### Board of Directors

**Public AGENDA (held in public)**

**Date:** Tuesday 28 August 2018  
**Time:** 0830hrs – 1100hrs  
**Venue:** Boardroom, Executive Corridor, Level D, Rotherham Hospital

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<td>Strategy and Strategic Planning</td>
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<td>Review of Board Members’ Interests</td>
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<td>Date of next meeting: <em>Tuesday 28 August 2018</em></td>
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*To ensure smooth transaction of business, the Chairman will invite questions from the public at the end of the meeting only.*

*In accordance with §152(4) of the Health and Social Care Act, 2012, a copy of this agenda has been provided to Governors prior to the Board Meeting.*
MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON TUESDAY 31 JULY 2018 IN THE BOARDROOM, LEVEL D

Present:

Mr M Havenhand, Chairman
Mrs G Atmarow, Non-Executive Director
Mr J Barnes, Non-Executive Director
Mrs L Barnett, Chief Executive
Mr G Briggs, Chief Operating Officer
Mrs H Craven, Non-Executive Director
Mr M Edgell, Non-Executive Director
Ms L Hagger, Non-Executive Director
Dr D Hannah, Non-Executive Director
Mr B Mellor, Non-Executive Director
Mr S Sheppard, Director of Finance

Apologies:

Mrs C Clements, Director of Workforce
Mr C Holt, Director of Strategy and Transformation
Mr C Morley, Chief Nurse
Dr C Wareham, Medical Director

In attendance:

Mrs H Dobson, Deputy Chief Nurse (representing the Chief Nurse)
Dr G Lynch, Guardian of Safe Working Hours (minute 282/18 only)
Ms A Milanec, Director of Corporate Affairs / Company Secretary
Mr R Slater, Associate Medical Director (representing the Medical Director)
Miss D Stewart, Corporate Governance Manager (minutes)

Observers:

Governors x1
Members of the Public x0
Colleagues x1

266/18 CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE

Mr Havenhand welcomed those present to the meeting with any apologies having been received and noted.

QUALITY AND SAFETY

267/18 PATIENT STORY

The Board of Directors received the patient story presented by the Deputy Chief Nurse.

The story detailed the experience of a patient with breast cancer and her resulting endeavours to improve the dignity of patients who were required to have surgical drains.
Following the manufacture of a textile bag to conceal her own surgical drain, this had developed into a thriving community of supporters making similar bags. The patient wished to continue to support the Trust by developing other comfort items to patients.

**PROCEDURAL ITEMS**

**268/18 DECLARATIONS OF CONFLICTS OF INTERESTS**

No conflicts of interest were declared. Colleagues were asked that should any conflicts become apparent during discussions, that they be declared at that time.

**269/18 MINUTES OF THE PREVIOUS MEETING**

The minutes of the previous meeting held on 26 June 2018 were agreed as a correct record subject to the following addition to minute 238/18a (Quality and Clinical Report).

“The Board, having discussed the matter in some detail, noted the position relating to ‘Looked After Children’”.

**270/18 MATTERS ARISING FROM THE PREVIOUS MEETING**

i. **Chairman’s Welcome and Apologies for Absence (minute 230/18 refers)**

Mr Havenhand reported that a significant number of colleagues, supported by their Trade Union representatives, had attended the 11 July 2018 Council of Governors meeting. A number of statements had been made relating to the Trust’s deliberations of a Wholly Owned Subsidiary and a petition had been presented which had been formally passed to Trust officers.

ii. **Quality and Clinical Report (minute 238/18a refers)**

Mr Edgell confirmed the July Quality Assurance Committee (QAC) had considered the position with regard to Looked After Children. The Committee had been reasonably assured regarding the focus being given through the tripartite discussions. However, further actions would be required to see the required continued improvements in order to achieve the target.

**271/18 ACTION LOG**

The Board of Directors considered and discussed the Board action log, with a number agreed to be formally closed or those which would continue to be monitored.
STRATEGY AND STRATEGIC PLANNING

REPORT FROM THE CHAIRMAN

The Board of Directors received the report from the Chairman.

Mr Havenhand reported that the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) would be moving to the next stage of its development in October 2018, with appointments having been made to the senior leadership team. Mrs Barnett was requested to ensure that the details were circulated to the Board.  

**ACTION – Chief Executive**

Additionally, the SYB ICS had received a presentation outlining the funding allocated to South Yorkshire and Humber for the successful Local Health and Care Record Bid. Mr Sheppard agreed to circulate details to the Board.  

**ACTION – Director of Finance**

As part of the 70th NHS birthday celebrations both the Chairman and Chief Executive had accompanied a number of colleagues to events held at Westminster Abbey and York Minster.

Mr Havenhand also mentioned the Board’s development programme which was being externally facilitated.

The Board of Directors noted the Chairman’s report.

REPORT FROM THE CHIEF EXECUTIVE

The Board of Directors received the report from the Chief Executive which outlined key strategic/operational issues and stakeholder engagement.

Mrs Barnett reported that in the main delivery of the 2018/19 Operational Plan, in terms of the quarter one milestones, was on track as summarised within the report. For the milestones not on track, each had specific actions to address the position. Only one milestone in quarter 1 was red rated and this related to completion of personal development reviews. Mrs Barnett confirmed that additional measures were in place to further support clinical colleagues to have their PDR, which were behind plan as a result of workforce pressures.

Following feedback at the meeting from Board colleagues, Mrs Barnett acknowledged that the table which summarised the quarter one objectives may not be consistent in format with information provided to other Committees, and that there was a requirement to revise the reporting format to ensure full alignment. Additionally, there may be opportunities to report a wider view rather than being a snapshot in time.  

**ACTION – Chief Executive**

With regard to the review of clinical services, Mrs Barnett confirmed that the work was being led by the Chief Operating Officer, and that she was confident that it would be completed within the timeframe. Meetings were already scheduled, with the format and structure having been agreed.
Engagement with the Clinical Directors and senior colleagues would be fundamental in development of the 2019/20 plans, she added.

Mr Havenhand set out his expectations that by the end of September 2018, the review would be complete for all major services in addition to the five services already undertaken in relation to the Hospital Services Review. Mrs Barnett confirmed that this would be completed as planned.

In terms of collaboration, work continued with partners across the South Yorkshire and Bassetlaw ICS and the Rotherham Place.

It was pleasing to report that colleagues had been recipients of a number of national awards. Five apprentices had been recognised at the World Skills regional heats and the Rotherham Advertiser Apprenticeship Awards. Additionally, three community nurses had been awarded the prestigious title of Queen’s Nurse by the community nursing charity, the Queen’s Nursing Institute. All of the awards were a testament to colleagues for their achievements, and the differences they make for patients.

The Board of Directors noted the report from the Chief Executive.

274/18 BUSINESS PLANNING CYCLE

The Board of Directors received the report from the Chief Executive in relation to the annual planning process.

Mrs Barnett indicated that the report aimed to build upon previous discussions by the Board to revise the approach and timetable for the annual planning cycle. The intention was that the respective plans would have been developed by December 2018, and thereafter only subject to refinement as a consequence of emerging regulatory guidance and any impact of performance in quarter 4.

The report outlined a number of milestones and reporting timelines to the Board and its Committees. It also provided an update on the strategy refresh, business planning (5 years), and the operational plan and budget.

With regard to sections 2.4 and 3.6 of the report which detailed the key reporting milestones to the Board and its assurance Committees, Mr Havenhand confirmed that the August deadline for provision of the revised Trust strategy would now move to September, and that the Board planner should be amended to reflect this.

ACTION – Company Secretary

Mr Sheppard confirmed that with regard to the 2019/20 Operational Plan, which would be year one of the 5 Year Plan, the level of the challenge would be known, although not in detail, by September 2018. The intention would be that the draft Operational Plan, including the financial elements, be submitted to the December 2018 Board of Directors.
He continued to state, that further discussions would thereafter be held by the Board during January and February 2019. During that period there would also be engagement with the Divisions to include approval of their budgets. The aim being that from 1 April 2019 the organisation would already be fully aware of the requirements.

Mrs Craven added that the matter had been considered by the Finance and Performance Committee (FPC) who had indicated that they would prefer final sign off of the Operational Plan and budgets by February 2019. Mrs Barnett confirmed that she was assured that the final draft plans would be in place as agreed and the final documented March 2019 deadlines would be achieved, adding that the Executives were committed to the task.

Mr Havenhand stated that further clarification was required about how the 5 Year Plan was factored into the business planning cycle.

The Board of Directors noted the Business Planning Timescales report, with further detailed discussions to take place at future Board Seminars.

OPERATIONAL PERFORMANCE

275/18 INTEGRATED PERFORMANCE REPORT

The Board of Directors received and noted the monthly Integrated Performance Report (IPR) introduced by the Chief Executive.

Mrs Barnett reported that the top achievements in month had been the 18 week RTT (referral to treatment time) incomplete, with the Trust’s performance in May having been confirmed as being the 6th best nationally. June was anticipated to provide a similar ranking. Similarly, performance against diagnostic waiting times had seen no patients waiting more than six weeks for a diagnostic test.

The most improved areas had been delayed transfers of care which had seen a reduction from 6.8% in the same month last year to 1.8%, with Rotherham being the most improved provider nationally. Cancelled Operations on the day, which had previously been discussed by the Board, had significantly improved and now stood at 0.7% in June which was better than the national average.

The most deteriorated areas had been the potential under reporting of incidents with NHSI data suggesting that the trust had reported fewer than would have been expected. Further analysis of the data suggested that any under reporting was in the ‘no harm’ and ‘low harm’ categories. The second most deteriorated area had been the e-referral slot issue rate (ASI) which now stood at 45.3% with the Trust being in the bottom quartile for acute providers. Mrs Barnett confirmed that actions were being taken to improve performance in these key areas.

Areas of key concern remained Looked After Children receiving initial health assessments within 20 days. Although the position was improving, it remained of concern. The second area related to the number of patients
leaving A&E without being seen. Both these matters continued to receive focussed attention.

The Board of Directors noted the Integrated Performance Report, with detailed information on a number of matters contained within subsequent reports.

275/18(a) QUALITY & CLINICAL REPORT

The Board of Directors received the Quality and Clinical Report presented by the Deputy Chief Nurse.

Mrs Dobson confirmed that the Trust had submitted the information relating to the Provider Information Request from the CQC. Since the last Board meeting, an unannounced CQC inspection had also taken place on 17th July. The focus of the visit had been the paediatric pathway through the Urgent and Emergency Care Centre to the ward and Non-invasive ventilation (NIV).

Preliminary feedback had been provided at the end of the inspection, following which the Trust had implemented a number of actions. Subsequent to the visit the QCQ had requested further information and would be reviewing this before they issued their final report.

It was highlighted by Mrs Craven that one of the risks on the later Risk Register report, was that there remained non-compliance with CQC Regulation 18 ‘must do’ action. This risk had been scored 16 (extreme risk) and related to the previous inspection in 2015. Mrs Barnett agreed to discuss this with the Chief Nurse, and request that he provide assurance to the Board that actions were being progressed to comply with these requirements.

**ACTION – Chief Nurse**

As the Board had previously expressed concern regarding provision of the dementia service, Mrs Dobson informed the Board that the Frailty Service was to be expanded. This would result in the duties previously undertaken by the Dementia Clinical Nurse Specialist being incorporated in the roles of five colleagues, thereby providing a more resilient model of care.

With regard to nurse staffing levels, Mrs Atmarow sought clarity on the nurse vacancy numbers as there appeared to be disparity between the figures quoted to the Board and those to the Strategic Workforce Committee (SWC). Mrs Dobson confirmed that the position; when including the anticipated outcome of recruitment plans, the vacancy was circa 75, which were predominantly in Medicine. It was highlighted that there was the potential to share the successful recruitment practices between the Divisions.

Appended to the report was the Gosport Independent Panel Report which had been discussed by QAC. The report highlighted the Trust’s ongoing work to learn from this investigation.

In light of the Gosport Report and the Supreme Court ruling regarding legal permission no longer being required to withdraw treatment from patients in permanent vegetative state, Ms Hagger raised the importance of establishing
a Clinical Ethics Committee. Whilst the inaugural meeting had been cancelled, Mrs Barnett confirmed that there was a commitment, and support from clinicians, for its establishment.

**ACTION – Medical Director**

Questions were asked whether learning from both complaints and Serious Incidents (SIs) was undertaken, and sought assurance, as this had not been evident from reviewed complaint files: the Non-Executive Directors regularly review a sample of complaints’ files as part the assurance of the complaints’ process. The Board was informed by Mrs Dobson, that that the Trust did take actions to learn from complaints which was a fundamental aspect of the approach and that the files did not include all the Trust information pertaining to subsequent dissemination of learning, and that separate processes were in place. Mr Edgell confirmed this position in his capacity as Chair of QAC.

Mr Edgell confirmed that QAC monitored the position for both SIs and complaints, with the Committee receiving a report which triangulated learning from the divisional governance meetings. However, the potential weakness remained that whilst learning was disseminated across teams and the wider Trust, it was important that over time the required actions continued to be in place. Mrs Dobson sought to assure the Board that regular auditing of action plans sought to mitigate against such matters

It was suggested by Mr Barnes that in order to provide assurance to the Board that the Executive Directors ensure that comprehensive procedures were in place in relation to complaints, particularly dissemination of learning. It was suggested that the Internal Auditors could review processes in place if required.

Mr Havenhand indicated that it was important for learning to result from complaints and SIs and for QAC to continue to monitor the position.

The Board of Directors noted the Quality and Clinical Report.

**275/18(b) OPERATIONAL PERFORMANCE REPORT**

The Board of Directors received and noted the Operational Performance Report, which was presented by the Chief Operating Officer.

Mr Briggs outlined the position with regard to the four-hour emergency access target. Whilst the position continued to improve, with June 2018 standing at 92.1% and quarter one at 88.5%, the position at times remained challenging.

July performance had seen the impact of the adverse hot weather conditions and availability of junior doctors, with the rota falling from 14 to 7 being on duty. It was anticipated that the staffing position would improve to 13, with the new intake of junior doctors on 1 August. However, there was likely to be some challenges during the first few weeks, with commitment to ensure an effective balance between effective induction and service needs.
Recent overseas recruitment would provide further support to the emergency department and medical specialities. The fourteen doctors were expected to join the organisation within the next two months and were currently awaiting GMC registration. Once inducted they were expected to join the rotas in December 2018.

Mr Briggs reported that there had been an increase in delayed transfers of care. In the main this had been due to challenges faced by Social Services, on which the Trust had not been sighted. A meeting had been held with all teams, including the Local Authority, to ensure that the position improved.

It was important that the system remained resilient all year round and that there were appropriate channels of communication and escalation to avoid service disruptions. Mrs Barnett indicated that she would ensure effective oversight and monitoring through the A&E Delivery Board.

**ACTION – Chief Executive**

The un-validated 62-day cancer position for May stood at 83.3%, which although above the planned recovery trajectory was below the national 85% compliance target.

Whilst the cancer recovery actions continued to support improvement, Mrs Craven voiced her concerns regarding the robustness of services, such as breast cancer, provided by either one or two clinicians.

Mrs Barnett confirmed that the Executives were aware of the challenges in these specialities and that the Divisions were proactively working to improve resilience, with measures included as part of the review of clinical services.

**ACTION – Chief Operating Officer**

The cancelled operations position continued to recover following implementation of the improvement actions, with cancellations now only resulting from clinical need or colleague sickness.

As indicated in the IPR, the second most deteriorated area had been e-referral slot issue rate (ASI). Mr Briggs confirmed that a task and finish group had been established to review the position and recovery was anticipated over the next six months.

The Board of Directors noted the Operational Report.

**275/18(c) WORKFORCE REPORT**

The Board of Directors received the Workforce Report presented by the Director of Finance in the absence of the Director of Workforce.

Mr Sheppard highlighted the continued improvements being seen with regard to sickness absence rates. Rolling 12-month performance was 4.10%; representing an improvement of 0.40% compared with June 2017. Additionally, the Trust had seen the best improvement rates across the country in June 2018.
With regard to personal development reviews (PDRs) overall compliance stood at 53.55% with a target of 90% by the end of September. The specific milestones in relation to budget holders and all Band 7s had been discussed at the performance meetings, with clinical specialities sighting staffing and activity levels as the reasons for non-compliance.

Ms Milanec clarified that the campaign to ensure 95% compliance for Information Governance Mandatory and Statutory Training by 31 March 2019 would commence in earnest during quarter three and contrary to the report it had not been agreed that the deadline to achieve the target would be brought forward to 31 December 2018.

The Board of Directors noted the Workforce Report.

275/18(d) **FINANCE REPORT**

The Board of Directors received and noted the month three Finance Report presented by the Director of Finance.

Mr Sheppard reported that the overall deficit in June had been £2,033k which was £4k favourable to the planned deficit. With a year to date favourable position of £152k against the £6,517k deficit plan.

The 2018/19 cost improvement programme of £9.7m, had seen positive performance in June and was favourable to plan by £137K and year to date was £225k above plan. Risk adjusted schemes to the value of £9.1m had been identified, with the total schemes now being in excess of £10.4m.

Expenditure against the £5,8000K capital programme was underspent in June by £310k. However, there remained a commitment that it would be fully utilised.

The cash balance had been £1.44m compared to the planned £1.35m, which was an £0.09m favourable variance.

With regard to the pay awards, the Board was informed that whilst there remained some elements of the settlement to be negotiated nationally, Trust colleagues had received their pay award in July with the arrears to be included in the August payroll. Funding from the Department of Health and Social Care had, and would continue to be, provided to the Trust to facilitate these payments.

In response to Mr Edgell questioning the necessity for a Trust agency metric and the NHISI agency ceiling metric, Mr Sheppard confirmed that the first had been required to support the budgets agreed with the Divisions. Mrs Barnett indicated that the approach had been discussed with the regulator and that the budgeted position did not negate the need for the Trust to seek to achieve the lower metric. The underlying issue remained to minimise expenditure for agency staff and wherever possible through substantive recruitment.
Mrs Craven as Chair of FPC commented that it was important for the Board to be aware of the improved line of sight and identification of potential risks now being provided in the reports presented to FPC. Additionally, attendance by each of the Divisions provided assurance in a number of areas.

FPC continued its detailed discussions with regard the cost improvement programme.

The Board of Directors noted the Finance Report.

ASSURANCE FRAMEWORK
276/18 GOVERNANCE REPORT

The Board of Directors received the Governance Report from the Director of Corporate Affairs/Company Secretary.

Ms Milanec specifically highlighted the publication by the CQC of their report, Learning Disabilities and CQC Inspection Reports, with NHSI also publishing their Learning Disability improvement standards for NHS Trusts. Mrs Barnett confirmed that she had discussed both publications with the Chief Nurse who had confirmed that the matters raised in them were being taken forward.

It was reported that since the time of writing, the Financial Reporting Council had published their revised UK Corporate Governance Code. Its content would be reviewed with the key highlights to be included in the next Governance Report.

The Board of Directors noted the Governance Report.

277/18 RISK MANAGEMENT REPORT

The Board of Directors received the Risk Management Report, which included the register of risks scoring 15 and above, presented by the Deputy Chief Nurse.

Mrs Dobson reported that the review of the risk management arrangements had been delayed but remained a priority. Mrs Barnett confirmed that she had discussed this with the Chief Nurse and Deputy Chief Nurse and that this would be progressed.

In acknowledging the reasons for the delay, Mr Havenhand indicated that it remained important for the review to be concluded as quickly as possible in order for the processes to be embedded and for the Board’s focus to shift to the organisational risks, and that an indication of this timeline be provided by the Chief Nurse.

ACTION – Chief Nurse

Mr Barnes suggested that (1) any implications resulting from Brexit should be considered for inclusion on the risk register, and (2) that some of the risks...
still referred to the Sustainability and Transformation Partnerships rather than the Integrated Care System. **ACTION – Chief Nurse**

The Board of Directors noted the Risk Management Report.

**REGULATORY AND STATUTORY REPORTING**

**278/18  WORKFORCE RACE EQUALITY REPORT 2018**

The Board of Directors received the Workforce Race Equality Standard (WRES) Report 2018.

Mrs Atmarow, as Chair of SWC, indicated that this, and the next agenda item, would normally have been considered by SWC in order that they could be assured on both the submission and any outstanding actions. However, this had not occurred as an SWC meeting had not taken place in July.

The closing date for organisations to upload their data would be 10 August 2018, with Trusts to publish the data on their corporate website, following sign off by the Board, before 28 September.

In order to ensure good governance was maintained, the Board gave delegated authority to the Chief Executive and the Chair SWC, to sign off the data submissions. **ACTION – Chief Executive and Chair of SWC**

**279/18  EQUALITY DELIVERY SYSTEM REPORT**

The Board of Directors received the Equality Delivery System (EDS2) Report.

As stated in the previous agenda item the report had not been considered by SWC. In order to ensure good governance was maintained, the Board gave delegated authority to the Chief Executive and the Chair SWC, to sign off the data submissions. **ACTION – Chief Executive and Chair of SWC**

**280/18  ANNUAL HEALTH AND SAFETY REPORT**

The Board of Directors received the 2017/18 Annual Health and Safety Report presented by the Director of Corporate Affairs/Company Secretary.

Ms Milanec took the opportunity to provide additional supplementary data to give context to the annual report. With regard to section 13.4 (Incidents requiring notification to the Health and Safety Executive and Department of Health) the report stated that the number of incidents had ‘significantly increased from previous years’. In fact, the number reported was 21 incidents for 2017/18, compared to 20 in 2016/17.

There had been an increase in abusive, violent or disruptive behaviour towards colleagues, with 263 reported incidents, compared to 191 in the previous year. Of this number, 103 incidents had been perpetrated by a
friend of the patient, which was nearly double the number in the previous year of 54. It was agreed that this would be highlighted to the Director of Estates and Facilities to ensure appropriate insight, and that actions are taken to reduce this in future,

It was clarified for the Board that following the Grenfell Tower incident all Trusts had been urgently requested by the Regulator to undertake specific checks. Mr Sheppard confirmed that he had liaised with South Yorkshire Fire and Rescue Service at the time and confirmed that they had completed the required checks as quickly as was practicable.

Ms Milanec would ensure that the required amendments and clarifications were made to the report before it was made available on the corporate website.  

**ACTION – Director of Corporate Affairs/Company Secretary**

The Board took the opportunity to congratulate colleagues for being awarded a fifth consecutive RoSPA (The Royal Society for the Prevention of Accidents) Gold Award for Occupational Health and Safety. As a consequence, the Trust had also been awarded Gold Medal status and was the only Trust in the country to achieve this status.

The Board of Directors received and noted the Annual Health and Safety Report.

**281/18 RESPONSIBLE OFFICER REPORT**

The Board of Directors received and noted the quarterly report from the interim Responsible Officer which was presented by the Associate Medical Director.

The report set out to provide information relating to medical appraisal and revalidation, with Mr Slater confirming that consultant colleagues valued the process which provided an independent review of practice.

Mrs Barnett indicated that whilst the data within the table would need to be verified with regard to its accuracy, she was confident that there was a robust process in place.

The Board of Directors noted the Responsible Officer report.

**282/18 GUARDIAN OF SAFE WORKING REPORT**

*Dr Lynch, Guardian of Safe Working Hours was welcomed to the meeting to present this item.*

The Board of Directors received the Guardian of Safe Working Hours Report.

Dr Lynch, whose role was to independently and objectively obtain feedback from Junior Doctors and provide a report to the Board on a quarterly basis, informed the Board that the number of exception reports in the quarter had
fallen to 25 compared to the 64 received in the previous quarter. The report also provided qualitative information with examples of commentary received direct from the junior doctors.

There had been no fines imposed for exceeding 48 hours’ average or 72 hours’ total weekly hours.

The Chief Executive advised that arrangements would be made for the Guardian of Safe Working to meet with the Medical Director, to discuss the reports in detail, before the next quarter report is due.

**ACTION – Director of Corporate Affairs/Company Secretary**

The Board of Directors noted the report.

**BOARD GOVERNANCE**

**283/18 SEAL REGISTER DETAILS**

The Board of Directors received and noted the report from the Director of Corporate Affairs/Company Secretary which detailed the use of the Seal.

**284/18 ANY OTHER BUSINESS**

There were no items of any other business.

**285/18 DATE OF NEXT MEETING**

The next meeting of the Board of Directors would be held on Tuesday, 28 August 2018.

*At this point the Chairman opened the meeting to any questions from those observing the proceedings in relation to the agenda items, for which there were none.*

Martin Havenhand  
Chairman        date
### Public meeting, action log

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<th>Report/Agenda Title</th>
<th>Minute Ref</th>
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<th>Comment/Feedback from Lead Officer(s)</th>
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<td>58</td>
<td>25-Jul-17</td>
<td>Escalations from Governors</td>
<td>269/17</td>
<td>To be added to action log: 3 staff governor vacancies out of 5 remain vacant. Execs to consider options available to co-op colleagues to ensure they are engaged and represented through CoG.</td>
<td>Co Sec</td>
<td>30/09/2018 (re constitution)</td>
<td>Update to July Board Meeting: Co Sec has met with two individuals who have shown an interest in becoming a governor. Three additional individuals have also enquired. 31 Jul BoD action: to remain open until at least draft Constitution brought to Board.</td>
<td>Open</td>
</tr>
<tr>
<td>52</td>
<td>26-Jun-18</td>
<td>Report from the Chief Executive</td>
<td>99/18</td>
<td>Final version of the Rotherham Place Plan to be shared with the Board for comment, when available.</td>
<td>DS&amp;T</td>
<td>28-Aug-18</td>
<td>Draft of final version was circulated to Board Members for comments by 7 August. Report provided at agenda item 329/18</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>51</td>
<td>26-Jun-18</td>
<td>Quality and Clinical Report</td>
<td>238a/18</td>
<td>Review of the contracting requirements relating to 'Looked After Children' to be carried out and reported to the Board.</td>
<td>DoF</td>
<td>24/07/2018 - 25/09/2018</td>
<td>A review of the current service and position has been undertaken by RCCG/TRFT representatives and completed. A joint review of the service delivery model to investigate alternative options has commenced. A deadline for these proposals has been set as 31 August 2018. Leave open - reviews not complete until 31 August 2018</td>
<td>Open</td>
</tr>
<tr>
<td>53</td>
<td>26-Jun-18</td>
<td>Workforce Report</td>
<td>238c/18</td>
<td>Consideration to be given to establish a trophy cabinet or similar in the main, public entrance</td>
<td>CEO</td>
<td>31-Jul-18</td>
<td>Director of Estates and Facilities has located a site in the main entrance - CEO to approve to progress</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>54</td>
<td>31-Jul-18</td>
<td>Report from the Chairman</td>
<td>272/18</td>
<td>Circulate details to the Board showing ICS leadership team details</td>
<td>CEO</td>
<td>28-Aug-18</td>
<td>Details included in agenda item 328/18</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>55</td>
<td>31-Jul-18</td>
<td>Report from the Chairman</td>
<td>272/18</td>
<td>Circulate details to the Board re the amount of the successful Local Health and Care Record Bid awarded to South Yorkshire and Humber (mentioned in 2.2 of the report)</td>
<td>DoF</td>
<td>28-Aug-18</td>
<td>Yorkshire and Humber (W. Yorks, S. Yorks, N. Yorks and Humberside) will receive up to £7.5M</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>56</td>
<td>31-Jul-18</td>
<td>Report from the Chief Executive</td>
<td>273/18</td>
<td>CEO to consider the format of the quarterly table of objectives to reflect consistency across committees and Board</td>
<td>CEO</td>
<td>30-Oct-18</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>Log N</td>
<td>Meeting</td>
<td>Report/Agora title</td>
<td>Minute Ref</td>
<td>Agenda item and Action</td>
<td>Lead Officer</td>
<td>Timescale/Deadline</td>
<td>Comment/ Feedback from Lead Officer(s)</td>
<td>Open /Close</td>
</tr>
<tr>
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</tr>
<tr>
<td>57</td>
<td>31-Jul-18</td>
<td>Business Planning Timescales</td>
<td>274/18</td>
<td>Board Planner to be updated with amended timelines (section 2.4 of report): Board seminar in Sept to discuss Trust strategy: STAC to consider and recommend (reviewed) Trust strategy in Sept 2018: Board to approve (reviewed) Trust strategy in Sept 2018:</td>
<td>Co Sec</td>
<td>25-Sep-18</td>
<td>complete</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>58</td>
<td>31-Jul-18</td>
<td>Quality and Clinical Report</td>
<td>275a</td>
<td>Risk 5268: non compliance re QCQ regulation 18 must do actions to be reviewed and assurance provided to Board</td>
<td>ChN</td>
<td>15-Aug-18</td>
<td>Details presented at Board Seminar on 15 August 2018</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>59</td>
<td>31-Jul-18</td>
<td>Quality and Clinical Report</td>
<td>275a</td>
<td>The establishment of a Clinical Ethics Committee to be progressed.</td>
<td>MD</td>
<td>25-Sep-18</td>
<td>Open</td>
<td>Open</td>
</tr>
<tr>
<td>60</td>
<td>31-Jul-18</td>
<td>Operational Performance Report</td>
<td>275b</td>
<td>CEO to highlight to A&amp;E Delivery Board the impact that social care challenges have been having on the Trust</td>
<td>CEO</td>
<td>28-Aug-18</td>
<td>This has been raised. COO will provide verbal update at the meeting</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>61</td>
<td>31-Jul-18</td>
<td>Operational Performance Report</td>
<td>275b</td>
<td>Fragile' services to be included as part of the forthcoming review of clinical services by the Trust</td>
<td>COO</td>
<td>30-Oct-18</td>
<td>Open</td>
<td>Open</td>
</tr>
<tr>
<td>62</td>
<td>31-Jul-18</td>
<td>Risk Management Report</td>
<td>277/18</td>
<td>Confirmation to be provided to Board as to when the ongoing risk management review will be complete</td>
<td>ChN</td>
<td>28-Aug-18</td>
<td>Chief Nurse advised that this should be complete by end of Quarter Three</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>63</td>
<td>31-Jul-18</td>
<td>Risk Management Report</td>
<td>277/18</td>
<td>Risk to be added to the risk register highlighting the implications of BREXIT</td>
<td>ChN</td>
<td>28-Aug-18</td>
<td>completed</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>64</td>
<td>31-Jul-18</td>
<td>Risk Management Report</td>
<td>277/18</td>
<td>Risks on the risk register referring to Sustainability and Transformation Partnerships, to be updated to refer to Integrated Care Systems</td>
<td>ChN</td>
<td>28-Aug-18</td>
<td>completed</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>65</td>
<td>31-Jul-18</td>
<td>Workforce Race Equality Report 2018</td>
<td>278/18</td>
<td>Submission to be signed off by CEO and Chair of SWC before submission on 10 August 2018</td>
<td>CEO / G. Atmarow</td>
<td>10-Aug-18</td>
<td>Verbal update to be provided at the meeting: documents submitted</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>66</td>
<td>31-Jul-18</td>
<td>Equality Delivery System 2018</td>
<td>278/18</td>
<td>Submission to be signed off by CEO and Chair of SWC</td>
<td>CEO / G. Atmarow</td>
<td>10-Aug-18</td>
<td>Documents did not require formal submission</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>Log No</td>
<td>Meeting Date</td>
<td>Report/Agora title</td>
<td>Minute Ref</td>
<td>Agenda item and Action</td>
<td>Lead Officer</td>
<td>Timescale/Deadline</td>
<td>Comment/ Feedback from Lead Officer(s)</td>
<td>Open /Close</td>
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<td>--------------------</td>
<td>----------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>67</td>
<td>31-Jul-18</td>
<td>Annual Health and Safety Report</td>
<td>280/18</td>
<td>Minor amendments to be made to the report before being uploaded onto the website.</td>
<td>Co Sec</td>
<td>28-Aug-18</td>
<td>completed</td>
<td>Recommend to Close</td>
</tr>
<tr>
<td>68</td>
<td>31-Jul-18</td>
<td>Guardian of Safe Working Hours report</td>
<td>282/18</td>
<td>Arrangements to be made to facilitate the Guardian meeting with Medical Director before next quarterly report is presented</td>
<td>Co Sec</td>
<td>30-Oct-18</td>
<td></td>
<td>Open</td>
</tr>
</tbody>
</table>
Report: Report from the Chief Executive

Presented by: Chris Holt, Acting Chief Executive
Author(s): Chris Holt, Acting Chief Executive

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Finance: Strong, financial foundations
Partners: Securing the future together

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
BAF: All as applicable
Corporate Risk Register: All as applicable

Purpose of this paper:
This paper outlines progress regarding a number of key strategic and operational issues and stakeholder engagement since the last Board of Directors’ meeting.

Summary of Key Points:

- Overall, the Trust is on track with the delivery of the 2018/19 Operational Plan, with mitigating plans in place to achieve some elements that are behind schedule;

- The Trust’s performance against the A&E four-hour access standard has faced significant challenge recently;

- Publication of a 10-year and a 5-year plan by NHS England and NHS Improvement sets out the proposed path for the NHS for the next few years;

- The Trust continues to engage with stakeholders, both locally and across the Integrated Care System, to improve the quality and sustainability of services for the population we serve;

- The Trust has been identified as the first Trust in England to be accredited as an Allocate Academy Organisation.

Board action required:
The Board of Directors is asked to note the report.
1.0 **Introduction**

1.1 This paper outlines progress regarding a number of key strategic and operational issues, and stakeholder engagement, since the July 2018 Board of Directors’ meeting.

2.0 **Strategic Issues**

2.1 The Trust continues to progress with its work to achieve delivery against the 2018/19 Operational Plan. For those few elements where delivery is not on track within original timelines, the Trust has mitigating actions in place to address this position.

2.2 The Board Assurance Committees have undertaken a more detailed review of progress against the objectives this month, prior to the half way point in the year, with the Board considering the outcome of this work later in the meeting.

3.0 **Performance Issues**

3.1 The Integrated Performance Report highlights the key performance within the Trust along with the top achievements and key concerns.

3.2 Performance against the 4-hour access standard has seen particular challenges through August. This has been as a result of workforce challenges within the Urgent & Emergency Care Centre as well social care delays within the hospital. Work is underway, including with Rotherham Place partners, led by the Chief Operating Officer to recover performance levels.

4.0 **NHS 10 Year Plan**

4.1 On 9 August, NHS England and NHS Improvement published a document on developing the long term plan for the NHS.

4.2 The NHS has been tasked with producing a 10-year strategic plan in return for an increase in funding and setting out how the service intends to deliver major improvements. The timing of the plan is expected to align with the autumn budget.

4.3 The Government have set a number of priorities for the 10-year plan (including delivering agreed performance standards, better integration between health and social care, and prevention of ill health) as well as five financial tests (including elimination of provider deficits, making better use of capital investment, and getting better at managing demand efficiently) to show how the service will achieve a more sustainable position going forward.

4.4 A delivery plan to underpin the first few years of the plan is also being developed for publication in late September 2018. This timeline also follows the 2017/18 operational planning guidance which allows Trusts to complete draft plans by Christmas, rather than the 2018/19 guidance where some Trusts were still finalising plans in July.

4.5 The Government is also planning to publish a plan covering three financial years from 2019/20 to 2021/22, in September 2018. It is suggested that there will be a “wholesale shift” in NHS funding rules, including the payment system and the end of “sustainability funding”.
4.6 The timelines for the above are:
   - Initial engagement and establishment of working groups and planning for policy
datavelopment in August;
   - Ongoing engagement via work streams and development of policy proposals in
September;
   - Test and finalise policy proposals and reconciliation against available funding in
October; and
   - Publication of 10-year plan at the time of budget in November 2018.

4.7 To ensure front line engagement, the majority of the working groups will include a provider
CEO representative.

4.8 Working groups will look at issues such as clinical priorities, transformation, productivity
and efficiency, and legislation.

4.9 We welcome these developments and the alignment with our own annual planning cycle,
and will ensure key points are reflected within our plans going forward.

5.0 **Stakeholder Engagement**

5.1 Trust colleagues continue to work with partner organisations across Rotherham Place
through the Integrated Care Partnership (ICP) and across South Yorkshire and Bassetlaw
(SYB) through the Integrated Care System (ICS) to improve the quality and sustainability
of health and care for the population we serve.

5.2 The regular meetings of the Rotherham Integrated Health and Social Care Place Board,
Rotherham Together Partnership Chief Executive Officer Group, Health Select
Committee and Health and Wellbeing Board have taken place during August 2018 to
support the delivery and review of the Rotherham Place Plan. We continue to work closely
with partners to achieve our shared plans.

5.3 The Integrated Rapid Response (IRR) team held an Unplanned Care and IRR open day
on 9th August 2018. This took place at Woodside and a number of staff attended the
event including the COO and myself and some members of the site team. The team were
really enthusiastic and motivated and highlighted to us the improvement in care offered
to patients by the recent introduction of locality based hubs and a dedicated team to
support urgent requests and visits to enable a more effective use of time during the
working day.

6.0 **Awards**

6.1 An event is being organised by Allocate to celebrate us being the first Trust in England to
be accredited as an Allocate Academy Organisation.

6.2 The accreditation demonstrates that we have achieved a quality benchmark of skills
throughout the team, to deliver effective workforce planning, using Allocate Software
solutions that have been fully accredited by Allocate. Hugh Ashley, General Manager
from Allocate will be coming to the Trust to present to the accredited team.
7.0 Conclusion

7.1 Overall the Trust remains on track regarding the delivery of the Operational Plan, with some strong delivery of a number of key standards and targets, and further improvement required in a number of key areas.

7.2 Partnership working remains a focus of attention to ensure the effective review and delivery of the Rotherham Place Plan and to improve the resilience and sustainability of services across South Yorkshire and Bassetlaw with ICS partners.

Chris Holt
Acting Chief Executive
August 2018
Report: Business Planning Cycle

Presented by: Chris Holt, Acting Chief Executive
Author(s): Chris Holt, Acting Chief Executive

Strategic Objective:
- Patients: Excellence in healthcare
- Colleagues: Engaged, accountable colleagues
- Governance: Trusted, open governance
- Finance: Strong, financial foundations
- Partners: Securing the future together

Regulatory relevance:
- NHSI: Licence Condition FT4 / Single Oversight Framework
- CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
- BAF: All as applicable
- Corporate Risk Register: All as applicable

Purpose of this paper:
This paper provides an update to the annual business planning cycle.

Summary of Key Points:
- The update approach outlines the annual planning cycle, along with key timeframes to complete each stage.
- Work is underway across all 3 stages of the cycle to see that these timeframes are achieved and the process is being standardised and formalised to ensure consistency year on year.
- Additional resource is being secured to support the 5-year business planning stage in particular and good engagement is taking place with partners to support this as well.

Board action required:
For noting.
1.0 **Introduction**

1.1 This paper provides an update on the proposed approach to annual planning and clarifies some of the terminology and key timeframes.

1.2 There is also a significant amount of work underway to progress the various elements and the paper provides an update on the current position.

2.0 **Overview**

2.1 As presented at the July board, the proposed annual planning cycle is organised based around three key elements. This is presented below with updated terminology to provide clarity:

- 5-year strategy development and refresh – overview of long term goals, ambitions and overall vision for the Trust;
- 5-year business planning – the way we are planning to deliver the strategy over the next 5 years;
- 1-year operational planning and budgeting – detailed planning for the next financial year (i.e. the first year of the 5-year plan);

2.2 The proposed terminology and timing of each phase of the annual cycle is therefore shown in the diagram below.

2.3 For clarity, the dates above are for presentation to the Board of Directors for approval.

2.4 Also, as outlined previously, whilst these stages link together, some work will be undertaken in parallel to ensure early development and planning, so that, for example, the Board of Directors will be in a position to consider the draft plan at the end of December.
2.5 A series of key milestones have been previously shared with the Board of Directors, to ensure clarity of oversight of key aspects by the board assurance committees and are set out below:

- Strategy and Transformation Committee (STaC) to review and endorse 5-year strategy update – September’18
- Board to approve final strategy update – September’18
- STaC to review and endorse the 5-year business plan – October’18
- STAC to review and endorse operational planning and budget assumptions – October’18
- Board to approve the 5-year business plan and the assumptions / targets that will underpin operational planning and budgeting activities – October’18
- Finance and Performance Committee (FPC) to review draft operational plan and budget – December’18
- Board to review draft operational plan and budget – December’18
- FPC to endorse final operational plan and budget – February’19
- Board to approve final operational plan and budget – February’19

2.6 Progress with the annual planning cycle will be reported to the Board as appropriate through the Chief Executive’s report.

2.7 Detailed plans will underpin the delivery of the milestones above. The detailed plans will be overseen on a day-to-day basis by the central coordinator and progress will be monitored by the Executive Committee.

3.0 5-year Strategy: refresh and development

3.1 As outlined in the paper presented in July’18, it is anticipated to undertake a refresh of the strategy this year and this will be facilitated through a board seminar on 12th September, and will allow all members of the board to contribute to any changes required and allow for an updated strategy to be presented to the Board at the end of September.

3.2 To support this refresh, an exercise is underway across all Divisions to undertake a high level review of all our clinical services, following the approach which was taken for the five services included within the Hospital Services Review.

3.3 This will see each clinical service considered against 6 key points:

- Must Have: what do we believe are the ‘red-lines’ for the clinical service and which we believe we must be providing or undertaking
- Would Like: which aspects of the clinical service do we consider as desirable to provide as they support or compliment the core offer
- Don’t Need: which aspects do we not need to be doing and can stop (if already providing) or we don’t wish to develop going forward
- Key Risks: what are the headline risks that we are faced with or anticipating
- Key Opportunities: what are the headline opportunities we can develop or build upon
- Key Priorities: what are they top 3 opportunities we should focus on going forward

3.4 The board seminar in September will then receive a synthesised version and conclusion of the findings from this exercise to help inform the overall refresh.
3.5 The updated strategy will be formally signed off by the Board in September.

4.0 5-year Business Plan

4.1 The 5-year Business Plan will articulate how the strategy will be delivered and describe the resources required to support delivery.

4.2 The business plan will outline the development plans for existing and new services and will build on the clinical service review work which will be completed as part of the strategy refresh and outlined above.

4.3 Underpinning corporate plans will also be developed that will enable services to be provided in the most sustainable way (from quality, workforce, operational and financial perspectives). Key areas of focus to include:
   - Workforce plan
   - Technology plan
   - Estates plan
   - Financial plan (including efficiency plans, capital needs and cash funding)

4.4 The plan will also provide a 5-year financial projection (a Long Term Financial Model) based upon potential income and expenditure forecasts and will consider work that is currently underway or anticipated to be done, as per the strategy. This will be structured around 4 key ‘sections’:
   - Base case: essentially the ‘do-nothing’ scenario and what the financial position will be if no efficiencies were delivered and / or new models of care introduced
   - Across the Trust: what the Trust could deliver over 5 years by focusing on our own services and working internally, and building upon opportunities outlined within Model Hospital and Getting It Right First Time (GIRFT) reviews
   - Across the Place: what could be delivered by working with partners across Rotherham Place, primarily though the implementation of opportunities within the Place Plan
   - Across the ICS: what could be delivered by working with partners across the Integrated Care System. This will also include potential collaboration opportunities with key partners direct.

4.5 Work is already well under way and an internal project team has been developed to lead on the work. Additional resource is also being secured to support the work as capacity is required in a few key areas (e.g. financial modelling, HR support).

4.6 A number of working sessions have also been held with key partners across Rotherham Place, notably the Clinical Commissioning Group, who are fully supportive of the approach and are making a valued contribution. Discussions are underway to secure input from the ICS with a proposal that the approach being undertaken by TRFT is used as a basis for other partners to adopt.

4.7 The 5-year business plan will be formally signed off by the Board in October.

5.0 1-year Operational Plan

5.1 The 1-year operational plan and budget describe the detailed targets and objectives for the next financial year (and the first year of the 5-year business plan) along with the governance arrangements required to support delivery. The operational plan will include:
• Quality and operational performance
• Activity and capacity
• Key objectives and business owners
• Staffing and resources
• Estates and technology
• Financial performance and efficiency plans
• Implementation timetable
• Key risks and mitigation strategies
• Governance arrangements for monitoring progress

5.2 The delivery of specific objectives and targets will be assigned to the relevant accountable role holders and committees within the Trust and managed through the Trust’s performance management framework.

5.3 Work is underway to formalise and standardise the process and templates to be used to ensure consistency and provide the Divisional and Corporate teams with a framework to work within. This will be done by 14th September and then communicated to the teams.

5.4 Outlining the approach and early assumptions to support the plan (from the 5-year business planning) will also be shared at the 6-month review workshop that is set up with Divisional and corporate teams on 16th October.

5.5 The final operational plan and budget will be formally signed off by the Board in February 2019.

6.0 Conclusion

6.1 The annual planning cycle is now being actively adopted as the approach towards strategy review and business planning.

6.2 Work is underway across all 3 stages, to support the timeframes outlined.

Chris Holt
Acting Chief Executive
August 2018
### Top Achievements

**18 Week RTT Incomplete - 94.8%**
Excellent elective waiting time performance has been sustained in July. June (94.3%) was confirmed as the 7th best waiting times nationally and performance for July is expected to provide a top 5 ranking.

**Mortality (SHMI) - 109.0**
The Summary Hospital Mortality Indicator (SHMI), covering the period of January 2017 to December 2017 has shown an increase in adjusted mortality rate from 106 to 109. Whilst this is not statistically significant the increase is of concern. (See mortality report for more details)

**Diagnostic Waiting Times DM01 - 0%**
For the month of July only 1 of 3918 patients was waiting more than 6 weeks for any diagnostic test, continuing Rotherham’s excellent performance.

### Most Improved

**Dementia Assessment - 88.4%**
Whilst not yet at national target levels of 90%. Dementia Assessment completion rate has improved from 82.1% in May to 88.4% in June. This is showing good progress following significant focus at all levels of the organisation.

**Hip Fracture Best Practice - 85.7%**
Performance for the month of June has demonstrated excellent quality of care on the Hip Fracture pathway. The 12 month rolling performance is 77.6% against a national average of 65% and a ranking of 23rd of 133 Acute Trusts

### Key Concerns

**Mortality (SHMI) - 109.0**
The Summary Hospital Mortality Indicator (SHMI), covering the period of January 2017 to December 2017 has shown an increase in adjusted mortality rate from 106 to 109. Whilst this is not statistically significant the increase is of concern. (See mortality report for more details)

**Diagnostic Waiting Times DM01 - 0%**
For the month of July only 1 of 3918 patients was waiting more than 6 weeks for any diagnostic test, continuing Rotherham’s excellent performance.

### Most Deteriorated

**e-Referral Slot Issues Rate (ASI) - 41.6%**
Whilst the ASI rate has reduced from 45.3%, current performance remains a significant deterioration on the same month last year (28%). A task and finish group has been established to bring performance back on track with a target of being less than 4% by March 2019.

**Urgent Care (4 Hour Standard) - 86.4%**
Whilst above the TRFT trajectory performance in July has declined from 92.1% in June and with it national ranking has dropped from 47 to 80.

### Integrated Performance Dashboard (July 2018)

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Performance</th>
<th>Trend</th>
<th>Benchmark</th>
<th>Data Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C1</strong> A&amp;E % Left without being seen</td>
<td>Jun-18</td>
<td>5.00%</td>
<td>6.35%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C2</strong> IP Friends &amp; Family Test (% Positive)</td>
<td>Jul-18</td>
<td>95.0%</td>
<td>96.9%</td>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td><strong>C3</strong> % LAC assessments reported &lt;20 days</td>
<td>Jul-18</td>
<td>95%</td>
<td>88%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C4</strong> New Complaints per WTE</td>
<td>Jul-18</td>
<td>7.6</td>
<td>5.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C5</strong> A&amp;E % Left without being seen</td>
<td>Jun-18</td>
<td>0.00%</td>
<td>0.93%</td>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td><strong>E1</strong> Ambulance Turnaround Times % &gt; 60 mins</td>
<td>Jul-18</td>
<td>0.8%</td>
<td>0.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E2</strong> Cancelled Operations</td>
<td>Jul-18</td>
<td>3.5%</td>
<td>2.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E3</strong> Delayed Transfer of care</td>
<td>Jul-18</td>
<td>90.0%</td>
<td>88.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E4</strong> Dementia Assessment</td>
<td>Jun-18</td>
<td>65.0%</td>
<td>85.7%</td>
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</tr>
<tr>
<td><strong>E5</strong> Hip Fracture Best Practice Compliance</td>
<td>Jun-18</td>
<td>100</td>
<td>109.0</td>
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</tr>
<tr>
<td><strong>E6</strong> Mortality (SHMI Rolling 12 Month)</td>
<td>Jun-18</td>
<td>60.0%</td>
<td>53.8%</td>
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<tr>
<td><strong>E7</strong> Stroke: admitted to ward within 4 hours</td>
<td>Jul-18</td>
<td>95.0%</td>
<td>86.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>R1</strong> Urgent Care (4 Hour)</td>
<td>Jul-18</td>
<td>85.0%</td>
<td>83.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>R2</strong> Cancer Standards 62 Day</td>
<td>Jun-18</td>
<td>90.0%</td>
<td>100.0%</td>
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<tr>
<td><strong>R3</strong> Cancer Standards 62 Day Screening</td>
<td>Jul-18</td>
<td>65.0%</td>
<td>25.8%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>R4</strong> Diagnostics (DM01)</td>
<td>Jul-18</td>
<td>0.0%</td>
<td>1.0%</td>
<td></td>
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</tr>
<tr>
<td><strong>R5</strong> Urgent Care (4 Hour Standard)</td>
<td>Jul-18</td>
<td>13.3%</td>
<td>13.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>R6</strong> e-Referral Slot Issues Rate</td>
<td>Jul-18</td>
<td>90.0%</td>
<td>91.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S1</strong> Access to Antenatal Services within 90 days</td>
<td>Jul-18</td>
<td>12.9</td>
<td>11.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S2</strong> C.Diff incidence rate per 100,000 bed days</td>
<td>Jul-18</td>
<td>16.5%</td>
<td>14.0%</td>
<td></td>
<td></td>
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<tr>
<td><strong>S3</strong> Emergency Caesarean Section Rate</td>
<td>Jul-18</td>
<td>95.0%</td>
<td>95.5%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>S4</strong> MRSA bacteraemia rate per 100,000 bed days</td>
<td>Jul-18</td>
<td>0.65</td>
<td>0.75</td>
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<td></td>
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<tr>
<td><strong>S5</strong> Potential under reporting of incidents</td>
<td>Jul-18</td>
<td>43.3%</td>
<td>36.4%</td>
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<tr>
<td><strong>S6</strong> VTE Assessment Completion %</td>
<td>Jul-18</td>
<td>95.0%</td>
<td>96.7%</td>
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<td><strong>S7</strong> Readmissions (Non Elective 28 day)</td>
<td>Jul-18</td>
<td>0.35%</td>
<td>0.41%</td>
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<td><strong>S8</strong> Incomplete 18 Week RTT</td>
<td>Jul-18</td>
<td>0.0%</td>
<td>0.3%</td>
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<tr>
<td><strong>W1</strong> Incident Reporting Culture - % Incidents Severe</td>
<td>Jul-18</td>
<td>4.99%</td>
<td>6.67%</td>
<td></td>
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<tr>
<td><strong>W2</strong> Variance from Plan</td>
<td>Jul-18</td>
<td>3.95%</td>
<td>4.10%</td>
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<td><strong>W3</strong> Proportion of Temporary Staff</td>
<td>Jul-18</td>
<td>3.95%</td>
<td>4.10%</td>
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<tr>
<td><strong>W4</strong> Staff Turnover</td>
<td>Jul-18</td>
<td>0.88%</td>
<td>0.58%</td>
<td></td>
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<td><strong>W5</strong> Sickness Rates (12 Month Rolling)</td>
<td>Jul-18</td>
<td>7.10</td>
<td>7.78</td>
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<td>METRIC</td>
<td>Target</td>
<td>Apr</td>
<td>May</td>
<td>Jun</td>
<td>Jul</td>
<td>Aug</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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<td>-----</td>
<td>-----</td>
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<tr>
<td>% of Stroke patients who spend at least 90% of their time on a stroke unit</td>
<td>&gt;= 80%</td>
<td>84%</td>
<td>92%</td>
<td>89%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>23/36</td>
<td>23/25</td>
<td>33/37</td>
<td>33/39</td>
<td></td>
</tr>
<tr>
<td>% of non-admitted higher risk TIA cases who are treated within 24 hours of first contact with any healthcare professional</td>
<td>&gt;= 60%</td>
<td>80%</td>
<td>70%</td>
<td>66%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9/15</td>
<td>7/10</td>
<td>2/3</td>
<td>6/8</td>
<td></td>
</tr>
<tr>
<td>% of People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital</td>
<td>&gt;= 90%</td>
<td>33%</td>
<td>60%</td>
<td>61%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12/36</td>
<td>15:25</td>
<td>22/26</td>
<td>21/39</td>
<td></td>
</tr>
<tr>
<td>Proportion of patients presenting with stroke with AF anti-coagulated on discharge</td>
<td>&gt;= 60%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3/3</td>
<td>5/5</td>
<td>8/8</td>
<td>3/3</td>
<td></td>
</tr>
<tr>
<td>Proportion of stroke patients scanned within one hour of hospital arrival</td>
<td>&gt;= 50%</td>
<td>44%</td>
<td>45%</td>
<td>58%</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>15/34</td>
<td>10/22</td>
<td>22/38</td>
<td>23/39</td>
<td></td>
</tr>
<tr>
<td>Proportion of stroke patients scanned within 24 hrs of hospital arrival</td>
<td>&gt;= 100%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>33/34</td>
<td>22/22</td>
<td>38/38</td>
<td>38/39</td>
<td></td>
</tr>
<tr>
<td>Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke</td>
<td>&gt;= 40%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9/9</td>
<td>26/26</td>
<td>19/19</td>
<td>15/15</td>
<td></td>
</tr>
<tr>
<td>Proportion of patients and carers with joint care plans on discharge from hospital</td>
<td>&gt;= 85%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>8/8</td>
<td>7/7</td>
<td>3/3</td>
<td>6/6</td>
<td></td>
</tr>
<tr>
<td>Proportion of stroke patients that are reviewed six months after leaving hospital</td>
<td>&gt;= 95%</td>
<td>91%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>21/23</td>
<td>28/28</td>
<td>28/28</td>
<td>25/25</td>
<td></td>
</tr>
<tr>
<td>Proportion of patients supported by a stroke skilled ESD team</td>
<td>&gt;= 40%</td>
<td>23%</td>
<td>52%</td>
<td>54%</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6/32</td>
<td>11/21</td>
<td>21/33</td>
<td>14/27</td>
<td></td>
</tr>
<tr>
<td>% of patients who receive thrombolysis following an acute stroke</td>
<td>&gt;= 11%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0/37</td>
<td>0/25</td>
<td>2/39</td>
<td>4/40</td>
<td></td>
</tr>
</tbody>
</table>

% of patients who receive thrombolysis following an acute stroke

Proportion of patients and carers with joint care plans on discharge from hospital

Proportion of stroke patients scanned within 24 hrs of hospital arrival

Proportion of non-admitted higher risk TIA cases who are treated within 24 hours of first contact with any healthcare professional

% of Stroke patients who spend at least 90% of their time on a stroke unit

Proportion of patients presenting with stroke with AF anti-coagulated on discharge

Proportion of stroke patients scanned within one hour of hospital arrival

Proportion of patients who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital

Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke

Proportion of patients who receive thrombolysis following an acute stroke

% of Stroke patients who spend at least 90% of their time on a stroke unit

Proportion of patients presenting with stroke with AF anti-coagulated on discharge
## Appendix 2 - June Tumour Site Breakdown*

<table>
<thead>
<tr>
<th>Tumour Site</th>
<th>62 Day from 2ww Target 85%</th>
<th>62 day CUG Target TBC</th>
<th>62 Day Screening Target 90%</th>
<th>31 Day 1st Treated Target 96%</th>
<th>31 Day Subsequent Surgery Target 94%</th>
<th>31 Day Subsequent Drug Target 98%</th>
<th>31 Day Subsequent Palliative Target TBC</th>
<th>2WW Target 93%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
</tr>
<tr>
<td>Acute Leukaemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>81.2%</td>
</tr>
<tr>
<td>Brain/Central Nervous System</td>
<td></td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>95.4%</td>
<td>93.9%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Childrens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecological</td>
<td>64.3%</td>
<td>69.2%</td>
<td>90.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>87.5%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Haematological</td>
<td>87.1%</td>
<td>87.1%</td>
<td>92.9%</td>
<td>92.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>85.3%</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>58.3%</td>
<td>58.3%</td>
<td>82.4%</td>
<td>82.4%</td>
<td></td>
<td></td>
<td>87.5%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Lower Gastrointestinal</td>
<td>75.0%</td>
<td>65.2%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>83.3%</td>
<td>100.0%</td>
<td>91.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Lung</td>
<td>91.3%</td>
<td>82.6%</td>
<td>93.1%</td>
<td>96.4%</td>
<td></td>
<td>100.0%</td>
<td></td>
<td>97.8%</td>
</tr>
<tr>
<td>Other</td>
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<td>100.0%</td>
<td>81.8%</td>
<td>69.2%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarcoma</td>
<td>33.3%</td>
<td>33.3%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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<td></td>
<td>100.0%</td>
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<tr>
<td>Skin</td>
<td>87.5%</td>
<td>87.5%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.0%</td>
<td></td>
<td></td>
<td>95.4%</td>
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<tr>
<td>Testicular</td>
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<td>100.0%</td>
</tr>
<tr>
<td>Upper Gastrointestinal</td>
<td>88.9%</td>
<td>88.9%</td>
<td>93.5%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>97.0%</td>
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<tr>
<td>Urological</td>
<td>85.0%</td>
<td>86.5%</td>
<td>83.0%</td>
<td>83.0%</td>
<td>98.6%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Total</td>
<td>84.2%</td>
<td>83.7%</td>
<td>91.2%</td>
<td>92.1%</td>
<td>97.3%</td>
<td>100.0%</td>
<td>97.6%</td>
<td>97.5%</td>
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*Pre-validation - subject to change
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<tr>
<th>Specialty</th>
<th>&lt;18Wks</th>
<th>18Wks+</th>
<th>% &lt;18Wks</th>
<th>&lt;18Wks</th>
<th>18Wks+</th>
<th>% &lt;18Wks</th>
<th>&lt;18Wks</th>
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<td>30</td>
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<tr>
<td>Trauma &amp; Orthopaedics</td>
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<td>577</td>
<td>23</td>
<td>96.17%</td>
<td>1409</td>
<td>63</td>
<td>95.72%</td>
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<td>Ear, Nose &amp; Throat (ENT)</td>
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<td>23</td>
<td>63.49%</td>
<td>619</td>
<td>35</td>
<td>94.41%</td>
<td>1063</td>
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## Diagnostics (DM01) - Patients Still Waiting at Month End
### July 2018

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BOARD MEETING: 28 August 2018

Agenda item: 314/18(a)

Report: Quality Report
Presented by: Chris Morley, Chief Nurse
Author(s): Helen Dobson, Deputy Chief Nurse

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Partners: Securing the future together

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
BAF: B1, B4, B7
Corporate Risk Register: 3908, 4733, 4174, 4080

Purpose of this paper:
To summarise a set of quality indicators and to provide assurance to the Board of Directors. This report complements the information presented in the Integrated Performance Report. A range of quality indicators are included in this report. Over time they may change as the narrative changes to reflect the content of the Integrated Performance Report.

Summary of Key Points:
The key points arising from the report are:

- There has been an improvement to the Classic Harm Free Score this month.
- Complaints responded to within the agreed timescale has reduced slightly to 93%.
- Of the 91 student nurses initially offered posts, 49 are currently expected to commence in September/October.
- There has been a further increase in completion of Initial Health Assessments for Looked After Children within 20 days. Actions to address the need for further improvements in the level of performance continue.
- The Trust has provided the Care Quality Commission with the required level of assurance around two inspected services following the unannounced focused inspection in July.

Board action required: For noting
1.0 Harm Free Care

1.1 The Classic ‘Harm Free’ Care score for the Trust has increased this month to 95.5% from 91.7% in June (this was amended to 93.7% externally once the data validation error was rectified). The error affecting last month’s results has now been resolved internally.

2.0 Complaints

2.1 The Trust received 92 concerns (79 in June) and 21 formal complaints (30 in June) in the month of July. 21 (93%) complaints were closed within 30 working days. Of the formal complaints received 5% (1) was risk rated as red, 19% (4) as amber and 76% (16) as yellow.

3.0 Friends and Family Test (FFT)

3.1 The Trust FFT positive scores for July were 96.9% for inpatients (97.5% in June) and 99.2% for day case (98.6% in June). The combined national average for these two areas remains at 96%. Maternity services remained at 98.1% in July (98.1% in June /97% national average), 96.2% for outpatients (98.3% in June/national average 94%). The Urgent and Emergency Care Centre achieved 94.5% (97.8% in June /national average 87%).

3.2 The Community positive score for July was 97.8% (95.9% in June/national average 95%).

4.0 Nurse Staffing Report

4.1 There has been an increase in Registered Nurse fill rates on days when compared to those for June; the fill rates on nights were marginally worse than those for June. There has been a small reduction in Healthcare Support Worker shift fill rates on both days and nights in July. Please see appendix 1.

4.2 The overall vacancy rate has marginally increased during July 2018; the largest number of vacancies continues to be in the Division of Medicine.

4.3 Of the 91 conditional offers made to soon-to-qualify nurses at the Trust recruitment open day and subsequent interviews, 41 of these have since withdrawn following successful interview at other local Trusts, 49 are due to qualify and start at TRFT in September / October 2018 and 1 is due to qualify and start in March 2019. This is a slight reduction from the 52 expected new starters reported in July.

4.4 On a shift by shift basis senior nurses redeploy staff to ensure that wards and additional capacity areas are appropriately staffed, including moving staff from areas which have actual staffing higher than required for the actual occupancy and case mix. These moves aim to consider seniority of staff and avoid moving newly qualified nurses if at all possible.

4.5 Ward A4 moved to Ward A3 on 27 July reducing the bed base from 34 to 27. Planned nurse staffing has been amended from this date to meet the requirements of the new bed base.
5.0 Looked After Children (LAC)

5.1 The number of Initial Health Assessments (IHA) completed within 20 working days (statutory) has increased between June (47%) and July (87.5%). It should however be noted that this improvement is as a result of a number of unattended appointments. Had all IHA’s booked taken place the compliance rate would have been 63.6%.

5.2 16 IHAs were completed in July, of which 14 were within 20 working days. Thirteen appointments didn’t proceed because either the child was not brought, the appointment failed on the day or the appointment was cancelled at short notice. Rescheduling these appointments will therefore have a detrimental impact on future months’ compliance against the 20 working day target.

5.3 A more detailed paper on the issues associated with meeting the LAC IHA target was discussed at the August meeting of the Quality Assurance Committee.

6.0 Care Quality Commission (CQC)

6.1 The CQC attended the Trust on 17th July for a focused unannounced inspection. The two areas of focus were care of respiratory patients with an emphasis on non-invasive ventilation and the paediatric pathway through the Urgent and Emergency Care Centre to the Paediatric Ward and onward external transfer. Following this, the Trust were asked to submit further evidence to provide assurance regarding the provision of these services.

6.2 The additional evidence was submitted to the CQC on 10th August. The Trust have been informed that this provides the required level of assurance. The Trust will continue to liaise closely with the CQC to ensure that identified actions continue to be enacted.

6.3 The Trust continues to prepare for the Well Led, Core Services and Use of Resources inspections during autumn 2018. This includes reviewing the information included in the Provider Information Request (PIR) to identify any issues that can be improved, undertaking briefing sessions to give staff the confidence to ‘sell’ their services, and learning from other organisations about how to prepare. Mock interviews and inspections of services have been arranged and commence during August.

6.4 The Board of Directors received further information on the forthcoming inspections at their seminar in August.

7.0 Quality Assurance Committee Update

7.1 The Committee received reports on three of the 2018/19 Quality Improvement Priorities, outlining proposals for how these will be delivered and monitored over the year. The rolling presentation programme enables all nine priorities to be presented each quarter. Reports presented this month were learning from the views of inpatients, missed or delayed diagnosis and effective outcomes for women and babies.

7.2 Monthly reports were received and discussed regarding Infection Control, and Looked After Children.
7.3 The Deputy Chief Nurse presented the first version of a new quarterly report on patient safety. Which triangulated information from a number of sources including incidents, serious incidents, inquests and claims. The report highlighted some of the learning from incidents and how this was being addressed.

7.4 Annual reports were received and discussed in relation to medical equipment safety, external visits, accreditations and inspections and health and safety.

7.5 A report was discussed regarding the learning from the Gosport Independent Panel Report. Good assurance was provided on all areas with a further audit being undertaken to strengthen assurance regarding the use of morphine.

7.6 The process for setting the quality priorities for 2019/20 was discussed and recognised to be more robust than previous years.

8.0 Hospital Acquired Infections

8.1 2018/19 trajectory is for zero cases. 1 hospital acquired case from April.

8.2 Clostridium difficile infection: The 2018/19 hospital trajectory is 25 cases. There have been 3 hospital acquired cases under the 2018/19 Public Health England (PHE) reporting algorithm which is what will be reported nationally.

8.3 Gram negative bacteraemia: National mandatory surveillance of gram negative bacteraemia is for the specific organisms of E.coli, Klebsiella species and Pseudomonas aeruginosa. No trajectory for providers was set but Clinical Commissioning Groups (CCG) were challenged to reduce cases within each CCG by 10%.

E. coli: 83 reported through the laboratory, 4 of these are from CCGs other than Rotherham. 12 are hospital acquired, 61 community acquired.

Klebsiella species-3 hospital acquired, 11 community.

Pseudomonas aeruginosa – 0 hospital acquired & 3 community acquired case.

8.4 There are a number of risk factors for gram negative bacteraemia with the best recognised being urinary catheterisation. A review of each case includes checking if the patient is under the care of the Continence team and very few of the cases identified through the Rotherham Microbiology laboratory have been under the team’s care.

8.5 The Infection Prevention and Control (IPC) team are working with the CCG IPC Nurse and the Local authority looking at other possible risk factors and prevention ideas with work with care homes in terms of education around hydration and continence hygiene already in progress.

8.6 There have been recent cases of patients with Tuberculosis (TB) being admitted to the Trust. Work is continuing, led by Public Health England, to manage these cases and to ensure that any potential contacts are traced and screened.
9.0 Dementia, Delirium and Person-Centred Care

9.1 The Dementia, Delirium and Person-Centred Care Group is progressing and monitoring a number of actions including use of ‘This is Me’ booklets, development of a new Person-Centred Care strategy, continuing to promote the ethos of ‘EndPJParalysis’ and completion of the National Audit of Dementia.

9.2 Collaborative working continues to address performance in relation to dementia assessments. This was 88.4% in June (82.1% in May) against a target of at least 90%.

10.0 Conclusion

10.1 The majority of areas are reporting similar performance to last month with some minor variation. In particular, Harm free Care, Looked After Children assessments and Dementia Assessments have increased.

10.2 Whilst as expected there continues to be slight attrition (3) in expected numbers of newly qualified nurses to commence employment in the autumn, there are currently 49 expected to join the Trust.

10.3 The Trust has provided the Care Quality Commission with the required level of assurance around two inspected services following the unannounced focused inspection in July. Preparations for further inspections continue.

Helen Dobson
Deputy Chief Nurse
August 2018
Appendix 1

Nurse Staffing report

1. Registered Nurse/Midwife (RN/M) shift fill rates (daytime) were 85.9% in July 2018 compared to 83.8% in June 2018 and 93.3% on nights compared with 94.0%. Healthcare Support Worker (HCSW) fill rates were 106.9% on days compared with 111.2% in June and for nights were 105.3% compared with 108.0%.

2. Ten in-patient areas had Registered Nurse fill rates (days) below 90%. These were A1, A2, A4, A5, A7, AMU, Community Unit, Stroke Unit, Fitzwilliam and Keppel. Of these, seven had a day time shift fill rate less than 80% and these were; A1 at 67.4% compared with 66.2% in June, A2 at 75.7% compared with 71.3%, A4 at 72.3% compared with 64.8%, A5 at 63.3% compared with 60.1%, AMU at 79.3% compared with 75.3%, Stroke Unit at 66.7% compared with 65.4% and Keppel at 66.1% compared with 70.8% in June.

3. Two areas had a fill rate below 80% on nights; these were AMU at 79.9% and Keppel at 77.6%. It should be noted that Keppel ward have been undertaking a trial with a planned reduction of RNs on night shifts from three to two, however this is not currently reflected in the eRoster template, therefore the percentage fill rate for this ward should be viewed with caution. The Division will present the outcome of the trial to the Chief Nurse and seek approval for an amendment to the ward staffing template.

4. There was 1 shift in the month with over 50% of RNs on duty being within the 12 month preceptorship period compared 5 in June. There has been an increase in the percentage of Registered Nurses/Midwives flexible staffing (internal bank) in the Division of Family Health and a reduction in the Divisions of Medicine and Surgery resulting in an overall increase. RN agency usage has marginally reduced in the Division of Medicine and increased in the Division of Surgery, there was no RN/M agency usage in the Division of Family Health during July. The percentage of shifts not staffed to plan has increased to 30.39% in July as compared with 28.18% in June.

5. There were no internal staffing never events relating to one Registered Nurse on duty during July 2018.

6. In the Community sickness absence has slightly increased with 7.7% currently absent from work compared with 7.05% last month. The majority of which are long term sickness, maternity related sickness and colleagues having planned surgery/treatment. There was a deficit of 5.1% of District Nurses against plan, which represents a worse position compared with June at 3.9% and can be accounted for by the increase in sickness and the school holidays.

7. Care Hours per Patient Day (CHpPD) is a metric introduced following Lord Carter’s review of efficiency in the NHS[1] to record a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. During July the overall actual CHpPD is 7.2 compared with 7.0 in June.

8. As of 31 July 2018 the overall nursing and HCSW vacancy is in a negative position at -176.65 wte compared with -174.74 at 30 June 2018. The position when recruitment plans are included is -82.91 as at 31 July 2018 compared with -76.38 wte at 30 June 2018.

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The overall band 5 vacancy has increased and remains in a negative position of -75.26 wte compared with -71.92 at 30 June 2018.

The band 2 vacancy is in a negative position at -41.01 wte, however it should be noted that although this has reduced slightly this month, the number remains high as a result of the reconfiguring of ward establishments in the Division of Medicine. Recruitment to these posts is currently underway.

9. 91 conditional offers were made to soon-to-qualify nurses at the Trust recruitment open day on 24 March and subsequent interviews on 19 April. 41 of these have since withdrawn following successful interview at other local Trusts. 49 are due to qualify and start at TRFT in September 2018 and 1 is due to qualify and start in March 2019. Colleagues are maintaining regular contact with those offered posts in an attempt to maintain their interest in TRFT as their preferred place to work and to covert the conditional offers to actual starters.

10. A recruitment open day is planned to take place on 18 August 2018 particularly aimed at nurses due to qualify in March 2019. Interviews will be held on the day for those wishing to be interviewed. A further date is set for interviews on 19 September 2018 for those who are unable to attend the open day or have a preference to be interviewed on this date.

11. The Division of Integrated Medicine held two evening recruitment events during July and have made six conditional offers to experienced RNs.

12. Ward A4 moved to Ward A3 on 27 July reducing the bed base from 34 to 27. Planned nurse staffing has been amended from this date to meet the requirements of the new bed base.
Report: Clinical Report

Presented by: Dr Carrie Kelly, Acting Medical Director
Author(s): As above

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Finance: Strong, financial foundations
Partners: Securing the future together

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
BAF: B1
Corporate Risk Register: 4080, 4174, 4933, 4935, 4936, 5052, 5068, 5100, 3813, 4877, 5076, 4384, 4762

Purpose of this paper:
This paper intends to provide the Board with an update on the Trust wide mortality position.

Summary of Key Points:
The Trust’s current position, following the national rebasing of Hospital Standardised Mortality Ratio (HSMR), up to May 2018 shows an improved position from last month.

The figure in the report is 105.4 and the national peer figure of 99.1. This sets the Trust at a 6.3 variance from the national average, this is the best position for the Trust for the last few months. Understandably it is the summer months where mortality is expected to be lower.

Board action required: The Board is asked to note this report.
1.0 **Introduction**

1.1 This report provides an update to the Board on a number of clinical governance matters.

2.0 **Mortality**

2.1 The Trust position on HSMR is 105.4 which is an improvement on the last few months where the figure has been higher.

2.2 The report attached at Appendix 1 includes two new sets of data in section A which show the national peer HSMR so that we can clearly identify whether we have a genuine improvement or there is a fall in the national average.

2.3 The HSMR has recently been rebased and as such the national figure is close to 100 as would be expected from a recently rebased target.

2.4 The data being reported is up to the end of May 2018.

2.5 The crude rate of mortality in proportion to discharges has seen a significant decrease with 74 deaths in the month, putting the crude rate in percentage of discharges slightly above 1.33% with a 3-month total of 1.59%.

2.6 Weekend crude rate has seen a decrease in trend on both days Saturday as having an increased rate compared to Sunday but overall a rate of 2.83%.

2.7 If analysing the mortality by day of admission it is seen that the weekend remains an issue as observed vs expected is more marked difference than other days of the week. It is seen that on all days there have been negative percentage changes since the previous period except for Tuesday but with Monday the only day that there are less than expected deaths than observed.

2.8 Again the Trust is pleased to report the length of stay in hospital Summary Hospital-level Mortality Indicator (SHMI) for zero days is still recording a downward trend with 35 less deaths than expected for the period. Zero days, 1 day, and 2 days’ length of stay and over 21 days’ length of stay, have all seen fewer deaths than expected.

2.9 In view of this it may be important to look at the period which is not highlighted to determine why the HSMR is above the national average. This has not been looked at previously and may explain some of the findings.

2.10 The crude mortality for the 21 days and over has shown the most marked improvement. The reported figure is 3.03% as opposed to 9.62% in the previous period.

2.11 There are some highlighted alerts on the Cumulative Sum (CUSUM) charts which will be analysed further. Septicaemia is currently the area where focus should start. The Trust has implemented many initiatives with regard to sepsis and these should be reviewed with vigour to avoid any further deterioration in the mortality figures.

2.12 The other alerts highlighted have fewer numerator cases and further analysis would not be beneficial with case numbers less than 20. These will obviously still be on the Mortality Group radar should further alerts be added.
2.13 The Mortality Group will be reinvigorated this month to ensure that there is continued focus on mortality is present throughout the Trust.

3.0 Research & Development (R&D) – Research Activity Report

3.1 The number of recruits into clinical research studies on the National Institute for Health Research (NIHR) Clinical Research Network portfolio at The Rotherham NHS Foundation Trust is 644, including 320 for Yorkshire Health Study, against a target of 550 for the financial year 2018/19 [data cut 15 August 2018, taken from NIHR]

3.2 There are 83 studies that are currently active (recruiting or in follow up), listed in Appendix 2.

3.3 There are 12 new studies in set up including 3 commercially sponsored studies.

3.4 Current funding for R&D includes the Clinical Research Network 17/18 allocation of £218,780, £20,000 Research Capability Funding, and commercial and non-commercial research income of £31,320 in the financial year 18/19 to date.

3.5 The team has been shortlisted in the Clinical Research Nursing category of the Nursing Times award for Advancing Patient Care Through Research in Rotherham, with the finalist to be decided in October 2018.

Dr Carrie Kelly
Acting Medical Director
August 2018
## Mortality Data

### 1. HSMR (Moving Annual Average) - Jun 17 to May 18

<table>
<thead>
<tr>
<th>HSMR 12 month rolling</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
<th>Apr-18</th>
<th>May-18</th>
</tr>
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<tbody>
<tr>
<td>THE ROTHERHAM NHS FOUNDATION TRUST</td>
<td>113.5</td>
<td>112.1</td>
<td>110.0</td>
<td>109.0</td>
<td>108.2</td>
<td>109.3</td>
<td>108.1</td>
<td>108.2</td>
<td>107.7</td>
<td>109.2</td>
<td>108.3</td>
<td>105.4</td>
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<tr>
<td>National Peer</td>
<td>99.7</td>
<td>99.4</td>
<td>99.1</td>
<td>99.2</td>
<td>98.7</td>
<td>98.5</td>
<td>98.9</td>
<td>98.8</td>
<td>99.1</td>
<td>100.1</td>
<td>99.8</td>
<td>99.1</td>
</tr>
<tr>
<td>Variance from the national peer</td>
<td>+13.8</td>
<td>+12.7</td>
<td>+10.9</td>
<td>+9.8</td>
<td>+9.4</td>
<td>+10.7</td>
<td>+9.2</td>
<td>+9.4</td>
<td>+8.6</td>
<td>+9.1</td>
<td>+8.4</td>
<td>+6.3</td>
</tr>
</tbody>
</table>

Note: HSMR has recently been rebased which will shift HSMR values higher

### 2. SHMI - Jan to Dec 17

<table>
<thead>
<tr>
<th>Provider</th>
<th>Spells</th>
<th>Expected</th>
<th>SHMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE ROTHERHAM NHS FOUNDATION TRUST</td>
<td>41,546</td>
<td>1,345.43</td>
<td>109.04</td>
</tr>
</tbody>
</table>

Note: NHS Digital publish SHMI every quarter (usually at the end of Jan, Apr, Jul, Oct)
<table>
<thead>
<tr>
<th>BTR REF</th>
<th>TITLE</th>
<th>SPECIALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-06-02</td>
<td>Yorkshire Health Study</td>
<td>Public Health</td>
</tr>
<tr>
<td>17-06-03</td>
<td>Stroke: MUSCAT</td>
<td>Neurology</td>
</tr>
<tr>
<td>17-06-04</td>
<td>Select a randomized controlled trial of a safer sex intervention</td>
<td>Infectious Diseases and Microbiology</td>
</tr>
<tr>
<td>17-06-05</td>
<td>Development of a population in chief</td>
<td>Obstetrics</td>
</tr>
<tr>
<td>17-06-06</td>
<td>Cancer Prognosis and Emergency Presentation Study (cPenPS) v2.0</td>
<td>Oncology</td>
</tr>
<tr>
<td>17-06-07</td>
<td>Head &amp; Neck OOD follow-up Study</td>
<td>Cancer</td>
</tr>
<tr>
<td>17-06-08</td>
<td>UKMMP: ST</td>
<td>Children and young people</td>
</tr>
<tr>
<td>17-06-09</td>
<td>MEASURES</td>
<td>Dermatology</td>
</tr>
<tr>
<td>17-06-10</td>
<td>CARE OUT (prevalent and high risk type 1 diabetes cohort) — ADDRESS-2</td>
<td>Diabetes</td>
</tr>
<tr>
<td>17-06-11</td>
<td>Ultrasound for Portal Path (supF))</td>
<td>Paediatrics and Child Health and Paediatrics</td>
</tr>
<tr>
<td>17-06-12</td>
<td>CARD 855 (Diabetes)</td>
<td>Cardiology</td>
</tr>
<tr>
<td>17-06-13</td>
<td>Trinity from Diagnostic therapy (SWIFT)</td>
<td>Musculoskeletal disorders</td>
</tr>
<tr>
<td>17-06-14</td>
<td>ABC-35</td>
<td>Anaesthesia</td>
</tr>
<tr>
<td>17-06-15</td>
<td>Anti-GoP</td>
<td>Cancer</td>
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<tr>
<td>17-06-16</td>
<td>PUP</td>
<td>Surgery</td>
</tr>
<tr>
<td>17-06-17</td>
<td>GC</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>17-06-18</td>
<td>QPM</td>
<td>Cardiology</td>
</tr>
<tr>
<td>17-06-19</td>
<td>Use-Audit Spectrum Cohort—OAC</td>
<td>Obstetrics and Child Health</td>
</tr>
<tr>
<td>17-06-20</td>
<td>Bridging the Age Gap in Breast Laser</td>
<td>Cancer</td>
</tr>
<tr>
<td>17-06-21</td>
<td>PREDNOS 2</td>
<td>Obstetrics and Child Health</td>
</tr>
<tr>
<td>17-06-22</td>
<td>PREDNOS</td>
<td>Cancer</td>
</tr>
<tr>
<td>17-06-23</td>
<td>HEPSP</td>
<td>Respiratory Medicine</td>
</tr>
<tr>
<td>17-06-24</td>
<td>High Intensity Specialist Led Acute Care (HILAC) Project</td>
<td>Consultants Trust-Wide</td>
</tr>
<tr>
<td>17-06-25</td>
<td>HIAB /C</td>
<td>Obstetrics and Child Health</td>
</tr>
<tr>
<td>17-06-26</td>
<td>HIAB/TOP</td>
<td>Dermatology</td>
</tr>
<tr>
<td>17-06-27</td>
<td>SMART End-to-End online survey</td>
<td>Cardiology</td>
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<tr>
<td>17-06-28</td>
<td>RPM</td>
<td>Cardiology</td>
</tr>
<tr>
<td>17-06-29</td>
<td>All-Angle Surveys Rehabilitation</td>
<td>Orthopaedics</td>
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<tr>
<td>17-06-30</td>
<td>Investigation of wellbeing (interventions in both Staff—Neighbour 1)</td>
<td>Health Services and Delivery Research</td>
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<tr>
<td>17-06-31</td>
<td>The Right Study</td>
<td>Haematology</td>
</tr>
<tr>
<td>17-06-32</td>
<td>Evaluation Cancer Research-Based Cancer Improvement Program</td>
<td>Cancer</td>
</tr>
<tr>
<td>17-06-33</td>
<td>JSI/Fast Track Focused Exploration</td>
<td>Cancer</td>
</tr>
<tr>
<td>17-06-34</td>
<td>Social Care study of Diagnostic assessment: Ambulance presence</td>
<td>Health Services and Delivery Research</td>
</tr>
<tr>
<td>17-06-35</td>
<td>SUCCEED Summary Project Outcome</td>
<td>Genitourinary Medicine and Urology</td>
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**In Follow Up**

<table>
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<tr>
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<tr>
<td>06-06-01</td>
<td>REACT</td>
<td>Cancer</td>
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<td>06-06-02</td>
<td>NOES</td>
<td>Oncology</td>
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<td>06-06-03</td>
<td>EUP</td>
<td>Diabetes</td>
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<td>06-06-04</td>
<td>NEXA</td>
<td>Cardiovascular</td>
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<td>06-06-05</td>
<td>OBDX</td>
<td>Cardiovascular</td>
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<td>06-06-06</td>
<td>TMBX</td>
<td>Cardiovascular</td>
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<tr>
<td>06-06-07</td>
<td>ARMS</td>
<td>Injuries and Emergency</td>
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<tr>
<td>06-06-08</td>
<td>PS</td>
<td>Urology</td>
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<tr>
<td>06-06-09</td>
<td>PREDNOS</td>
<td>Health Services and Delivery Research</td>
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<tr>
<td>06-06-10</td>
<td>PREDNOS</td>
<td>Cancer</td>
</tr>
<tr>
<td>06-06-11</td>
<td>Impact of vascular condition on quality of life</td>
<td>Cardiology</td>
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**Non-Portfolio Studies**

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<thead>
<tr>
<th>BTR REF</th>
<th>TITLE</th>
<th>SPECIALITY</th>
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</thead>
<tbody>
<tr>
<td>17-03-01</td>
<td>Evaluating the age extension to the NHS breast screening Programme</td>
<td>Cancer</td>
</tr>
<tr>
<td>17-03-02</td>
<td>The after prostate cancer</td>
<td>Cancer</td>
</tr>
<tr>
<td>17-03-03</td>
<td>Smart COPD</td>
<td>Respiratory Medicine</td>
</tr>
<tr>
<td>17-03-04</td>
<td>Data linkage for urgent care data</td>
<td>Injuries and Emergency</td>
</tr>
<tr>
<td>17-03-05</td>
<td>Barrier to routine rehabilitation in haematopoietic stem cell Transplant</td>
<td>Haematology</td>
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<tr>
<td>17-03-06</td>
<td>Trust-Wide</td>
<td>Public Health</td>
</tr>
<tr>
<td>17-03-07</td>
<td>CARD 855</td>
<td>Cancer</td>
</tr>
<tr>
<td>17-03-08</td>
<td>Impact of vascular condition on quality of life</td>
<td>Cardiology</td>
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</table>

**Supporting Post Graduate Qualifications**

<table>
<thead>
<tr>
<th>BTR REF</th>
<th>TITLE</th>
<th>SPECIALITY</th>
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<tbody>
<tr>
<td>17-03-09</td>
<td>Women with Gestational Diabetes</td>
<td>Health Services and Delivery Research</td>
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<tr>
<td>17-03-10</td>
<td>Measurement of Heparin Variability</td>
<td>Cardiology</td>
</tr>
<tr>
<td>17-03-11</td>
<td>Cardiac Rehabilitation Study</td>
<td>Cardiovascular Medicine</td>
</tr>
<tr>
<td>17-03-12</td>
<td>Analysis of electronic prescription in UK hospitals</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>17-03-13</td>
<td>The role of self compassion in practice and related adjustment and wellbeing</td>
<td>Haematology</td>
</tr>
<tr>
<td>17-03-14</td>
<td>Evaluation of Markers for Early Diagnosis for the Development of a Seizure Panel</td>
<td>Biomedical Science</td>
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**Sponsored by TRT**

<table>
<thead>
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<th>BTR REF</th>
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<tbody>
<tr>
<td>06-03-01</td>
<td>Prostate cancer</td>
<td>Haematology</td>
</tr>
<tr>
<td>17-03-02</td>
<td>Motion in Knee Arthroscopy</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>17-03-03</td>
<td>Improving quality of life for patients and carers living with Interstitial Lung Disease</td>
<td>Respiratory Medicine</td>
</tr>
<tr>
<td>17-03-04</td>
<td>SUCCEED</td>
<td>Cardiology</td>
</tr>
<tr>
<td>17-03-05</td>
<td>Introduction to Interdisciplinary Education (towards OVER-30 Support)</td>
<td>Dental and Oral Health</td>
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**No C&C Studies**

<table>
<thead>
<tr>
<th>BTR REF</th>
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<th>SPECIALITY</th>
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<tbody>
<tr>
<td>17-03-06</td>
<td>Breast cancer matching in fertility clinics</td>
<td>Obstetrics and Gynaecology</td>
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<tr>
<td>17-03-07</td>
<td>Clinical leader’s views on UK cartels of patient survey questions</td>
<td>Health Services and Delivery Research</td>
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<tr>
<td>17-03-08</td>
<td>Evaluating the ten year impact of the Production Ward</td>
<td>Health Services and Delivery Research</td>
</tr>
<tr>
<td>17-03-09</td>
<td>Referral—Referral for Life and Emergency Departments (local)</td>
<td>General practice</td>
</tr>
</tbody>
</table>
Operational Performance Report

George Briggs, Chief Operating Officer

Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Finance: Strong, financial foundations
Partners: Securing the future together

NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring /responsive / well-led

B1 B2 B4

As appropriate

Purpose of this paper

This paper provides an overview of performance, for each key operational indicator, for July 2018, summarising headline progress and actions being taken to address operational objectives.

Summary of Key Points

Sustainability and Transformation Standards

- Emergency 4-hour Access target – July 2018 position: 86.6% the submitted trajectory was 86%. The year to date position is 88.1%
- The Rotherham Cancer 62 Day position for Quarter 1 (Q1) 2018 is 83.3% after reallocations against the 85% compliance target
- Diagnostics (DMO1) – the un-validated position for DMO1 for July 2018 is 0% this reflects 0 breach
- 18 week Referral to Treatment (RTT) incomplete pathway – unvalidated position for June 2018 is sustained at 94.5% (94.3% previous month)

Action Required

For noting.
1.0 **Introduction**

This paper covers key operational indicators, an overview of performance in July 2018, summarising headline progress and actions being taken to address areas of concern and deliver improvements.

2.0 **Four-hour emergency access target**

2.1. Performance for July 2018 against the 4-hour access target was 86.6% and this shows a deterioration in last month. The trajectory is 86%, therefore, we are slightly above trajectory.

The Quarter 2 (Q2) position is at 86.84% (as at end of July 2018) putting us 80th out of 131 Trusts nationally.

The initial results for August so far show we are directly on trajectory as of 16 August 2018.

2.2 Performance has been linked to staff rota compliance which has been compromised over the last 2 months. Junior doctor availability has been reduced and summer holidays have had a considerable effect on the availability of permanent and locum staff. This has compromised the ability of the team to maintain a sustainable daily performance. Analysis has shown an increase in activity throughout June and July along with a large increase in breaches.
Total attends show a clear spike in activity at the start of July settling down in early August 2018.

The Trust closed 8 beds in the acute wards (A4) to facilitate a maintenance of staffing levels and this necessitated increasing community beds from 6 at the end of June to 14 in July 2018.

3.0 **Cancer**

3.1. The Rotherham 62-day cancer position for April 2018 is 83.7% after reallocations (unvalidated) slightly up from last month and above trajectory against the local Integrated Care System target of 80% but will remain below the national 85% compliance target.

![National performance cancer 62 days]

Rotherham is the black line
Summary Performance

<table>
<thead>
<tr>
<th>Target</th>
<th>Operational Standard</th>
<th>RFT Q1 2017/18</th>
<th>RFT Q2 2017/18</th>
<th>RFT Q3 2017/18</th>
<th>RFT Q4 2017/18</th>
<th>RFT Q1 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>2ww</td>
<td>93%</td>
<td>95.8%</td>
<td>94.9%</td>
<td>96.4%</td>
<td>93.4%</td>
<td>92.8%</td>
</tr>
<tr>
<td>31 Day First Definitive Treatment</td>
<td>96%</td>
<td>97.0%</td>
<td>98.4%</td>
<td>98.2%</td>
<td>96.6%</td>
<td>97.6%</td>
</tr>
<tr>
<td>62 Day from 2ww</td>
<td>85%</td>
<td>86.0%</td>
<td>86.5%</td>
<td>81.6%</td>
<td>81.8%</td>
<td>83.7%</td>
</tr>
<tr>
<td>Breast Symptoms 2ww</td>
<td>93%</td>
<td>94.7%</td>
<td>93.5%</td>
<td>94.8%</td>
<td>79.6%</td>
<td>72.1%</td>
</tr>
<tr>
<td>31 Day Subsequent Treatment Surgery</td>
<td>94%</td>
<td>97.0%</td>
<td>97.6%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Drug</td>
<td>98%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

3.2 The current forecast position against the 62-day cancer pathway is that Q2 will achieve the 85% compliance target. The position is complex and reliant upon a number of factors. We are half way through the quarter and have unvalidated 13.5 breaches. The best prediction is 12 more potential breaches.

3.3 A significant amount of work continues around the management of Cancer 62 Day to achieve the Q2 position with an unexpected challenge being that there were 8 more breaches than planned carried over from Q1 to Q2 due to pathways shared with the tertiary centre, not being closed in Q1. We are working very closely with the tertiary partner on how we address this, but the pressures they are experiencing are understood by system partners.

3.4 Focus remains on making sure we get patients to the tertiary centre by day 38, with a number of actions having been taken to support this. As a result of the work that we have undertaken, our referral rate has improved considerably over recent months and is now being recognised.

3.5 Summary – we are on the limit of Q2 being achievable, currently being at 84.4% against a target of 85%. The highest level of proactive escalation remains in place with most specialties on deep dive level review through weekly Patient Tracking List.

4.0 18 Week RTT Incomplete

4.1 The unvalidated position for May 2018 is 94.5% against the 92% 18 week RTT incomplete target. This represents a continued strong operational performance against this performance metric.

4.2 This puts the Rotherham NHS Foundation Trust (RNHSFT) in the upper quartile performance in the country. Over 60% of Trusts are failing the standard nationally.

4.3 Gynaecology

Gynaecology is the main area of concern within our 18-week programme and 200 patients are showing at 18 weeks plus with a performance of 84.4%. The service has implemented the following actions to ensure recovery:
• The joint post with Sheffield Teaching Hospitals NHS Foundation Trust has commenced
• An additional full day list has also commenced alternate weeks within our theatres which will alleviate the pressures
• Gynaecology Medinet proposal
  o The Gynaecology team are planning on using Medinet to fill vacant theatre slots
  o The company provide staff and expertise to undertake theatre lists including:
    ▪ Gynaecologists
    ▪ Theatre staff
    ▪ Scrub nurses
    ▪ Recovery and ODP staff
    ▪ Portering etc.
  o Available on a weekend or mid-week

We have also reviewed outsourcing options to prevent a further deterioration, and have a cost neutral option with a national provider, if required.

4.4 Cancelled Operations

27 patients had a cancellation in July 2018, due to:

5 ran out of time
7 overran
4 equipment issues
2 beds
2 HDU beds
7 others

5.0 6 Week Wait Diagnostic Tests

5.1 The unvalidated position for DMO1 for June 2018 is 0%, which shows 0 people waited 6 weeks or longer for diagnostic tests.

6.0 Operational Objectives update July 2018

<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale &amp; SRO</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Bed state management across inpatient areas</td>
<td>September 2018</td>
<td>Project scoping discussion held in May. Specification to be developed and examples from other providers sought. The project pilot is underway developing an initial project.</td>
</tr>
<tr>
<td>Develop a more accurate assessment of demand and capacity for community district</td>
<td>September 2018</td>
<td>Demand and capacity modelling has been added to</td>
</tr>
<tr>
<td>nursing</td>
<td>Associate General Manager – Head of Performance</td>
<td>the acute and community program and initial model developed using internal skills and external company Goo-roo</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A more integrated demand and capacity modelling tool across the Trust which takes cognisance of the community and acute services</td>
<td>Monthly General Manager – Surgery</td>
<td>Above trajectory and above national target</td>
</tr>
<tr>
<td>Deliver 18 week RTT standard at or above 17/18 performance As per trajectory Monthly</td>
<td>Monthly General Manager – Clinical Support Services</td>
<td>Above trajectory and above national target</td>
</tr>
<tr>
<td>Deliver 6 week wait diagnostics at or above 17/18 performance As per trajectory</td>
<td>Monthly General Manager – Clinical Support Services</td>
<td>Above local ICS cancer alliance trajectory of 80% and below 85% national target</td>
</tr>
<tr>
<td>Deliver 62-day GP referral on quarterly basis As per trajectory</td>
<td>Monthly General Manager – Clinical Support Services</td>
<td></td>
</tr>
<tr>
<td>Commence reporting against 28 day standard</td>
<td>June 18 General Manager – Clinical Support Services</td>
<td>Local shadow requirement from July 18</td>
</tr>
<tr>
<td>Deliver DTOC performance below 3.5% standard As per trajectory</td>
<td>Monthly Head of Nursing - Operations</td>
<td>DTOCs (delayed transfers of care) are monitored daily and are averaging below 2%</td>
</tr>
<tr>
<td>Maintain inpatient LOS within top-decile</td>
<td>Monthly General Managers</td>
<td>Continued performance at upper quartile</td>
</tr>
<tr>
<td>Improve 7 day services outcomes over weekends</td>
<td>March 2018 Programme Lead</td>
<td>Base line check complete focused work on the AMU and elderly wards to improve discharges admissions and ward rounds. National audit showing 87% initial standard above the 85% standard Update attached Aug 18</td>
</tr>
<tr>
<td>Achieve month-on-month performance improvement As per trajectory</td>
<td>Monthly</td>
<td>Performance over may has improved for all above apart from cancer 2week waits for breast</td>
</tr>
<tr>
<td>Achieve 90% 4 hour access performance As per trajectory</td>
<td>September 2018 90%</td>
<td>Performance above local trajectory at 89.8% (Local Trajectory 81%) National trajectory 90% end of September 2018</td>
</tr>
<tr>
<td>Achieve 95% 4 hour access performance As per trajectory Mar-19</td>
<td>March 2019 95%</td>
<td>National target 95% March 19</td>
</tr>
</tbody>
</table>

6.1 7 day services update

All Trusts are measured against the following key standards:

- Standard 2 - Patients wait no longer than 14 hours to first Consultant review from time of admission
• Standard 5 - Patients get access to diagnostic tests with a 24-hour turnaround time for urgent requests and 12 hours and for critical patients

• Standard 6 - Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols

• Standard 8 - Patients with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

Spring 2018 - 7 Day Services Survey Results:

We have received congratulations on our excellent results in spring 2018 7 Day Services Survey, reaching compliance against the four clinical priority standards:

<table>
<thead>
<tr>
<th>CS2 Revalidated</th>
<th>CS5 Revalidated</th>
<th>CS6 Revalidated</th>
<th>CS8 Revalidated</th>
<th>Number of Standards Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>93%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
<td>4</td>
</tr>
</tbody>
</table>

7.0 Improvement Planning

7.1 The Trust continues in its “Action on AE” program with a focus on Home First “Why not today why not now”.

7.2 The junior doctor rotas and the ENP ANP cover are reliant upon training posts and agency posts. The new doctor rota has commenced and staff are undertaking induction and training. Compliance with standards within the Emergency Department has been patchy.

The international recruitment has recruited 7 middle grades to support the Emergency Department and 7 to support General Medicine, all of whom have now been given visas by the home office, and all have formal GMC approval.

7.3 Auditing of wards re compliance with planned improvements has commenced with a disappointing results so far:

- Board rounds inconsistent and non-existent
- Ward rounds non-standard, no Consultant led rounds on a Wednesday in Medicine
- Minimal TTOs the night prior to discharge
- Discharge letters not complete
- Internal waits
8.0 **Conclusion**

Performance against the 4-hour access standard in July 2018 has been challenged considerably although on trajectory. We have seen some failures in performance over the last 2 months, with key operational points of failure around capacity within the Emergency Department and increased numbers of medically fit patients. Performance against the DMO1 diagnostic target in month has remained good.

Performance against the Cancer 62-day target has remained under the national standard a result of both activity demand and access across a number of pathways delays. Whilst action is underway to achieve Q2 as per revised plan, this remains a high risk.

Trust performance against the 18-week RTT incomplete target for the month continues to perform well.

George Briggs  
Chief Operating Officer  
August 2018
Report: Workforce Report

Presented by: Paul Ferrie – Interim Director of Workforce
Author(s): Danielle Hardy, Workforce Information Analyst

Strategic Objective:
 Patients: Excellence in healthcare
 Colleagues: Engaged, accountable colleagues
 Governance: Trusted, open governance
 Finance: Strong, financial foundations
 Partners: Securing the future together

Regulatory relevance:
 NHSI: Licence Condition FT4 / Single Oversight Framework
 CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
 BAF: B4, B5
 Corporate Risk Register: 2978, 2979, 4762, 4959, 3520, 3908, 4877, 5068, 5226, 4516, 4935,

Purpose of this paper:
This paper provides the Board of Directors with an update on key workforce issues.

Summary of Key Points:

- Staff in post in July 2018 is 3680.05 whole time equivalent (WTE), a reduction of 7.30 WTE compared to June 2018.
- Rolling 12 month sickness absence is 4.10%. Compared with July 2017 rolling 12 month sickness absence has decreased by 0.33%.
- In month sickness absence is 3.71% for July 2018, 0.24% below the 3.95% target. Compared with July 2017 in month sickness absence has decreased by 0.16%.
- Overall Personal Development Review (PDR) compliance for the organisation is 58.39%, target is to achieve 90% by the end of September.
  - All Board members and their first line reports completed their PDR in April.
  - In relation to budget holder appraisals; current compliance levels rate at 90.20%.
  - 90.42% of all band 7s and above have completed their PDR process.
- Senior clinical leadership development programme being developed for launch in quarter 3.
- The Trust's new occupational health contract and service provision will be implemented from 01 September 2018.

Board action required: For Noting
1.0 Recruitment and Retention

1.1. Turnover in July 2018 is 0.58% (99.42% retention), 0.24% increase against July 2017.

1.2. Clinical Support Services have had the most leavers in July 2018, 14 (12.05 WTE) followed by Family Health, 11 (10.44 WTE). The most popular leaving reason was relocation, 13 (9.44 WTE) followed by Voluntary resignation to undertake further education or training with 8 (6.10 WTE) leaving the Trust.

2.0 Sickness Absence

2.1. The Trust’s sickness absence for July 2018 is 3.71%, which is below the 3.95% target and is favourable when compared with July 2017; a 0.16% decrease.

2.2. Short term absence has decreased to 1.14% from previous month (1.65%) and long term sickness absence has increased to 2.57% from previous month (2.15%).

2.3. Rolling 12 month sickness absence level remains at 4.10%, however, compared with July 2017 the rolling 12 month sickness absence has decreased by 0.24%.

3.0 Mandatory and Statutory Training (MaST)

3.1 The Trust core MaST compliance has remained stable at 87%, 2% above the Trust target of 85%.

3.2 The table below highlights the Trust’s overall mandatory and statutory core training compliance by division, against the 85% target at the end of July 2018.

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>91.01%</td>
</tr>
<tr>
<td>Corporate Operations</td>
<td>90.92%</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>89.36%</td>
</tr>
<tr>
<td>Family Health</td>
<td>91.13%</td>
</tr>
<tr>
<td>Medicine</td>
<td>82.43%</td>
</tr>
<tr>
<td>Surgery</td>
<td>85.79%</td>
</tr>
</tbody>
</table>

3.3 The table below highlights the Trust’s mandatory and statutory core training compliance for each subject by division at the end of July 2018. Information Governance RAG rating is based upon divisional performance against the national target of 95%.

<table>
<thead>
<tr>
<th>Division</th>
<th>Conflict Resolution</th>
<th>Equality, Diversity and Human Rights - 3 Years</th>
<th>Equality, Diversity and Human Rights - No Specified Renewal</th>
<th>Infection Prevention and Control - Level 1 - 3 Years</th>
<th>Preventing Radicalisation - Levels 1 &amp; 2 (Basic Prevent Awareness) - 3 Years</th>
<th>Preventing Radicalisation - Levels 1 &amp; 2 (Basic Prevent Awareness) - No Renewal</th>
<th>Dementia Awareness - No Renewal</th>
<th>Fire Safety - 1 Year</th>
<th>Hand Hygiene - 1 Year</th>
<th>Information Governance - 1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>88.62%</td>
<td>94.31%</td>
<td>92.61%</td>
<td>96.47%</td>
<td>89.87%</td>
<td>97.50%</td>
<td>97.27%</td>
<td>85.55%</td>
<td>82.71%</td>
<td>89.42%</td>
</tr>
<tr>
<td>Corporate Operations</td>
<td>89.66%</td>
<td>96.98%</td>
<td>94.61%</td>
<td>97.63%</td>
<td>72.63%</td>
<td>81.47%</td>
<td>96.12%</td>
<td>93.32%</td>
<td>93.97%</td>
<td>92.89%</td>
</tr>
</tbody>
</table>
3.4 Compliance remains above the Trust target of 85%. Information Governance compliance has seen a reduction in compliance of 1%. To avoid the normal high volume of renewals in March 2019, the intention is to bring forward the 95% IG target to December 2018; which will provide an element of contingency to deliver this objective.

3.5 Two new competencies (Health, Safety and Welfare and Freedom to Speak Up) will be required from 01 April 2019. If these new competencies were included in the target now the MaST compliance rate would be 80.11%. (Improved from 77% last month).

4.0 **Personal Development Review (PDR)**

4.1 The Personal Development Review (PDR) compliance is now at 58.39% for the Trust. The table below shows overall PDR compliance by division at the end of July 2018:

<table>
<thead>
<tr>
<th></th>
<th>Count Complete</th>
<th>Count Complete</th>
<th>Count Complete</th>
<th>Count Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>865</td>
<td>543</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Corporate Operations</td>
<td>461</td>
<td>372</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>245</td>
<td>163</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Family Health</td>
<td>598</td>
<td>406</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medicine</td>
<td>1027</td>
<td>458</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Surgery</td>
<td>759</td>
<td>362</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>3955</strong></td>
<td><strong>2304</strong></td>
<td><strong>24</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>

4.2 PDR reviewer and reviewee workshops are still being delivered across the Trust; these are available for individual bookings; along with individual and team bespoke sessions being delivered on request. These workshops support colleagues to prepare and contribute towards a quality PDR.

5.0 **Leadership, Culture and Engagement**

5.1 The next Leadership, Exploration and Discovery (LEAD) cohort will be 17 - 21 September 2018. The next LEAD Forum event is on 04 September with a focus on Quality Improvement. The Chief Nurse will be speaking on this subject with the Deputy Chief Nurse from the NHS Improvement Academy. Learning and Development supported a Quality Improvement Masterclass for managers on 30 July, the outcomes will be used to inform the Trust’s Quality Improvement Programme.

5.2 Learning and Development have launched an approach which will ensure clear, comprehensive engagement with local schools around their careers agenda.

5.3 Following completion of the procurement process a scoping meeting was held on 16 August with the new supplier (Maquire Healthcare) to support the Trust develop
a senior clinical leadership programme. The training content will be finalised and the programme launched in quarter 3.

5.4 At the end of July there are 238 active Nursing mentors - 66% of the 80% target and an increase of 8% since last month. There are currently 45 members of staff booked on to attend a mentor update.

5.5 The 5 Trainee Nursing Associate Apprentices (existing staff) have now commenced in their roles working on the medical and surgical wards and are all now attending their required alternative placements one day each week with our District Nursing and Integrated Rapid Response teams. Also, to meet the Nursing and Midwifery Council requirements, each of our Trainee Nursing Associate apprentices will also spend time on placement in mental health within RdASH.

5.6 Existing staff were interviewed to start the Assistant Practitioner Foundation Degree Apprenticeship in September 2018 and January 2019. We are currently offering 12 staff the opportunity to commence this programme. We are also now looking at establishing a "Buddy Group" with our year 1 and 2 staff who are on the course.

5.7 The 20 staff studying the Level 2 Functional Skills qualifications in English and Maths, within the Trust, to support increasing interest in Assistant Practitioner apprenticeship and Trainee Nurse Associate roles are due to take their exams this month which will support their progression onto higher level training programmes.

5.8 Abiola Lugboso, Assistant Practitioner in Therapy Services will represent the Trust at the World Skills national finals at the NEC in Birmingham which will take place in November.

6.0 Medical Digital Programme (Allocate Optima)

6.1 Medic On-Line (leave management) – this has successfully been implemented across all Divisions with the exception of Anaesthetics who currently utilise a separate IT system (this is to be reviewed with the Clinical Lead).

6.2 e-Job Plan – 137 out of 180 individuals have been trained on the system; training continues on a 1:1 basis as required and has also been arranged in the community for Palliative Care. Out of 156 job plans on the system, there are currently 6 job plans in draft, 104 in discussion, 29 in various stages of sign-off and 17 locked down.

6.3 JD e-Rostering – this will commence in Q4 and an implementation plan is being developed led by the Head of Medical Workforce in liaison with the HR Systems Team.

7.0 The Hub

7.1 The Trust’s new intranet ‘The Hub’ has continued to gain positive feedback since its successful launch in July. The Hub provides colleagues with a range of benefits including an improved search function, easy navigation, regular news updates and individual team areas.
7.2 A major improvement and key feature of The Hub is the improved access to policies, procedures and guidelines.

7.3 The Hub's creation and ongoing development has received input from teams across the Trust who are continuing to populate the site with their own content. This ensures The Hub is an intranet built by colleagues, for colleagues.

8.0 Improving communications channels

8.1 The Communications Team are currently undertaking an audit and user survey of the Trust’s existing internal communications channels. This information will then be used to introduce a refreshed communications offering which will ensure colleagues, in all roles across the organisation, have access to the information, news and updates they need.

9.0 New Occupational Health Provision

9.1 People Asset Management Group (PAM) were appointed as the Trust’s occupational health service provider in April 2018 following a joint tender with RDASH and Sheffield Health & Social Care. The new contract will go-live from 01 September 2018.

9.2 The current Workplace Health & Wellbeing team will TUPE to the new provider on 01 September and the Trust has been working closely with the new provider on this successful transition.

9.3 As part of this new OH provision an Employee Assistance Programme (EAP) will be made available for all our employees to access; and a series of promotional and educational materials will be made available to support the EAP launch in October.

Paul Ferrie
Interim Director of Workforce
August 2018
Report: Finance Report

Presented by: Simon Sheppard, Director of Finance
Author(s): As above

Strategic Objective:
- Colleagues: Engaged, accountable colleagues
- Governance: Trusted, open governance
- Finance: Strong, financial foundations
- Partners: Securing the future together

Regulatory relevance:
- NHSI: Licence Condition FT4 / Single Oversight Framework
- CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
- BAF: B9, B10
- Corporate Risk Register: 4379, 4380, 4629, 4363, 4516

Purpose of this paper:
This paper provides the Board of Directors with an update on performance against the Trust’s key financial duties in the context of the 2018/19 financial plan, namely:

- Delivery against the planned income and expenditure plan for the 2018/19 financial year
- Cost Improvement Programme Performance
- Capital Expenditure
- Cash Position

Summary of Key Points:

- The Trust is delivering ahead of plan for July, year to date, and forecasting delivery of the year-end financial plan.
- An overall deficit of £1,717k in month (July) which is £21k favourable to the planned deficit.
- A year to date favourable position of £174k against the £8,255k deficit plan
- The Trust is underspent against the capital programme in July.
- The Trust is ahead of its Cost Improvement Programme at the end of July and forecasting delivery of the year-end target, £9.7m
- The Trust ended July 2018 with a cash balance of £1.62m compared to a planned level of £1.35m which is an £0.27m favourable variance
- At the end of July 2018 the Trust incurred agency costs of £4,038k inclusive of supporting the additional capacity. This year to date spend is in line with the internal budget but in excess of the NHSI agency ceiling. Actions to support delivery of the agency budget are detailed in the report.

Board action required:

For noting of the financial position
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
- Performance against the internal agency spend and against the NHSI ceiling
- Cost Improvement Programme
- Capital
- Cash

<table>
<thead>
<tr>
<th></th>
<th>In Month Plan</th>
<th>In Month Actual</th>
<th>In Month Variance</th>
<th>YTD Plan</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>I&amp;E Performance</td>
<td>(1.74)</td>
<td>(1.72)</td>
<td>0.02</td>
<td>(8.26)</td>
<td>(8.08)</td>
<td>0.17</td>
</tr>
<tr>
<td>TRFT Agency Spend</td>
<td>0.95</td>
<td>1.01</td>
<td>(0.06)</td>
<td>3.98</td>
<td>4.04</td>
<td>(0.05)</td>
</tr>
<tr>
<td>NHSI Agency Ceiling</td>
<td>0.72</td>
<td>1.01</td>
<td>(0.28)</td>
<td>2.97</td>
<td>4.04</td>
<td>(1.07)</td>
</tr>
<tr>
<td>Efficiency Programme (CIP)</td>
<td>0.56</td>
<td>0.98</td>
<td>0.42</td>
<td>1.92</td>
<td>2.57</td>
<td>0.65</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>0.31</td>
<td>0.03</td>
<td>0.29</td>
<td>0.96</td>
<td>0.36</td>
<td>0.60</td>
</tr>
<tr>
<td>Cash Balance</td>
<td>1.35</td>
<td>1.62</td>
<td>0.27</td>
<td>1.35</td>
<td>1.62</td>
<td>0.27</td>
</tr>
</tbody>
</table>

1.2. As at the end of 31 July 2018 (month 4) the Trust is reporting favourable variances against all of the key metrics with the exception of agency spend against the NHSI ceiling. The following sections provide further information against these financial metrics.

2. **Income & Expenditure (in month)**

2.1. As the Board of Directors is aware, the Trust submitted its final operational and financial plan on the 30 April 2018. The financial plan for 2018/19 is to deliver a £20.3m deficit or better.

2.2. Month 4 performance is shown in the table below
2.3. The key points to highlight to the Board at the end of July are;

- An overall deficit of £1,717k in month (July) which is 21k favourable to the planned deficit.
- A year to date favourable position of £173k against the £8,255k deficit plan
- Clinical income in line with the budget, although there is a favourable position against day cases, offset with underperformance on elective activity.
- The overall pay bill is £167k better than plan, being driven by substantive vacancies off set by bank and agency.
- The 2018/19 pay award for Agenda for Change (Afc) staff was transacted in July with the back pay being paid in August.
- Non pay costs are showing an adverse position against budget predominately due to excluded drugs and devices, £884k year to date, which is offset by income.

2.4. To support delivery of the financial plan, there are now monthly Financial Operational Meetings with each Division, led by the Director of Finance and supported by the Chief Operating Officer and senior members of the finance team.

2.5. These meetings with Divisional teams have focused on;

- Month 4 financial performance at a Divisional level both in terms of income and expenditure, but also clinical activity and income
- Year-end forecast including risks and opportunities. These risks and opportunities, including actions to mitigate the risk or secure the opportunity have been discussed at the Finance & Performance Committee.
- Clear actions required to improve performance and/or mitigate any risks.
- Escalation of any issues to the Executive Management Committee

2.6. Whilst the financial performance to date is encouraging there is continued focus on delivering the monthly profiles throughout the remaining months of 2018/19. Performance to date and the monthly plans are shown in the table below. It is critical to the delivery of the overall financial plan that the Trust continues to deliver against the monthly profiles.
2. **Agency Expenditure**

2.1. As was the case in 2016/17 and 2017/18 providers have received an agency target from NHSI for the new financial year. The target for 2018/19 is an annual spend of £8.8m which is a reduction of £1.4m from the £10.2m target in 2017/18.

2.2. Whilst the Trust will strive to meet the target, this ambition needs to be set in the context of 2017/18 costs being in excess of £11m. These costs were predominately driven by medical vacancies and the requirement to use agency staff. In light of the spend in 2017/18 the Trust has therefore set an internal budget for agency expenditure profiled across the financial year to reflect forecast costs.

2.3. During 2018/19 performance against both the NHSI ceiling and internal budget will be monitored.

2.4. At the end of July 2018 the Trust incurred costs of £4,038k inclusive of supporting the additional capacity. This year to date spend is slightly above the internal budget, £55k, 1%, and £1,070k adverse to the NHSI ceiling.

2.5. Further actions implemented to support delivery against these targets include:

- Agreement and monitoring of the key vacant posts – individual recruitment strategies
- Working with external partners to secure permanent recruitment including from overseas
- Expansion of the direct engagement model
- Overseas recruitment to key posts
- Enhanced controls in certain areas

Progress against these actions and the impact on the agency spend will be reported through the operational committees and assurance committees.
3. **Cost Improvement Programme**

3.1. The Trust has a cost improvement (CIPs) target for 2018/19 of £9.7m, 3.6% of costs.

3.2. The month end and year to date position is shown below and includes both cash releasing and efficiency schemes, the headlines being:

- Performance in July of £979k, £420k favourable to plan. The over-performance is predominantly due to a 'catch-up' in savings from Month 1 - 4. A 3-month trend analysis was undertaken prior to transacting the additional schemes to prove validity in line with the governance process.

- Year to date performance £646k above the plan

<table>
<thead>
<tr>
<th>Month</th>
<th>In-Plan (£000)</th>
<th>Actual (£000)</th>
<th>Variance (£000)</th>
<th>YTD In-Plan (£000)</th>
<th>Actual (£000)</th>
<th>Variance (£000)</th>
<th>% YTD Performance to Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-18</td>
<td>116</td>
<td>205</td>
<td>89</td>
<td>427</td>
<td>399</td>
<td>-28</td>
<td>94%</td>
</tr>
<tr>
<td>May-18</td>
<td>126</td>
<td>343</td>
<td>217</td>
<td>568</td>
<td>658</td>
<td>90</td>
<td>179%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>119</td>
<td>138</td>
<td>18</td>
<td>369</td>
<td>337</td>
<td>-33</td>
<td>91%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>20</td>
<td>62</td>
<td>42</td>
<td>57</td>
<td>143</td>
<td>86</td>
<td>251%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>55</td>
<td>109</td>
<td>53</td>
<td>210</td>
<td>539</td>
<td>330</td>
<td>257%</td>
</tr>
<tr>
<td>Sep-18</td>
<td>123</td>
<td>123</td>
<td>0</td>
<td>491</td>
<td>492</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Oct-18</td>
<td>559</td>
<td>979</td>
<td>420</td>
<td>1,922</td>
<td>2,568</td>
<td>646</td>
<td>134%</td>
</tr>
</tbody>
</table>

3.3. In addition to the in-month performance, continued focus and action is being taken to secure the £9.7m in year target and the full year effect of £13.1m

3.4. At the time of writing the Trust has identified schemes with a risk adjusted value of £9.7m, an increase of £0.6m from last month. Total schemes identified for 2018/19 are now £10.7m in excess of the annual target.

4. **Capital**

- Total capital expenditure plans have been produced in accordance with the maximum internally generated funds available to the Trust and in conjunction with appropriate colleagues throughout the Trust
- The Trust has a planned capital expenditure programme for 2018/19 of £5,800K
- Expenditure year to date (to 31 July 2018) is £364K representing an under-spend of £599K against the year to date budget
- The Trust as part of the South Yorkshire & Bassetlaw Integrated Care System is currently awaiting feedback on several draft business cases as part of the national capital programme.
• Work continues to produce a longer-term view of capital requirements together with subsequent funding options that will be used to inform the Trust’s five-year financial planning outlook. This will be reported to the Board in line with the agreed timetable.

5. Cash

• The trust ended July 2018 with a bank balance of £1.62m compared to a planned level of £1.35m which is an £0.27m favourable variance
• All non NHS and NHS suppliers are paid within the payment terms approved by the Board of Directors (45 days)

Simon Sheppard
Director of Finance
August 2018
BOARD MEETING: 28 August 2018

Report: Governance Report

Presented by: Anna Milanec, Director of Corporate Affairs/ Company Secretary

Author(s): As above

Strategic Objective: Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Finance: Strong, financial foundations
Partners: Securing the future together

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
BAF: B6
Corporate Risk Register: none

Purpose of this paper:
This paper intends to provide the Board with details of progress against various governance issues, and provides an horizon scan of governance based matters that are pertinent to the Board / the Trust.

Summary of Key Points:

- Financial Reporting Council (FRC) publish new “Guidance on Board Effectiveness” and revised version of “The UK Corporate Governance Code” (2.0);
- The Principal Accounting Officer for the Department of Health and Social Care (DHSC) has published his Accounting Officer System Statement which includes notice of a Consultation to be shortly launched about Wholly Owned Subsidiaries in the NHS (3.0);
- An "Emerging Concerns Protocol" has been agreed to by a number of healthcare regulators. The Protocol aims to protect and maintain the health, safety and well-being of those who use health care services by efficient information sharing under particular circumstances (4.0);
- The CQC are investigating never events, and considering what measures could help prevent their occurrence (5.0);
- Legal developments in the case of Dr Hadiza Bawa-Garba are published (6.0);
- Details provided of open public consultations (7.0);
- A number of briefings issued in month by NHS Providers (8.0); and
- A reminder that Parliament remains in recess until 4 September 2018

Board action required: The Board is asked to note this report.
1.0 Introduction

1.1 This report provides an update on board governance, and regulatory matters affecting board governance, for the period from mid-July 2018.

2.0 The UK Corporate Governance Code

2.1 The revised UK Corporate Governance Code (‘the revised Code’) was issued on 16 July 2018, and applies to accounting periods beginning on or after, 1 January 2019.

2.2 Whilst the Code sets out the governance standards expected of UK public company boards, it provides good practice guidelines for all entities subject to public and stakeholder scrutiny, operating a ‘board’ like structure.

2.3 It is not the radical shake-up of corporate Britain that some commentators expected from the revision, but rather, it emphasises long term business behaviours and an integrity in the board room, upon which, trust can be built between company and stakeholder.

2.4 The revised Code broadens the definition of ‘governance’ and seeks to promote transparency by emphasising the importance of:
   - Positive relationships with stakeholders;
   - A strategy aligned with a healthy corporate culture;
   - High quality board composition with a focus on diversity;
   - Remuneration which supports long term success.

2.5 Whilst the NHS has led the way in promoting a ‘freedom to speak up’ culture, the revised Code proposes a similar method for directors and the workforce to raise concerns, and for there to be a non-executive director, workforce advisory panel, or a director appointed from the workforce, who can support such a strategy.

2.6 There is continued emphasis on the importance of constructive challenge in the Boardroom, and more responsibilities for Nomination Committees concerning succession planning that develops a more diverse pipeline of candidates for leadership roles.

   Link: https://www.frc.org.uk/getattachment/88bd8c45-50ea-4841-95b0d2f4f48069a2/2018-UK-Corporate-Governance-Code-FINAL.PDF

2.7 Together with the revised Code, the FRC published its revised “Guidance on Board Effectiveness” ("the Guidance") (replacing the 2011 version). This is provided “to stimulate boards’ thinking on how they can carry out their role, and encourage them to focus on continually improving their effectiveness.”

2.8 The Guidance is neither mandatory nor prescriptive, but each chapter provides a suggestion as to questions that boards should be asking themselves (see appendix 1);

2.9 Again, whilst the guidance is aimed at the boards of public companies, it provides a wealth of examples of good practice that can be considered for alternative corporate structures.

   Link: https://www.frc.org.uk/getattachment/61232f60-a338-471b-ba5a-bfed25219147/2018-Guidance-on-Board-Effectiveness-FINAL.PDF
3.0 Accounting Officer System Statement – Wholly Owned Subsidiaries

3.1 As Principal Accounting Officer for the Department of Health and Social Care (DHSC), Martin Donnelly-Thompson has published his Accounting Officer System Statement which includes notice of a Consultation to be shortly launched about Wholly Owned Subsidiaries (WOS) in the NHS;

3.2 There are many legitimate reasons why Trusts establish such companies (bringing contracted services back into the NHS, generation of profit to reinvest in patient care, flexibility on terms and conditions such that recruitment and retention of staff is achieved) whilst delivering focus on improving the services provided.

3.3 However, it is intended that during 2018/19, the proposed creation of subsidiaries will become a reportable transaction to NHSI under the Transactions Guidance, irrespective of size.

3.4 This will ensure that transactions are visible to NHS Improvement and that assurance can be provided that Trusts had properly identified and reviewed associated risks. There is also a formal requirement under HM Treasury1 that individual Trust Accounting Officers and, inter alia, NHSI, ensure that the establishment of these companies is not for the sole purpose of tax avoidance.

3.5 A further measure is being introduced for Trusts to inform NHSI of any subsequent changes [not yet defined] to these companies.

4. Emerging Concerns Protocol

4.1 In October 2016, the Health and Social Care Regulators Forum2, convened a meeting of professional regulators, system regulators and other partners to discuss how working together as a safety system could support the delivery of high-quality care.

4.2 One action from the meeting was to develop a protocol for regulators, which would help them share information about emerging concerns with each other and system partners in a timely fashion; the Emerging Concerns Protocol.

4.3 This would include information that might undermine or harm the reputation of the professions or the regulators and their registrants, and particularly information that caused ongoing concern but may not be shared under existing arrangements.

4.3 The purpose of the protocol, launched in July 2018, is to provide a clearly defined mechanism for organisations with a role in the quality and safety of care provision to share information that may indicate risks to people who use services, their carers, families or professionals.


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1 HM Treasury, Managing Public Money, updated 7 March 2018
2 Made up of Care Quality Commission, General Medical Council, General Pharmaceutical Council, Health Education England, Health and Care Professions Council, Local Government and Social Care Ombudsman, Parliamentary and Health Service Ombudsman and the Nursing and Midwifery Council
5.1 It has been reported (HSJ) that the CQC are investigating why the number of ‘never events’ is not reducing despite increased transparency and reporting; 469 such incidents occurred between April 2017 and March 2018, a large number relating to surgical procedures.

5.2 The World Health Organisation\(^3\) (WHO) recognised the use of ‘SOPs’ (standard operating procedures) in 2008 as a prevalent feature in many high risk industries, but also noted that their adoption in healthcare was slow because of clinicians’ resistance. Nevertheless, the WHO surgical safety checklist is one example of a SOP that is used in theatres on a daily basis.

5.3 Details have not yet been released as to how surgical standardisation could be implemented, but it has been suggested that elements of the surgical pathway, e.g. patient identification, surgical site confirmation, etc. could be considered.

5.4 A final report is expected in October 2018.

6.0 Legal developments

6.1 On 13 August, the Court of Appeal\(^4\) rejected the General Medical Council’s (GMC) bid to strike off junior doctor, Dr Hadiza Bawa-Garba after she had been convicted of manslaughter by gross negligence in 2015.

6.2 The paediatrician was suspended from the medical register for a year in June 2017 by the Medical Practitioners Tribunal (MPT) after they found no evidence to suggest that there should be concerns about the doctor’s clinical competence. The ‘fitness to practice’ panel took into consideration, wider systemic failings at the Trust where the doctor worked, which included IT failures, a lack of senior consultant presence, delayed results and poor staffing levels, which meant Dr Bawa-Garba was covering multiple wards.

6.3 The GMC appealed against this decision in the High Court claiming that it was “not sufficient to protect the public”, and as a result, Dr Bawa-Garba was struck off in January 2018.

6.4 This month, the Appeal Court judges ruled that the High Court had been wrong to interfere with the earlier decision to suspend for one year, and they restored the lessor sanction of a one-year suspension. They concluded that the Medical Practitioners Tribunal Service was an expert body, and reaffirmed the position of ‘fitness to practice’ panels as the correct venue for ruling on a professional’s ability to continue working.

7.0 Consultations

7.1 The following public consultations are currently open:

- The Future of Adult Social Care, Local Government Association, closing 26 September 2018


\(^4\) [2018] EWCA Civ 1987
Changes to the statutory scheme to control the costs of branded health service medicines, DHSC, closing 18 September 2018.


8.0. Briefings

8.1 The following briefings have been issued in month by NHS Providers (NHSP) and can be found on the NHSP website:
- Key questions for the future of STPs and ICSs;
- Developing the long term plan for the NHS;
- Report of the Joint Committee on the Draft Health Service Safety Investigations;
- Brexit briefing: latest briefing on Brexit negotiations including an overview of the Brexit White Paper; and
- Government response to the consultation on Transforming Children and Young People’s Mental Health Provision.

9.0 To note

9.1 Parliament remains in recess and is due to return on 4 September 2018.

Anna Milanec
Director of Corporate Affairs/ Company Secretary
August 2018
Two examples of the sets of prompts included in the FRC Guidance on Board Effectiveness in relation to board leadership and company purpose.

## Questions for boards

- How well are our values and expected behaviours embedded in our human resources policies, processes and practices?
- Are we treating our people as a strategic asset?
- Have we taken workforce views and priorities into account in developing our approach to investing in our people?
- Are behavioural objectives included in leadership and employee goals, and are behaviours formally assessed as part of performance review activity?
- What are we doing to address gender pay gaps?
- Are we doing enough to train and develop our people with the skills they will need in the future?

## Questions for boards

- How do we know that management is identifying and addressing future challenges and opportunities, for example, changes in technology, environmental issues or changing stakeholder expectations?
- What proportion of board time is spent on financial performance management versus other matters of strategic importance?
- Is the balance between the focus on immediate issues and long-term success appropriate?
- Are we playing an active role in shaping long-term investment plans to underpin delivery of strategy and value creation?
- Is sufficient board time allocated to idea generation, opportunity identification and innovation?
- Are we using scenario analysis to help us assess the strategic importance and potential impact of our challenges and opportunities?
- Are we securing the benefits of ‘big data’ to give us a competitive edge?
- How will we assess and measure the impact of our decisions on financial performance, the value for shareholders and the impact on key stakeholders?
- Are shareholders driving the company to act in a way that is out of line with its purpose, values and wider responsibilities?
Board Assurance Framework

Presented by: Anna Milanec, Director of Corporate Affairs, Co Secretary
Author(s): As above, and Lisa Reid, Head of Governance

Strategic Objective: Governance: Trusted, open governance

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: Well-led

Risk Reference:
BAF: B1, B2, B3, B4, B5, B6, B7, B8, B9, B10, B11 and B12.
Corporate Risk Register: 4174, 4933, 5052, 5100, 3813, 5076, 4762, 4740, 5442, 5516, 3997, 5268, 4959, 5052, 5100, 4740, 5442, 5523, 4064, 4959, 5520, 2978, 4762, 4959, 3520, 3908, 4740, 5442, 4064, 2978, 4959, 5521, 5522, 5525, 5183, 5268, 3813, 5525, 3813, 5518, 5332, 4363, 4933, 5052, 5517, 4379, 5154, 5331, 5518, 5519 and 5520

Purpose of this paper:
As part of the oversight of the Board Assurance Framework for 2018/19, this update for Q1 is presented to the Board of Directors for consideration.

Summary of key points:
- Highest strategic risks relate to the Trust’s financial position and ongoing workforce costs;
- Details of Board Committee recommended current risk scores for Q1 and risk appetites are provided in appendix 1 with further detail;

Board action required:
For approval:
1) Q1 current risk scores
2) Risk appetite scores
as they appear in the grid at Appendix 1.
1.0 Introduction

1.1 Following the approval of the risk descriptions by the Board in May 2018, the BAF was updated for 2018/19 and this Q1 update is presented to the Board to consider end of Q1 risk scores and risk appetites which have been proposed by lead executives, and reviewed by Board Committees.

2.0 Q1 Outcome

2.1 Details of the Q1 risk ratings are provided in Appendix 1, and include any revisions made by Board Assurance Committees.

3.0 Recommendations from Committees

3.1 The Quality Assurance Committee recommended the following:
   - **B1**: a reduced current risk score from $4(L) \times 5(C) = 20$ to $3(L) \times 5(C) = 15$ to reflect the improved position in relation to patient care following the reduction in demand experienced during the winter period. No change in risk appetite $[3(L) \times 5(C) = 15]$.
   - **B2**: a reduced current risk score from $4(L) \times 5(C) = 20$ to $3(L) \times 4(C) = 12$ reflecting the improved position on the 4 hour access target and progress towards achievement of the cancer target in Q2. A reduced risk appetite from $3(L) \times 5(C) = 15$ to $2(L) \times 4(C) = 8$.
   - **B3** (refocused risk): A current risk score of $3(L) \times 3(C) = 9$. A risk appetite of $2(L) \times 3(C) = 6$.

3.2 The Strategy & Transformation Committee recommended the following:
   - **B11** (new risk): A current risk score of $2(L) \times 4(C) = 8$ A risk appetite score of $2(L) \times 4(C) = 8$
   - **B12**: A reduced current risk score from $3(L) \times 5(C) = 15$ to $3(L) \times 4(C) = 12$ reflecting the refocussing of this risk compared to 2017/18. A slight reduction in risk appetite from $2(L) \times 5(C) = 10$ to $2(L) \times 4(C) = 8$ again as a result of the refocused BAF risk identity.

3.3 The Strategic Workforce Committee recommended the following:
   - **B4**: a slight reduction in current risk score from $5(L) \times 5(C) = 25$ to $4(L) \times 5(C) = 20$ based on a rebasing of the risk score. A change in risk appetite from $3(L) \times 5(C) = 15$ to $4(L) \times 4(C) = 16$
   - **B5**: a slight reduction in current risk score from $5(L) \times 5(C) = 25$ to $5(L) \times 4(C) = 20$. The retention of a likelihood score of 5 being due to doctor annual leave. A slight reduction in risk appetite from $3(L) \times 5(C) = 15$ to $3(L) \times 4(C) = 12$.

3.4 The Audit Committee recommended the following:
   - **B6**: No change in current risk score $[3(L) \times 5(C) = 15]$ Following the Audit Committee discussion regarding the proposed risk appetite of $2(L) \times 5(C) = 15$, a revised risk appetite of $2(L) \times 4(C) = 8$ is proposed which represents an increase in risk appetite for this BAF item compared to 2017/18 $[2(L) \times 2(C) = 4]$.
   - **B7**: (new risk): A current risk score of $4(L) \times 4(C) = 16$ A risk appetite score of $2(L) \times 3(C) = 6$
   - **B8**: An increased current risk score of $3(L) \times 4(C) = 12$ $[2(L) \times 4(C) = 8]$ A slight reduction in risk appetite from $3(L) \times 3(C) = 9$ to $2(L) \times 4(C) = 8$ reflecting the refocussing of the BAF risk identity to include cyber-security.
3.5 The **Finance & Performance Committee** considered the BAF and the following was recommended:

- **B9**: a reduction in current risk score from $5(L) \times 5(C) = 25$ to $4(L) \times 5(C) = 20$ based on performance against the CIP at Q1. A reduction in risk appetite from $3(L) \times 5(C) = 15$ to $2(L) \times 5(C) = 10$

- **B10**: a reduction in current risk score from $5(L) \times 5(C) = 25$ to $4(L) \times 5(C) = 20$ reflecting financial performance in Q1. A slight reduction in risk appetite from $3(L) \times 5(C) = 15$ to $2(L) \times 5(C) = 10$

Lisa Reid  
Head of Governance  
August 2018
## Appendix 1

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk title</th>
<th>Risk Owner</th>
<th>Oversight Committee</th>
<th>Date on which oversight Committee agreed Q1 BAF scores</th>
<th>Q4 current risk score</th>
<th>Q1 current risk score</th>
<th>Risk Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements</td>
<td>ChN / MD</td>
<td>QAC</td>
<td>18 July 2018</td>
<td>4x5</td>
<td>3x5</td>
<td>3x5</td>
</tr>
<tr>
<td>B2</td>
<td>Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards</td>
<td>COO</td>
<td>QAC</td>
<td>18 July 2018</td>
<td>4x5</td>
<td>3x4</td>
<td>2x4</td>
</tr>
<tr>
<td>B3</td>
<td>Changes to clinical pathways required to make services sustainable in the ICS, may initially lead to a decrease in the quality of care locally. Uncertainty over future services configuration.</td>
<td>MD</td>
<td>QAC</td>
<td>18 July 2018</td>
<td>N/A</td>
<td>3x3</td>
<td>2x3</td>
</tr>
<tr>
<td>B4</td>
<td>The Trust's Plan cannot be delivered due to insufficient workforce capability and / or capacity</td>
<td>DoW</td>
<td>SWC</td>
<td>23 August 2018</td>
<td>5x5</td>
<td>4x5</td>
<td>4x4</td>
</tr>
<tr>
<td>B5</td>
<td>Workforce costs cannot be reduced nor workforce productivity improved</td>
<td>DoW</td>
<td>SWC</td>
<td>23 August 2018</td>
<td>5x5</td>
<td>5x4</td>
<td>3x4</td>
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<tr>
<td>B6</td>
<td>Insufficiently robust Trust-wide (internal) governance arrangements impede the delivery of a number of plans / objectives</td>
<td>DoF / DoST / Co Sec</td>
<td>Audit</td>
<td>17 August 2018</td>
<td>3x5</td>
<td>3x5</td>
<td>2x4</td>
</tr>
<tr>
<td>B7</td>
<td>Misaligned governance and decision-making may arise from divergent Trust, Place and ICS interests and objectives</td>
<td>Co Sec</td>
<td>Audit</td>
<td>17 August 2018</td>
<td>N/A</td>
<td>4x4</td>
<td>2x3</td>
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<tr>
<td>B8</td>
<td>Risk to delivery of business as robust business resilience planning is not fully embedded (increased focus on potential cyber-attacks)</td>
<td>COO / DoST</td>
<td>Audit</td>
<td>17 August 2018</td>
<td>2x4</td>
<td>3x4</td>
<td>2x4</td>
</tr>
<tr>
<td>B9</td>
<td>Planned efficiencies are not delivered</td>
<td>DoF</td>
<td>FPC</td>
<td>22 August 2018</td>
<td>5x5</td>
<td>4x5</td>
<td>2x5</td>
</tr>
<tr>
<td>B10</td>
<td>The financial plan is not delivered</td>
<td>DoF</td>
<td>FPC</td>
<td>22 August 2018</td>
<td>5x5</td>
<td>4x5</td>
<td>2x5</td>
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<tr>
<td>ID</td>
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<td>Date on which oversight Committee agreed Q1 BAF scores</td>
<td>Q4 current risk score</td>
<td>Q1 current risk score</td>
<td>Risk Appetite</td>
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</tr>
<tr>
<td>B11</td>
<td>Implementation of the Rotherham Place Plan cannot be achieved because partner organisations are unable to agree on integrated service models</td>
<td>DoST</td>
<td>STC</td>
<td>13 July 2018</td>
<td>N/A</td>
<td>2x4</td>
<td>2x4</td>
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<tr>
<td>B12</td>
<td>The Integrated Care System priorities cannot be addressed due to partner organisations being unable to agree on a sustainable service model across the SYB footprint</td>
<td>DoST</td>
<td>STC</td>
<td>13 July 2018</td>
<td>3x5</td>
<td>3x4</td>
<td>2x4</td>
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</table>
BOARD MEETING: 29 August 2018

Report: Responsible Officer Annual Report

Presented by: Dr Alison Cooper, Interim Responsible Officer
Author(s): Dr Alison Cooper, Associate Medical Director Medical Appraisal & Revalidation

Strategic Objective: Colleagues: Engaged, Accountable Colleagues

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
BAF: B5
Corporate Risk Register: 3989

Purpose of this paper:
To present to the Board details of activity related to Medical Appraisal and Revalidation as per NHS England and GMC Regulations.

This report is presented in order to seek Board Approval for the required Statement of Compliance (Appendix E).

Summary of Key Points:
- Annual Organisational Audit (AOA) 2017-18 was submitted to NHS England on time.
- Key Performance Indicators see appendices Audits A-D.
- We have 210 doctors with a prescribed connection to Rotherham.
- Overall Appraisal rate has improved in the last 12 months to 88.6% (vs 85.2% 16/17).
- 20 Appraisals were completed for short term contract holders which do not appear in the audit data.

Board action required:
For approval
1.0 Introduction;

1.1 Medical Revalidation was introduced in 2012 with the aim of improving the quality of care provided to patients. It is expected that compliance is demonstrated by:

- Monitoring the frequency and quality of medical appraisal
- Checking there are effective systems in place for monitoring conduct and performance
- Confirming feedback from patients and colleagues is regularly sought and informs appraisal
- Ensuring appropriate pre-employment background checks are carried out.

1.2 Revalidation introduced for the first time a formal statutory role in professional regulation for healthcare organisations as employers. It has effectively created an employer-mediated professional regulatory regime.

1.3 Recent high profile cases have caused concern about the use of Reflection as part of Appraisal. These concerns do not appear to have adversely impacted on the engagement of career grade staff at Rotherham and Appraisers have been updated regarding best practice.

1.4 It is possible to collate and anonymise themes from Appraisal which may be useful to the Trust, for example delays and concerns about job planning and the impact of vacancies and long term locums on service delivery and development are both becoming more common discussions at Appraisal

2.0 Performance

2.1 Key performance indicators are reported to NHS England quarterly and benchmarked against comparable organisations nationally. Overall performance has improved to 88.6% (vs 85.2% 16/17).

2.2 There has been a significant improvement in engagement from short term contract holders to 90.9% (vs 55.2% 16/17) a group identified by the Pearson review as an area of difficulty.

2.3 Actions required by the internal audit have been completed.

2.4 There were 8 actions identified by NHS England as part of the review in September 2017 of which only three are not complete. Two are a part of ongoing discussions with LNC.

2.5 Against a target of 20 Appraisers there were 16 active Appraisers delivering an average of 12 appraisals each (vs a requirement of 5-10 per annum). Not all Appraisers have been able to agree the recommended time in job plans to support this role.

2.6 Each Appraiser is provided with collated and anonymised feedback about their performance as an Appraiser to inform their own development.
2.7 Appraisal outputs were externally reviewed and the feedback discussed at Appraisal Forum.

2.8 The RO Advisory group has met and agreed terms of reference.

2.9 Third parties who employ doctors for whom Rotherham is the designated body are now asked annually for assurance of the doctors’ good standing.

2.10 Six doctors had unapproved/incomplete or missed appraisal in 17/18.

3.0 **Action Plan**

3.1 Continue to work collaboratively to improve supporting information provided to doctors by the Trust.

3.2 Develop the RO Advisory group to meet best practice recommendations.

3.3 Complete the actions required by NHS England.

3.4 Recruit additional Appraisers.

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Dr Alison Cooper  
Interim R.O  
August 2018

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Enclosures:

- Appendices A-D Key Performance Audits
- Annex E Board of Directors Statement of Compliance
Audit of all missed or incomplete appraisals audit 2017/18

<table>
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<th>Doctor factors (total)</th>
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<tr>
<td>Maternity leave during the majority of the ‘appraisal due window’</td>
<td>5</td>
</tr>
<tr>
<td>Sickness absence during the majority of the ‘appraisal due window’</td>
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<tr>
<td>Prolonged leave during the majority of the ‘appraisal due window’</td>
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<tr>
<td>Suspension during the majority of the ‘appraisal due window’</td>
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<tr>
<td>New starter within 3 month of appraisal due date</td>
<td>2</td>
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<tr>
<td>New starter more than 3 months from appraisal due date</td>
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<tr>
<td>Postponed due to incomplete portfolio/insufficient supporting information</td>
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<tr>
<td>Lack of Time Doctor</td>
<td>3</td>
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<td>Lack of Engagement of Doctor</td>
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<td>Other Doctor factor (imminent Retirement)</td>
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<table>
<thead>
<tr>
<th>Appraiser factors</th>
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<tr>
<td>Unplanned absence of appraiser</td>
<td>1</td>
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<td>Appraisal outputs not signed off by appraiser within 28 days</td>
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<td>Lack of time of appraiser</td>
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<td>Other appraiser factors (describe)</td>
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<td>(describe)</td>
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<table>
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<th>Organisational factors</th>
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<td>Administration or management factors</td>
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<tr>
<td>Failure of electronic information systems</td>
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<td>Insufficient numbers of trained appraisers</td>
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<td>Other organisational factors (describe)</td>
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## Quality assurance audit of appraisal inputs and outputs

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<th>Total number of appraisals completed</th>
<th>186</th>
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</thead>
<tbody>
<tr>
<td>Number of appraisal portfolios sampled (to demonstrate adequate sample size)</td>
<td>Number of the sampled appraisal portfolios deemed to be acceptable against standards</td>
</tr>
<tr>
<td>Appraisal inputs</td>
<td>25</td>
</tr>
<tr>
<td>Scope of work: Has a full scope of practice been described?</td>
<td>25</td>
</tr>
<tr>
<td>Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?</td>
<td>25</td>
</tr>
<tr>
<td>Quality improvement activity: Is quality improvement activity compliant with GMC requirements?</td>
<td>25</td>
</tr>
<tr>
<td>Patient feedback exercise: Has a patient feedback exercise been completed?</td>
<td>Yes. 4 /25(only req every 5 years)</td>
</tr>
<tr>
<td>Colleague feedback exercise: Has a colleague feedback exercise been completed?</td>
<td>4/25</td>
</tr>
<tr>
<td>Review of complaints: Have all complaints been included?</td>
<td>yes</td>
</tr>
<tr>
<td>Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included? Trust data &amp; incidents recorded in MAG forms do not always match. The discrepancy largely relate to timing of events relating to date of appraisal</td>
<td>yes</td>
</tr>
<tr>
<td>Is there sufficient supporting information from all the doctor’s roles and places of work?</td>
<td>yes</td>
</tr>
<tr>
<td>Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example</td>
<td>25</td>
</tr>
<tr>
<td>• Has a patient and colleague feedback exercise been completed by year 3?</td>
<td>25</td>
</tr>
<tr>
<td>• Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)?</td>
<td>25</td>
</tr>
<tr>
<td>• Have all types of supporting information been included?</td>
<td>25</td>
</tr>
<tr>
<td>Appraisal Outputs</td>
<td>25</td>
</tr>
<tr>
<td>Appraisal Summary</td>
<td>25</td>
</tr>
<tr>
<td>Appraiser Statements</td>
<td>25</td>
</tr>
<tr>
<td>PDP</td>
<td>25</td>
</tr>
</tbody>
</table>
### Audit of revalidation recommendations

#### Revalidation recommendations between 1 April 2017 to 31 March 2018

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations completed on time (within the GMC recommendation window)</td>
<td>12</td>
</tr>
<tr>
<td>Late recommendations (completed, but after the GMC recommendation window closed)</td>
<td>0</td>
</tr>
<tr>
<td>Missed recommendations (not completed)</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>12</td>
</tr>
</tbody>
</table>

**Primary reason for all late/missed recommendations**

For any late or missed recommendations only one primary reason must be identified: N/A

- No responsible officer in post: 0
- New starter/new prescribed connection established within 2 weeks of revalidation due date: 0
- New starter/new prescribed connection established more than 2 weeks from revalidation due date: 0
- Unaware the doctor had a prescribed connection: 0
- Unaware of the doctor’s revalidation due date: 0
- Administrative error: 0
- Responsible officer error: 0
- Inadequate resources or support for the responsible officer role: 0
- Other: 0
- Describe other: 0

**TOTAL [sum of (late) + (missed)]**: 0
### Audit of concerns about a doctor's practice 2017/18

<table>
<thead>
<tr>
<th>Concerns about a doctor's practice</th>
<th>High level</th>
<th>Medium level</th>
<th>Low level</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of doctors with concerns about their practice in the last 12 months</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capability concerns (as the primary category) in the last 12 months</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Conduct concerns (as the primary category) in the last 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health concerns (as the primary category) in the last 12 months</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

#### Remediation/Reskilling/Retraining/Rehabilitation

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2017 who have undergone formal remediation between 1 April 2017 and 31 March 2018&lt;br&gt;&lt;br&gt;*Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice&lt;br&gt;&lt;br&gt;*A doctor should be included here if they were undergoing remediation at any point during the year</td>
<td>1</td>
</tr>
<tr>
<td>Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)</td>
<td>Number</td>
</tr>
<tr>
<td>Staff grade, associate specialist, Specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)</td>
<td>Number</td>
</tr>
<tr>
<td>General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)</td>
<td>Number</td>
</tr>
<tr>
<td>Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)</td>
<td>0</td>
</tr>
<tr>
<td>Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)</td>
<td>Number</td>
</tr>
</tbody>
</table>
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc.) All DBs | Number |
| 0 |

Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) All DBs | Number |
| 0 |

**TOTALS** | Number |
| 1 |

**Other Actions/Interventions** | Number |
| 0 |

**Local Actions:**

Number of doctors who were suspended/excluded from practice between 1 April 17 and 31 March 18: | Number |
| 0 |

Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included

Duration of suspension:

Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included

- Less than 1 week | Number |
| 0 |
- 1 week to 1 month | Number |
| 0 |
- 1 – 3 months | Number |
| 0 |
- 3 - 6 months | Number |
| 0 |
- 6 - 12 months | Number |
| 0 |

Number of doctors who have had local restrictions placed on their practice in the last 12 months? | Number |
| 1 |

**GMC Actions:**

Number of doctors who:

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were referred to the GMC between 1 April 15 and 31 March</td>
</tr>
<tr>
<td>Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April 17 and 31 March 18</td>
</tr>
<tr>
<td>Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March</td>
</tr>
<tr>
<td>Had their registration/licence suspended by the GMC between 1 April and 31 March</td>
</tr>
<tr>
<td>Were erased from the GMC register between 1 April and 31 March</td>
</tr>
</tbody>
</table>

**National Clinical Assessment Service actions:**

Number of doctors about whom NCAS has been contacted between 1 April and 31 March: | Number |
| 2 |
2017/18 Statement of Compliance

ANNEX E

The Board of The Rotherham NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;
   Comments: Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;
   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;
   Comments: On-going difficulty in maintaining adequate numbers

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);
   Comments: Yes

5. All licensed medical practitioners\(^1\) either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;
   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners\(^1\), which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;
   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners\(^1\) fitness to practise;
   Comments: Yes and requires updating

\(^1\)
8. There is a process for obtaining and sharing information of note about any licensed medical practitioners’ fitness to practise between this organisation’s responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners\(^2\) have qualifications and experience appropriate to the work performed; and

Comments: Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes

Signed on behalf of the Designated Body

Louise Barnett
Chief Executive
The Rotherham NHS Foundation Trust

Date:
BOARD MEETING: 28 August 2018

Agenda item: 318/18

Board Report: Register of Directors’ Interests

Presented by: Anna Milanec, Director of Corporate Affairs / Company Secretary
Author(s): Dawn Stewart, Corporate Governance Manager

Strategic Objective: Governance: Trusted, open governance

Regulatory relevance:
NHSI: NHS FT Code of Governance A.1.j, Licence condition FT4
CQC Domain: effective / well-led

Risk Reference:
BAF: B6
Corporate Risk Register: No specific risks on the risk register

Overview:

The Trust is required to maintain a Register of Interests for the Board which is available to the public. The Register is routinely updated as new information is provided by Board members.

NHS England (NHSE) Conflicts of Interest Guidance, which came into force in June 2017, requires all colleagues to declare material interests on an annual basis and within 28 days of a new interest arising. Regular communications are in place reminding all colleagues to make any relevant declarations, and all colleagues at band 8D (or equivalent) and above are required to either make a declaration or submit a nil return. The new Register of Staff Interests is published on the Trust website.

The Board of Directors work plan also provides opportunities twice a year for the Board Register to be formally presented to ensure that it remains accurate.

Board action required: For approval

Anna Milanec
Director of Corporate Affairs / Company Secretary
August 2018

1 §20 (1) (d), Schedule 7, National Health Service Act 2006
## Register of Interests of the Board of Directors

### Non-Executive Directors

<table>
<thead>
<tr>
<th>Name</th>
<th>Interests Declared</th>
</tr>
</thead>
</table>
| Martin Stephen Havenhand  | - Sister employed as Practice Manager at Sheffield Orthopaedics  
- Niece is Associate Operations Director of One Health  
- Director of Corporate Trustee                                                                                                                                                                      |
| Gabby Atmarow             | - Serving Magistrate on both the Adult and Family Bench of Leeds Magistrates Court  
- Director of Corporate Trustee                                                                                                                                                                       |
| Joe Barnes                | - Member of the Labour Party  
- Director of Corporate Trustee                                                                                                                                                                          |
| Heather Craven            | - Owner and Director of Brandon Ltd  
- Director of Corporate Trustee                                                                                                                                                                          |
| Mark Edgell               | - Employed in a senior role by the Local Government Association (LGA), leading their work with all Councils and partners (including NHS England and PHE) in Yorkshire and Humber, East Midlands and North East.  
- Wife employed as a midwife by Sheffield Teaching Hospitals NHS FT  
- Wife employed as Senior Lecturer in Midwifery at Northumbria University  
- Trustee (Non-Executive Director) of Sustrans  
- Member of the Labour Party  
- Director of Corporate Trustee                                                                                                                                                                      |
| Lynn Hagger               | - Company Secretary, Suburbaret Ltd  
- Director of Corporate Trustee                                                                                                                                                                          |
| David Hannah              | - Trustee of ‘The Fifty Fund’ – Nottingham based charity  
- Shareholder of Nottingham Emergency Medical Service  
- Wife is a practice nurse in Hucknall, Nottinghamshire  
- Director of Corporate Trustee                                                                                                                                                                         |
| Barry Mellor              | - Director of Corporate Trustee                                                                                                                                                                                          |

### Alphabetical order

- Gabby Atmarow
- Joe Barnes
- Heather Craven
- Mark Edgell
- Lynn Hagger
- David Hannah
- Barry Mellor

### Executive Directors

<table>
<thead>
<tr>
<th>Name</th>
<th>Interests Declared</th>
</tr>
</thead>
</table>
| Louise Barnett        | - Director of Corporate Trustee  
- Husband’s work includes contact with a range of healthcare and commercial organisations                                                                                                                                 |
<p>| Chief Executive       |                                                                                                                                                                                                                      |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>George Briggs, Chief Operating Officer</td>
<td>Managing Director and Shareholder in Briggs Health Ltd</td>
</tr>
<tr>
<td></td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td>Cheryl Clements, Executive Director of Human Resources</td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td></td>
<td>Joint Director of MSL Partners Ltd</td>
</tr>
<tr>
<td>Chris Holt, Director of Strategy and Transformation</td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td></td>
<td>No general interests to declare</td>
</tr>
<tr>
<td>Christopher Morley, Chief Nurse</td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td></td>
<td>No general interests to declare</td>
</tr>
<tr>
<td>Simon J Sheppard, Director of Finance</td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td></td>
<td>Wife employed as a Specialist Nurse at Sheffield Children’s NHS Foundation Trust</td>
</tr>
<tr>
<td>Conrad Wareham, Medical Director</td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td></td>
<td>Chair of the North Trent Adult Critical Care Operational Delivery Network</td>
</tr>
<tr>
<td>John Beeston, Director of Clinical Services for Diagnostics &amp; Support</td>
<td>No general interests to declare</td>
</tr>
<tr>
<td>Jeff Garner, Director of Clinical Services for Surgery</td>
<td>Owner and Director of JAAS Editing Ltd</td>
</tr>
<tr>
<td></td>
<td>Editor in Chief of TRAUMA</td>
</tr>
<tr>
<td></td>
<td>Member of Council and executive member of TRAUMA CARE</td>
</tr>
<tr>
<td></td>
<td>Major Trauma Consultant – Sheffield Teaching Hospitals from 1st May 2018</td>
</tr>
<tr>
<td>Jane Terris, interim Director of Clinical Services for Integrated Medicine</td>
<td></td>
</tr>
<tr>
<td>Daksha Patel, Director of Clinical Services For Family Health</td>
<td>No general interests to declare</td>
</tr>
<tr>
<td>Company Secretary/Director of Corporate Affairs</td>
<td>none</td>
</tr>
<tr>
<td>Anna Milanec, Company Secretary</td>
<td>None</td>
</tr>
</tbody>
</table>