Emergency Care featured as an example within the Darzi report and in terms of improved outcomes, responsiveness to the population need, improved productivity and improved accessibility, the proposed SDEC was a great fit but acknowledged the targeted shift for the NHS as a whole from hospital into community services. They reflected that the response from the Commission in relation to the SDEC in terms of both the support and challenge was helpful, and clarified the emphasis the Trust had placed on accessibility and which had justified its location at the hospital in Rotherham's case due to service interdependencies and targeted pathways. The intention was that SDEC would augment facilities like the transfer of care hub, which was a multi-team co-ordination centre for Rotherham, comprised of social care, community care, primary care, and the ambulance service, enabling them to direct patients straight into SDEC pathways, avoiding the UECC.

They also explained that alongside the SDEC development, work was underway on a community services review in conjunction with partners which considered primary care, social care, mental health and voluntary sector service modelling and configuration, which they felt reflected that work in progress was not solely hospital centric.

The Assistant Director of Transformation, South Yorkshire ICB added that, linked to Councillor Bennett-Sylvester's previous question, considerations around what services should rather than could be delivered in what setting were important and necessitated a strategic approach which included all place partners. They acknowledged that whilst there was an opportunistic element to the SDEC funding bid, there was real commitment to that collaborative strategic direction setting to best serve Rotherham people.

The Chair queried how public engagement event which took place on 26 March 2025 was publicised, whether it was well attended and whether there were any clear emerging themes from feedback received.

The Chief Operating Officer, TRFT advised that early feedback was positive and provided opportunities to take further discussions forward. The Trust's Patient Engagement Team were involved in promoting the event, but more specific details were not known.

The Chair asked whether any other engagement activities were undertaken or planned with stakeholders.

The Chief Operating Officer, TRFT confirmed that the Trust had engaged with all staff groups involved in the SDEC development and involved them in developing the plans and defining service requirements. Staff and Patient governors were consulted as were unions.

The Chair thanked officers for their responses to comments and questions.

**Resolved:-**

That the Health Select Commission:

1. Noted that the investment secured by TRFT to address patient flow and capacity challenges through the development of the SDEC (Same Day Emergency Care) and the UECC (Urgent and Emergency Care Centre) expansion at Rotherham Hospital was welcomed.

2. Requested that members be provided with an overview of feedback received via the public event that took place on 26th March 2025, and any other consultation activities undertaken relating to the SDEC development/UECC expansion.

3. Requested a further update be provided regarding the SDEC development/UECC expansion at an appropriate stage during the next municipal year, to give members the opportunity to consider its impact for Rotherham residents post implementation. The appropriate update method would be confirmed at a later stage.

4. Requested that TRFT provide an update regarding the collaborative work with Healthwatch Rotherham regarding attendance behaviours. The appropriate update method would be confirmed at a later stage.

## 55. 18 WEEK WAITING TIME CHALLENGE

The Chair invited Bob Kirton, Managing Director, TRFT and Sally Kilgariff, Chief Operating Officer, TRFT to introduce the presentation.

The Managing Director, TRFT explained the purpose of the presentation was to illustrate planned care waiting times. They wanted to emphasise that the Trust recognised the personal impact on individuals on waiting lists, and acknowledged that whilst the presentation contained a lot of numbers, they remained focussed on recognising that each number represented an impacted individual, and that each individual impact was felt more widely through family members, colleagues, employers and so on.

They described the data provided within the presentation as an overview of the operational context of referrals into TRFT, but added that every aspect of planned services delivered were measured.

The Managing Director, TRFT felt that it was important for Councillors to note that there had been significant increases in waiting lists post pandemic, which was a national issue. In addition, the impact of industrial action in 2024 had impeded ability to reduce waiting lists.

Their intention was to provide an overview of the current waiting list, an overview of current performance in relation to the referral to treatment standard (RTT), which was the national 18 week standard, but also the diagnostics six week standard. The national ask of the NHS at the time of the meeting was not to have anyone waiting over 65 weeks for treatment, and an updated on TRFT's position in relation to that would be outlined, alongside details of initiatives planned to improve quality and delivery of patient care.

With respect to elective and diagnostic referrals, the key point to note was the volume of referrals to the Trust, which for 2025 was approximately 9 ,000 a month in the year to date. That was higher than 2024 and significantly higher than prior years. The same level of increase was seen in diagnostic referrals as well, all of which exerted pressure on the service.

From an improvement initiative perspective in respect of referrals, the teams were digitally working clinical triage at the point of referral. Where specialist advice could be provided this was done, and the Trust linked up with primary care and others to provide that advice and support. This was intended to ensure that TRFT was also optimising outpatient clinical clinic capacity. A comprehensive review was also underway to ensure processes aligned with the Trust access policy, and national policy to ensure that high quality care was delivered to the patients who needed it most. Things were increasingly evening out since the pandemic, but during that period there was the need to prioritise patients based on clinical need.

There was a range of public health initiatives that were integrated to improve demand management and patient outcomes. GPs held frustrations with certain pathways such as orthopaedics, where ongoing opiate prescriptions were required for pain management whilst awaiting treatment. The 'Waiting Well' initiative was one of the mechanisms intended to address those frustrations, which considered the offer to those awaiting treatment.

In terms of the size of the wait list, Councillors would note from the presentation that this had reached a peak in excess of 33,000 people waiting, which was notably higher than pre Covid waiting list sizes. This was borne of a rising amount of elective care in conjunction with some of

the socioeconomic challenges experienced across Rotherham which impacted TRFT's ability to manage demand and there was also complexity of patient need which had driven delays in delivering treatment.

The Managing Director, TRFT described the overwhelming sense, from discussion with frontline staff, of financial challenges compounded by demand challenges in both urgent and planned care pathways but that the experiences of practitioners in other discipline and sectors such as social care, mental health and the voluntary and community sector were all identifying the same themes; people needed more. They felt that in the face of the pressures described, a 'one size fits all' approach was no longer feasible and the Trust needed to be more flexible around what they did and how they did it.

This was the driver for implementing improvement initiatives which provided additional capacity for outpatients, diagnostics and elective surgeries in order to reduce the waiting list, and as the data in the pack reflected, the Trust had had some success with that. There was also an ongoing external review that considered waiting list data quality, to improve accuracy and progress pathways. New care models including 'Super Clinics' and 'High Impact Theatre Lists' were implemented to maximise capacity, and collaborative work had been undertaken in conjunction with others to address Rotherham's public health challenges aimed to optimise health prior to treatment.

In terms of performance against the standard, which was the main way that TRFT were measured, this had improved from 60% in April 2024 to just below 64% in February 2025. Whilst the trust remained focussed on the offer to Rotherham patients, comparatively that positioned TRFT 30th nationally which was top quartile.

At the time of the meeting, the national ask was to have no patients waiting over 65 weeks. TRFT had worked diligently in 2024 to reduce the number of patients waiting over 65 weeks, and had consistently maintained this in low single figures since Autumn 2024. Those low single figure cases were driven by individual personal reasons for delaying treatment, and not by the inability to deliver on TRFT's part.

Whilst it was recognised that the Trust was having a lot of success around reductions on medical pathways, it was acknowledged that surgical was a pinch-point, particularly with respect to theatre time and access to anaesthetists. As such, orthopaedics, gynaecology and oral maxillofacial surgery remained the biggest challenges.

The Managing Director, TRFT explained there were two orthopaedic patients who had been waiting more than 65 weeks, however, the expectation was that there would not be anyone in that category by the end of March 2025.

In those greatest remaining areas of challenge, the Trust had undertaken performance meetings with the clinical and operational teams and confirmed that there were effective plans in place to address issues, which noted that continual improvement was evident. The Managing Director, TRFT commented that whilst the position in those areas was not where they wanted to be, the situation was moving forward positively.

In terms of diagnostics, the Managing Director, TRFT remarked that what Rotherham had achieved was remarkable, being ranked second nationally against the 6-week diagnostic standard. In practice, this meant that less than 1% of people were waiting more than six weeks for diagnostics including imaging, cardiology, endoscopy, audiology and urodynamics amongst others. As such, this was consistent delivery across a range of services, which reflected the wider organisational mindset achieved and the pervasive desire to get it right for the public. It was noted that positive performance in this area benefitted physicians and surgeons, and enable them to develop appropriate courses of treatment, whereas poor performance in this area could adversely impact that planning and patient outcomes in turn.

The Chief Operating Officer, TRFT discussed some of the improvement initiatives implemented to address the waiting time challenge. They explained that there was an elective delivery programme which focussed on pathways in the four specialities that represented particular challenges around wait times, trauma and orthopaedics, ear, nose and throat, oral and maxillofacial surgery, and gynaecology, alongside theatre and anaesthetics and endoscopy.

This work involved optimising administrative processes to deliver efficient and effective scheduling, maximise clinic utilisation and reduce follow-up in line with the nationally advocated patient initiated follow up (PIFU) initiative and maximise utilisation of community pathways. A significant aspect of the delivery programme concerned theatre and anaesthetics. This sought to maximise utilisation of theatre capacity, ensure effective pre-assessment and involved the introduction of a locally generated new theatre scheduling tool and a review of theatre workforce needs to ensure staffing capacity aligned with operational requirements. The third element of the programme was endoscopy, which also aimed to deliver efficiency whilst maintaining quality of care, focussing on productivity and resource utilisation, which included reconfiguration work involving estates and infrastructure to improve patient flow.

The Chief Operating Officer, TRFT described the Further Faster 20 transformation programme implemented in 20 Trust nationally in areas where there were high waiting lists coupled with economic inactivity in local populations, which Rotherham was part of. Through that programme the Trust were able to access national support through the ‘Getting It Right First Time’ (GIRFT), via which national clinical experts worked with TRFT in support of that elective delivery programme,

positively augmenting work already undertaken and facilitating change at pace.

They added that additional activity had also been undertaken to address waiting times. This had involved running additional clinics through a mixture of insourcing internally and outsourcing to private sector organisations.

The Managing Director, TRFT cautioned that whilst there was dedication to improvement and a commitment to innovation and partnership working, they held reservations regarding the funding settlement for the coming year and what it was feasible to deliver within the constraints that applied. They confirmed TRFT's desire was to work at faster pace than reflected nationally, and suggested that the data presented indicated the dedication to positive performance improvement within the organisation.

The Chair thanked the Managing Director, TRFT and the Chief Operating Officer, TRFT for the presentation and invited questions or comments.

Councillor Thorp wanted to address the increasing trend in respect of elective and diagnostic referrals and the reference to insourcing and outsourcing. Whilst outsourcing was perhaps understandable as a concept at face value, they wanted to understand what was meant by insourcing in practical terms, whether these initiatives increased outpatient clinic capacity and whether either or both approaches were financially sustainable in the longer terms and represented options which priorities patient safety and experience. Councillor Thorp cited personal experience of NHS care being outsourced which had caused difficulties when additional support from NHS services was subsequently required.

The Managing Director, TRFT advised that insourcing was bringing teams onto site to work outside of normal operating hours, or in the absence of appropriate medical cover. The Chief Operating Officer, TRFT added that both approaches enabled the effective use of resources to increase clinic capacity, using existing staff, estates and infrastructure so far as possible, but acknowledged that there was a balance to be struck with respect to staff health and wellbeing and that this represented a challenge.

In terms of patient experience and safety, the Trust was working closely with staff to ensure broad understanding of the different ways in which NHS services were delivered including insourced and outsourced care and treatment options, and recognised that this was a change for many. It was acknowledged that there may be misconceptions amongst some NHS staff that independent providers didn't do 'the full job' and culturally there remained work to do address that.

Councillor Havard referred to page 30 of the agenda pack around new models of care, the 'Super Clinics' and the 'High Impact Theatre Lists' being trialled. They wanted to know what these new care models were in practice, how they were expected to assist in reducing waiting list sizes

and if there were any risks associated with trialling and adopting those models in terms of patient safety?

The Chief Operating Officer, TRFT explained that there were different models in place at different parts of the pathway. One aspect was an increased offer of advice and guidance to GPs to avoid unnecessary clinic referrals which involved waits for affected patients, instead increasing GP led treatment programmes. Another aspect was around the PIFU initiative, utilising virtual and telephone follow up model as appropriate, with due regard given to clinical need applying standard operating procedures and criteria to ensure those patients that need to be seen in person receive the appropriate follow up.

Part of the learning adopted through the Further Faster 20 team's national evidence related to the 'Super Clinics' and High Intensity Theatre Lists'. This was where lots of the same procedure were undertaken, usually at the weekend, where additional support was brought in to facilitate delivery as this had proved successful in other areas. This was at an early stage of development within the Trust. The practical example of cataract procedures and how these types of approach could positively impact on waiting lists was provided.

Councillor Havard wanted to understand whether the outsourcing referred to included where patients were sent to other NHS hospitals for treatment.

The Managing Director, TRFT explained that whilst there were lots of services which could be delivered locally, certain services such as paediatric orthopaedics, revisions, spinal work etc. were only undertaken via the teaching hospitals or specialist children's hospitals. The outsourcing referred to typically related to independent providers for adults. The Trust did receive mutual aid, all of which is beneficial to the waiting list because it allows patients to be seen more quickly, alongside mutual aid between NHS sites for diagnostics or elective, however given TRFT's favourable position, they were more likely to be the provider of mutual aid than the recipient.

Councillor Clarke queried the integration of public health initiatives referred to on page 29 of the agenda pack. They specifically related that to the cancer pathway in terms of the initiative to ensure patients were fit for operations and cited personal experience of the fantastic facility at Attercliffe. They wanted to understand whether those types of service were to be delivered more locally given that some Rotherham residents may not have family members able to take them to facilities further afield and the nature or treatments and surgeries may make the use of public transport inappropriate or increase risks to patients.

The Chief Operating Officer, TRFT explained that the Trust worked in partnership with Yorkshire Cancer Alliance who had piloted fitness for treatment/surgery in parts of South Yorkshire which had seen the offer in Rotherham expanded. They outlined that the difficulty was whether that

could be extended to non-cancer pathways and delivered at scale, however they were aware that the Trust was running services at the Badsley Moore Lane site rehabilitation centre as part of the Active Together programme.

Councillor Clarke asked whether data was gathered relating to patients who had participated in that programme, and the level of success achieved.

The Chief Operating Officer, TRFT confirmed that data collection and analysis was part of the process, given that this was a pilot programme and therefore was closely monitored in terms of impact.

The Managing Director, TRFT added that there was more work to do in that area, but noted that since they had taken up the role at TRFT, they were pleasantly surprised by the amount of work underway in Rotherham. They had attended the Badsley Moore Road Breathing Space site and observes a large number of participants utilising the hydrotherapy pool, gyms and taking classes which was incredibly positive.

Councillor Tarmey reflected on the financial pressures NHS Trusts were subjected to across the country, and noted that some had implemented recruitment freezes or had taken the decision not to replace staff members on retirement. They queried whether TRFT were considering something similar and what impact that could have on waiting times if it were necessary.

The Managing Director, TRFT advised that there was significant external scrutiny around finance and financial controls which had resulted in enhanced control mechanisms with a predominant focus on reducing agency spend across different staff groups and delivering a permanent workforce capable of meeting delivery needs.

It was acknowledged that some bank and agency spending would remain, and it was clarified that vacancies in clinical areas were being filled. They advised that the Trusts approach was to consider how things could be done differently and more efficiently, such as the role of Advanced Clinical Practitioners within specific teams, improved collaborative and partnership working with any staff reductions drawn from non-clinical areas and governed by quality assessment processes.

Councillor Yasseen noted that the Trust's position with respect to the 6-week diagnostic standard was excellent and reflected the dedication of staff within those teams. They queried whether the learning from that success could be utilised in other areas where less progress had been made.

The Chief Operating Officer, TRFT commented that focussed support had played a critical role in that achievement, which had led to a strong grasp of what drove positive performance in relation to diagnostics at all levels

of delivery and ultimately reduced waiting times. They advised that the Trust were applying the same principles across other pathways, but in the case of diagnostics, that was an area where they could focus on a number of pathways intensely.

Over the last few months, with the support of the national team, focus had shifted to those specialties that represented challenges, with deep dives and intense focus on capacity and plans, using those same principles. Councillor Yasseen wanted to focus on 65 week waits, and commented that a year and four months was a substantial period of time. They acknowledged that there had been improvement in the Trust's position, but held concerns for patients who faced significant waits or extended economic inactivity through no fault of their own who were reliant on welfare and could be adversely affected by welfare reforms. They queried whether the Trust were considering those impacts when making clinical and scheduling decisions against those on waiting lists to reduce the overall taxpayer burden.

The Chief Operating Officer, TRFT referred to the intention behind the Further Faster 20 programme which was to look at areas within high waiting lists. Work had been done to analyse data against the working age population and affected specialities, although that specific data was not included in the presentation within the agenda pack. The theatre scheduling tool developed in conjunction with prioritisation of working age cases was to be trialled, and whilst early days, this was expected to address the concerns raised. They added that there was also a broader focus on prioritisation with respect to health inequalities, and that whilst the primary focus was reducing the overall waiting list, the Trust were layering on those additional factors in an appropriate manner.

The Managing Director, TRFT added that there were a number of national initiatives relating to health and work, and that South Yorkshire was one of the trailblazers looking at issues such as health and growth accelerators. They commented that whilst there were approximately 10 million people of working age considered economically inactive nationwide, Rotherham was in a strong position in terms of initiatives to address economic inactivity such as Skills Street. However, they acknowledged that it would be nice to arrive at a position where barriers to economic activity presented by the type or speed of health service required by an individual factored into decision making as this was based on clinical priority at present. They postulated that whilst the conversation was in relation to waiting lists in this particular case, arguably there was the need to become more sophisticated in relation to long-term conditions which required ongoing treatment and management also, such as mental health, musculoskeletal and respiratory/cardiological issues to deliver more responsive to the needs of the working age population, working in partnership with the Council, employers and other stakeholders.

Councillor Bennett-Sylvester queried the extent to which industrial action over the last 12 months and other exceptional circumstances such as

Covid had impacted upon the current waiting time position. They explained that they understood that Rotherham had not been significantly adversely affected by industrial action, but wanted to understand whether the Trust's comparative positive position had resulted in patients electing to receive care at Rotherham, and driven waiting list growth during that period.

The Chief Operating Officer, TRFT explained that the main impact of industrial action at TRFT was having to stand down some elective care work to support emergency care. Different trusts were affected in different ways but one of the challenges was understanding who was taking industrial action. The Trust tried to minimise that wherever possible, but it did see some impact. It was believed that patients did not transfer elsewhere, and remained on existing pathways. This was not something the Trust tracked and may not be possible to review retrospectively, but was certainly not something TRFT had seen or had any anecdotal evidence of.

Councillor Bennett-Sylvester referred to the referral to treatment standard set out on page 31 of the agenda pack. They were interested to know whether there was any temptation to chase easy fixes to drive waiting lists down, and sought reassurance that there was no data driven directive to pick off the 'low hanging fruit'.

The Managing Director, TRFT clarified that the Trust had taken the opposite approach. Nationally the focus had been on eradicating 78 week waits, then 65, then 52 and so on. At TRFT, focus on the 18-week standard was never lost through strict clinical prioritisation and robust governance practice.

The Chief Operating Officer, TRFT added that when trying to drive down waiting times, the Trust considered every service and every speciality in line with the approach the Managing Director outlined. Over the coming months the intention was to further reduce outpatient waits.

Councillor Havard suggested that it would be helpful if the data provided could be broken down further to identify the affected services and specialities, allowing the Commission to consider any areas they might want to review in more detail.

The Managing Director, TRFT advised that the Trust held sufficient data detail that hundreds of pages of data could have been presented to the commission, but it was felt best to focus on the key headlines, identifying key areas of concern in the commentary accompanying the graphs and data points. The key concerns were orthopaedics, gynaecology and oral and maxillofacial surgery where it was acknowledged there were a lot of challenges, but equally a lot of ongoing work with commissioners, place partners and rigorous governance processes ensuring that focus was maintained on driving forward improvements in those areas.

Councillor Havard had become aware of concerns around the funding allocation for Rotherham Hospice and wanted to understand from the Assistant Director of Transformation, South Yorkshire ICB whether any progress had been made in this area.

The Assistant Director of Transformation, South Yorkshire ICB advised that the ICB was in a very challenging financial position locally, with uncertainty around certain budget allocations. That said, there was an absolute commitment to ensure that partners knew funding arrangements and had the ability to ensure service continuity as soon as possible. The ICB were working really closely with hospice colleagues and they were confident that that position would be resolved as soon as possible.

Councillor Thorp echoed Councillor Havard's request for a more detailed breakdown of the data by service/speciality.

The Chief Operating Officer, TRFT advised that there had been discussions around the level of data to submit to the Commission, and it was acknowledged that on this occasion it may not have been pitched at quite the right level. Some of the data requested may have been included in the TRFT board public meeting pack, so may be accessible from there, but otherwise would need to be provided separately. The Trust's next target was to reduce the longest waits to 52 weeks, where almost all waits sat within 5 specialities; orthopaedics, gynaecology, oral and maxillofacial surgery, urology and general surgery and more detailed data on those areas could be shared with the Commission.

Councillor Bennett-Sylvester asked whether the impact of socio-economic factors would be considered within the external review of data quality, and able to influence and improve access to advice and guidance for patients already on a pathway.

The Chief Operating Officer, TRFT clarified that the external review was intended to eradicate duplicate entries, ensure waiting times were correctly reflected etc. However, there was work being conducted by the Public Health Consultant jointly appointed by the Trust and the Council in terms of understanding where there were differences from a health inequalities and deprived communities' perspective. This included reviewing waiting lists to ensure that patients weren't facing disproportionate waits, considering the drivers of non-attendance within certain populations and demographics and implementing initiatives to address any barriers identified. There was also early pilot work being conducted around the use of AI to identify patients at increased risk of failing to attend and provide reminders, or other appropriate means of support attendance.

The Chair remarked that whilst all Commission members would agree that the reduction in patients waiting over 65 weeks was encouraging, but wanted to understand whether there was a clear plan and a target

timescale for reducing this consistently over time to an agreed national standard or indeed an internal target, and if so what was that target and timescale and when did TRFT realistically expect to achieve that.

The Managing Director, TRFT advised that the national ask for this year was to have no one waiting over 65 weeks, so TRFT were already delivering on that. However, they wanted to do more and appreciated that the people of Rotherham would want more. They explained that the Trust was working with NHS England amongst others who were surprised that they were still discussing the Referral to Treatment 18 week standard, as many other Trusts were solely focussed on the 65 week ask. The next specific target for the Trust was to achieve no one waiting over 52 weeks, which was particularly relevant to the 5 specialities the Chief Operating Officer referred to. The longer-term goal was to work towards the national constitutional standard which was what people would expect and what the Trust wanted to deliver. The specific timescales associated with that were not yet known, due to reliance on ongoing work with commissioners relating to the 2025/2026 plan. There was no targeted trajectory agreed with the Trust Board aside from the general intent to continually reduce the waiting time, however once there was certainty around the financial plan, the Trust would be in a position to set out a more detailed response in terms of the targeted trajectory, ideally broken down by service as it was anticipated that this would vary by service. The performance seen in diagnostics was cited as the performance the Trust aspired to across the board.

The Chief Operating Officer, TRFT added that the national ask in terms of diagnostics was to deliver 5% of patients waiting no more than 6 weeks by March 2026, and as TRFT were already delivering under 1% they were significantly ahead of target on that. Within the year, TRFT had delivered a 3.5% improvement on the referral to treatment standard, against which the target was 65% or a 5% improvement, with the Trust already having achieved 63.

The Chair thanked the Managing Director and Chief Operating Officer for the presentation and their thorough and considered responses to members' questions.

**Resolved:-**

That the Health Select Commission:

1. Noted the exceptional performance in relation to the diagnostic 6 week standard, and requested that TRFT consider what had driven the level of success in order to replicate it reliably and consistently in other areas.

2. Requested an update on progress towards achieving the targeted waiting times at relevant intervals based on the achievement timeline

to be confirmed following certainty regarding the financial plan. The appropriate update method would be confirmed at a later stage.

3. Requested that data provided in future in respect of waiting times be broken down by service/speciality, so that Councillors can consider any potential areas of concern they may wish to explore further.

## 56. HEALTH SELECT COMMISSION WORK PROGRAMME - 2024/2025

**Resolved:-**

That the Health Select Commission:

1. Approved the work programme.

2. Agreed that the Governance Advisor was authorised to make any required changes to the work programme in consultation with the Chair/Vice Chair and report any such changes back to the next meeting.

## 57. SOUTH YORKSHIRE, DERBYSHIRE AND NOTTINGHAMSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Members were advised that the JHOSC meeting scheduled for 12 March 2025 was cancelled. The meeting dates for the next municipal year were to be confirmed. Relevant updates and copies of minutes would be shared following each meeting held.

## 58. URGENT BUSINESS

There was no urgent business to discuss. However, the Chair reminded members that Quality Accounts were expected imminently and requested that any members interested in reviewing and responding to Quality Accounts that had not already made themselves known to the Governance Advisor do so at the earliest opportunity to ensure their inclusion in meeting arrangements.