**Board of Directors**  
**Public AGENDA** (held in public)

**Date:** Monday 26 September 2016  
**Time:** 1100hrs – 1330hrs  
**Venue:** Boardroom, Executive Corridor, Level D, Rotherham Hospital

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### Board Governance Planning (Governance)

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<td>356/16</td>
<td>Review of Annual Board Planner</td>
<td>Enc.</td>
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<td>1315</td>
<td>357/16</td>
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*To ensure smooth transaction of business, the Chairman will invite questions from the public arising from the clinical presentation, and 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 30 AUGUST 2016 IN THE BOARDROOM, LEVEL D

Present: Mr M Havenhand, Chairman  
Mrs L Barnett, Chief Executive  
Mrs G Atmarow, Non-Executive Director  
Mr J Barnes, Non-Executive Director  
Mrs C Clements, Director of Workforce  
Ms L Hagger, Non-Executive Director  
Mr C Holt, Chief Operating Officer  
Ms T McErlain-Burns, Chief Nurse  
Mr B Mellor, Non-Executive Director  
Dr C Wareham, Medical Director  

In attendance: Mr J Beeston, Director of Clinical Services, Diagnostics and Support  
Mr M Bloy, deputy Director of Finance (attending for Mr Sheppard)  
Mr J Garner, interim Director of Clinical Services, Surgery  
Ms A Milanec, Director of Corporate Affairs / Company Secretary  
Dr S Nakash, Director of Clinical Services, Emergency Medicine  
Miss D Patel, Director of Clinical Services for Family Health  
Miss D Stewart, Corporate Governance Manager (minutes)  

Apologies: Mr M Edgell, Non-Executive Director  
Mrs A Hope (formerly Legg), Non-Executive Director  
Dr J Miles, Director of Clinical Services for Medicine  
Mr S Sheppard, Director of Finance  

Observers: Member(s) of staff x1  
Public Governors x2  
Members of the general public x1  

309/16 CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE

Mr Havenhand welcomed those present to the meeting, with apologies having been received from Mr Edgell, Mrs Hope (formerly Legg), Dr Miles and Mr Sheppard. The Board noted that Mr Bloy would be deputising for Mr Sheppard at the meeting.

QUALITY AND SAFETY  
310/16 PATIENT STORY

The Chief Nurse provided two patient stories, one of a positive and one of a negative nature.
The negative story related to poor general communication and an absence of sufficient explanation for actions taken following an emergency admission. Additionally a relative had expressed their concerns that fundamental nursing needs had not been met.

Following receipt of the formal complaint, a meeting had been held with the relatives with the concerns investigated and addressed. Whilst Ms McErlain-Burns acknowledged that the action taken to specifically address the lack of speedy responses to telephone calls, with the senior nurse carrying a DECT phone should be applauded, the staff had been asked to monitor that this did not result in interruptions being experienced for other patients as there were other actions which may be more appropriate.

The positive complimentary story came from a patient who had delivered her first child and had been appreciative of the support and interactions with the midwifery team during her labour.

PROCEDURAL ITEMS

311/16 DECLARATIONS OF CONFLICTS OF INTERESTS

There were no declarations of any conflict of interest. Should any become apparent during discussions they would be highlighted.

312/16 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 26th July 2016 were AGREED as correct record, subject to:

Minute 274/16(a) Quality Report
Third paragraph, second line to insert the following in bold text:

……there was no identifiable reason for the deterioration as there had been no increase in avoidable pressure ulcers, and only small increases in ………

313/16 MATTERS ARISING FROM THE PREVIOUS MEETING

There were no matters arising from the previous meeting which were not either covered by the agenda or action log.

314/16 ACTION LOG

The Board of Directors CONSIDERED and DISCUSSED the Board action log.

A number of actions had been proposed for formal closure and were AGREED by the Board. The remaining log items would continue to be reported or would form agenda items for future meetings.

In relation to log number 59 and the mortality data, it was confirmed that the data in the Quality Report submitted to the July meeting had been correct. To
provide additional assurance on the matter the Board requested that the Quality Assurance Committee receive a full summary of the position. 

**ACTION – CW**

It was AGREED that the action log would be updated accordingly.

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**STRATEGY AND STRATEGIC PLANNING**

**315/16 REPORT FROM THE CHAIRMAN**

The Board of Directors RECEIVED and NOTED the report from the Chairman.

Mr Havenhand reported that development of the longer term vision for Rotherham through the Rotherham Together Partnership continued. As a key stakeholder, Mr Havenhand on behalf of the Trust had provided his views to a specialist branding company engaged by the Partnership to create a consistent narrative of Rotherham.

The establishment of an Acute Federation Board, which had been discussed at the 26 July 2016 meeting, had been further considered at the Working Together Partnership – Providers meeting on 1 August 2016. The governance and regulatory concerns around the proposed arrangements had been raised, with a consensus that the arrangements would promote collaborative working, with recommendations to be considered by the respective Trust Boards. It had also been agreed not to use the term ‘Board’ and an alternative name was being proposed.

Whilst later reports would outline the timeframe for the submission of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan, Mr Havenhand informed the Board that submission timeframes had now changed to the 21st October. Due to regulatory requirements the annual planning cycle had also been brought forward, with the two year operational plan now to be submitted at the end of December.

The Board NOTED the report.

**316/16 REPORT FROM THE CHIEF EXECUTIVE**

The Board of Directors RECEIVED and NOTED the Chief Executive’s monthly report, which provided an overview of strategic issues, quality and operational matters and stakeholder engagement.

Mrs Barnett reported that preparations continued for the announced Care Quality Commission four-day re-inspection commencing on 27 September 2016. It was anticipated that the organisation would take the opportunity not only to showcase the improvements made since the first inspection, but also the continued transformation taking place, albeit against the current workforce and financial constraints.
With regard to the strategic objectives, progress continued as outlined within the appendix to the report. However, Mrs Barnett conceded that there remained a number of areas which required strengthening.

In relation to the strategic objectives tracker, Ms Hagger sought clarity on a number of specific sections and questioned how they aligned, if at all, to performance as detailed in the Integrated Performance Report (IPR). Mr Holt clarified for the Board that the appendix to the Chief Executive report outlined achievement against the milestones for each objective and did not reflect actual performance against the indicators in the IPR.

Whilst the intention was for the Board to receive on a quarterly basis more in-depth analysis and supporting information for each of the strategic objectives, members were invited to contact the Company Secretary should they require sight of this material to clarify any questions they may have.

**ACTION - ALL**

Mrs Barnett confirmed to the Board that the quarter one Sustainability and Transformation Plan requirements had been achieved, resulting in the associated funding having been received. However, it remained vital that action was taken to mitigate any risks to delivery for future quarters.

The Board was informed that a Guardian of Safe Working had been appointed, reporting the Medical Director. This was a new role created as part of the implementation of the new Terms and Conditions for Doctors in Training.

With regard to the Carter Review and potential savings within the NHS Supply Chain, it was noted that an immense amount of information and datasets had been gathered at a national level. Once information from this national exercise was available it would be shared with the Finance and Performance Committee to ascertain if there were any further opportunities within the cost improvement programme.

**ACTION - SS**

As indicated by the Chairman, the timetable for the submission of the two year operational plan had been brought forward to December, which was four months ahead of the normal schedule. The planning guidance was anticipated to be released in September, with the Board timetable to be adjusted to ensure the required discussions were held by the Board and its Committees.

The Board NOTED the Chief Executive’s report.

**OPERATIONAL PERFORMANCE**

**317/16 MONTHLY INTEGRATED PERFORMANCE REPORT**

The Board of Directors RECEIVED and NOTED the monthly integrated performance report (IPR).

Mrs Barnett provided a summary overview of the IPR before moving to the comprehensive report provided by each Executive Director. The summary areas were:
- Healthcare associated infection rates continued to remain low with no MRSA bacteraemia cases, and C.Difficile remained within the threshold
- There continued to be recruitment and retention challenges in a number of specialities
- Excellent performance against the majority of the cancer pathways, which was reflected in the Trust being in the top quartile for a number of indicators
- The emergency pathways continued to be challenging as a consequence of increased demand and staffing issues
- 90% of the total number of clinicians now had completed job plans
- Mandatory and Statutory Training (MAST) compliance rates continued to show improvement, with plans in place for those areas requiring additional support
- The financial position showed an under performance in relation to income and expenditure. Action would be taken to improve the position including delivery against the cost improvement programme.

With regard to the last item, Mr Havenhand reiterated that the financial position remained a key organisational and Board concern and as such, it would receive additional scrutiny to ensure improvements were seen.

The Board NOTED the Integrated Performance Report.

317/16(a) QUALITY REPORT

The Board of Directors RECEIVED and NOTED the Quality Report provided by the Chief Nurse and Medical Director.

Ms McErlain-Burns confirmed that in relation to healthcare associated infections there continued to be zero MRSA bacteraemia cases. One recent potential case had been independently reviewed by Public Health England, who had indicated that there had been no lapses in care at the Trust and, as such, the case would be attributable to a third party. In relation to C Difficile, the organisation continued to perform better than the trajectory.

There had been a short period in July when one ward had seen a number of patients suffering symptoms of diarrhoea. This had been well managed by the ward staff and infection prevention and control team.

At the last meeting, concerns had been raised regarding the safety thermometer and harm free care. It noted that the position had significantly improved in July with the Trust once again being in line with national scores. This turnaround had been as a result of the deep dive that had found that the deterioration in performance had been due to an increase in new pressure ulcers in the community. However, further analysis indicated that many of the patients had not been receiving care from the Trust. It was important that the organisation remained vigilant to the sensitivity of the measure and as there was no provision for any supporting narrative as part of the national reporting process, any variations would need to be documented within the Board report.
In terms of feedback on services, there had been a slight increase in complaints with 27 having been received compared to 17 in the previous month. Whilst the overall Friends and Family target of 95% across all areas continued to be maintained there had been a slight reduction of response rates in a number of areas.

The nurse staffing position was provided in detail within the report and supporting appendix, with Ms McErlain-Burns commenting on the rollout of the e-rostering system within the organisation and the next stages following the system being embedded would be to strengthen processes.

Turning to the sections from the Medical Director, Dr Wareham was pleased to inform the Board that mortality in relation to HSMR continued to remain below 100 and SHMI had now fallen to within the normal range ensuring that the Trust was no longer an outlier in relation to the mortality statistics. Crude mortality remained unchanged. The systems and processes established to turn the position around would continue with weekly monitoring. The Board noted the positive progress as a result of the actions implemented in response to the mortality data.

In relation to the medical staffing position, a number of appointments had been recently made, although there remained ongoing concerns regarding the overall level of vacancies. This had resulted in a number of medical red flag shifts; however, there had been no reports of harm consequently.

Mr Havenhand indicated that there had been good progress in relation to the completion of the job planning process as detailed within the report and thanked colleagues for their focus on this matter. However, he anticipated that processes would be embedded within the organisation to ensure completion within quarter one in future years.

It was understood that the Finance and Performance Committee had requested that Mr Sheppard and Dr Wareham provide further information on job planning for a future meeting. However, Mrs Barnett indicated that the work, which should also involve Ms McErlain-Burns, should have a clearly defined remit, timescale and built into the reporting cycle.

The Board of Directors NOTED the Quality Report.

**317/16(b) OPERATIONAL PERFORMANCE REPORT**

The Board of Directors RECEIVED and NOTED the Operational Performance Report from the Chief Operating Officer.

Mr Holt indicated that the 4 hour emergency access target remained challenging, with the position for July being below the required 95%. This reflected the continued increase in demand and staffing issues particularly for the middle grade doctors. Despite these pressures, the winter ward had been closed at the end of July. Additionally a recent review of conversion rates
indicated that the Trust had a very low number of unnecessary admissions via the emergency department.

Despite these ongoing challenges, national benchmarking data showed the Trusts performance against the metric placed it in the best 10% nationally. The report also provided comparative benchmarking against other local trusts, with Mr Mellor commenting that a stable workforce was one of the factors for local Trusts consistently achieving the target and the importance to stabilise the position in Rotherham.

Recent changes to the national system had seen the establishment of collaboration groups. The first of a series of events had been attended by trust representatives and had brought into focus the challenges within the system and areas of good practice. However, the session had not covered the more challenging areas of demand and workforce. In relation to the good practice, Mr Holt commented that many of the areas highlighted had either already been implemented or were known to the Trust.

With regard to the Sustainability and Transformation Plan trajectory for 4-hour access, in response to a question from Mr Barnes, Mr Holt indicated that whilst the target had not been achieved in July and August it remained challenging but it would still be possible to return to trajectory for September and quarter two.

With regard to the contract negotiations for the walk in centre, Mr Holt confirmed that the Trust would be the primary provider of the contract, in collaboration with Care UK, from September 2016. This approach was supported by the Clinical Commissioning Group.

Performance against the 18-week referral to treatment pathway continued to be good. However, there was a deteriorating position, but no decline in quality, due an increase in the number of patients on the pathways. The specific specialities were known, with detailed action plans being implemented some of which would require additional investment.

There had been deterioration in 6-week diagnostic waits in endoscopy due to capacity not being able to meet the demands on the service. Although alternative options were being considered, the Board were informed that the position was unlikely to improve in August and September.

Mr Havenhand in conclusion, commented that the transformation programme and service changes instigated by the Trust had ensured that the organisation was placed in a more positive position despite continued challenges. The core challenge remained staffing and it was important to address these recruitment issues.

The Board of Directors NOTED the operational performance report.
317/16(c) **WORKFORCE REPORT**

The Board of Directors RECEIVED and NOTED the workforce report from the Director of Workforce.

Mrs Clements confirmed that as stated by the Chief Executive, 90% of job plans had now been completed.

Bank and agency costs continued to reduce, with the NHS Improvement agency diagnostic having been completed and submitted.

In relation to workforce development, the planning submissions had been made to Yorkshire and Humber Health Education England. The Trust would need to be mindful of any resulting funding and financial implications.

Whilst there were a number of newly qualified nurses in the process of joining the Trust, there remained a high turnover of staff in a number of specialities.

In relation to a number of HR metrics, there had been a slight increase in sickness absence rates. Whilst both Mandatory and Statutory Training and completion of Personal Development Reviews had improved in month.

The Board was informed that the British Medical Association would be meeting to discuss proposed further industrial action by the junior doctors. Early indications were that this would take place in October. Mr Havenhand requested that the Board be provided with information as to the key matters relating to the action.

**ACTION - CC**

The Board NOTED the Workforce Report with workforce and agency spend remaining key areas of focus.

317/16(d) **FINANCE REPORT**

The Board of Directors RECEIVED and NOTED the finance report for month four which had been prepared by the Director of Finance.

In the absence of the Director of Finance, the report was presented by the Deputy Director of Finance (Mr Bloy) who highlighted the following points:

- A £437k surplus to the end of July which was £451k adverse to plan
- A financial sustainability risk rating of 2 against the plan of 3
- An underspend against the capital programme of £919k
- Recovery plans to be implemented

The Board was informed that there were a number of themes within the financial position:

- Increased non-elective income had taken the Trust above the threshold tariff for non-elective income resulting in only 70% of the tariff being received from the Clinical Commissioning Group.
It would be prudent to discuss the position with the Clinical Commissioning Group in relation to activity levels and opportunities to re-invest the 30%.

- The run rate on bank and agency spend continued to reduce, although pay costs remained significantly above budget
- There was overspends on drugs budgets and clinical supplies
- The cost improvement programme was significantly behind trajectory.

In order to meet the quarter two and year-end forecasts a number of key actions would be required and were documented within the report. These were in addition to those required for the cost improvement programme. All actions had been discussed at the performance meetings and would be further reinforced through planned communications and directives to budget managers. Mrs Barnett confirmed for the Board that the messages within the organisation would be strengthened in relation to the financial position.

Mr Bloy would be meeting with each Divisional team to ensure that the requirements and actions were fully understood. The training for budget managers would also continue and ensure a consistent message within the organisation.

Mr Havenhand stated that it would be vital for these sessions to require mandatory attendance as it was important that all budget holders were aware of the critical financial position.

In response to a question from Mr Barnes in relation to the reserve movements, whilst Mr Bloy provided an explanation, it was agreed that clarification of the position be provided to the Finance and Performance Committee.

**ACTION – SS**

Consolidation of the existing loan portfolio would not be undertaken due to the considerable redemption penalties and this would not affect the cash position.

The Board noted that the Finance and Performance Committee had discussed the position with regard to outstanding invoices for services provided to other organisations. Mrs Barnett confirmed that clarity had been sought on all income arrangements and robust processes were in place, and progress was now being seen.

It was agreed that the Board to Board with the Clinical Commissioning Group would be utilised to raise some of these matters and gather their support in achieving the quarter two Sustainability and Transformation Plan targets.

With regard to the section of the report which outlined the financial forecast and actions to be taken, Mr Havenhand reiterated the importance for the Board to have an increased level of assurance in the actions being taken to address the financial challenges. As part of this assurance, the Board would require details of how the position would be handled differently to previous years.
The Board of Directors NOTED the month finance report and the specific actions to be taken to provide sufficient assurance for the Board on delivery of both the quarter 2 and the overall annual financial plan.

BOARD GOVERNANCE

318/16  GOVERNANCE REPORT

The Board of Directors RECEIVED and NOTED the Governance Report from the Director of Corporate Affairs/Company Secretary, which highlighted issues relevant to the Board.

With regard to Information Governance (IG), the Board were informed that the data was not to the level of previous months due to staff sickness and annual leave within the small IG team. It was anticipated that activity levels would return to normal in the next month.

Consultation on the Single Oversight Framework (SOF) from NHS Improvement (NHSI) had closed, with the response from NHS providers provided for the Board. Concerns had been raised from a number of organisations on such matters as the lack of appropriate legislative and regulatory framework in which sustainability and transformation plan collaborations would develop.

The Board was informed that NHSI had appointed four high performing Trusts to be accredited to lead groups or ‘chains’ of NHS providers to improve efficiency and quality of clinical services by sharing excellent practice.

The Board noted the report produced by the charity, Action Against Medical Accidents, which had looked at the Care Quality Commissions duty of regulating the Duty of Candour.

The Board of Directors NOTED the governance report.

319/16  REVIEW OF DIRECTORS' INTEREST

The Board of Directors RECEIVED and NOTED the current Register of Interests for the Board.

As part of the twice a year review, members were requested to inform the Company Secretary, via e-mail, of any required changes.

ACTION - ALL

The omission of ‘Director of Corporate Trustee’ from the entry for the Executive Directors would rectified.

ACTION - AM

BOARD GOVERNANCE PLANNING

320/16  REVIEW OF BOARD ANNUAL PLANNER

The Board of Directors RECEIVED and APPROVED its forward annual planner.
It was AGREED that for the September 2016 meeting the Board would receive as part of the Operational Report an update on winter planning with the final plan to be submitted to the 1st November 2016 Board meeting.

ACTION - CH

321/16 DATE OF NEXT MEETING

The next meeting of the Board of Directors would be held on Monday 26 September 2016.

The Chairman opened the meeting to any questions or comments from observers on any aspect of the discussions held.

Mr Wray, Lead Governor, commented that year on year the Trust appeared to have difficulty in achieving the cost improvement targets within the timeframes and questioned if they were taken seriously within the Divisions.

Mr Vickers, Public Governor commented that staffing levels and financial matters influenced upon staff morale and anticipated that this was being considered by the Trust. The Chief Executive confirmed that this was being undertaken and highlighted a number of ways that this was being approached within the organisation.

Martin Havenhand
Chairman

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<th>Log No</th>
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<th>Action</th>
<th>Report/Agenda title</th>
<th>Minute Ref</th>
<th>Action</th>
<th>Lead Officer(s)</th>
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<td>22-Apr-16</td>
<td>Action Log</td>
<td>136/16</td>
<td>Log number 19 updated: Detailed report to BoD re nursing workforce in general and details of how to expand the ANP role (including definitions and job titles)</td>
<td>DoW</td>
<td>26/07/2016 29/11/2016</td>
<td>Verbal update on progress to be provided at Sept meeting</td>
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<td>22-Apr-16</td>
<td>Report from Chairman</td>
<td>137/16</td>
<td>Chairman to share proposed RTP Vision with the BoD once agreed between RTP partners.</td>
<td>Chair</td>
<td>October?</td>
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<td>39</td>
<td>24-May-16</td>
<td>Sustainability and Transformation Report</td>
<td>180/16</td>
<td>Details of the Care UK Contract to be shared with BoD when available</td>
<td>DoF</td>
<td>26-Jul-16</td>
<td>Verbal update on progress to be provided at Sept meeting</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>28-Jun-16</td>
<td>Evaluation of Children's Ward pilot</td>
<td>237/16</td>
<td>Update report to be provided to the December BoD</td>
<td>ChN</td>
<td>20-Dec</td>
<td></td>
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</tr>
<tr>
<td>55</td>
<td>26-Jul-16</td>
<td>Chairman's Report</td>
<td>271/16</td>
<td>External Board Review to be commissioned</td>
<td>CoSec</td>
<td>in progress</td>
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</tr>
<tr>
<td>57</td>
<td>26-Jul-16</td>
<td>Chief Executive's Report</td>
<td>272/16</td>
<td>Details of progress on the Trust Values work to be brought back to the Board</td>
<td>DoW</td>
<td>26/09/2016 01/11/2016</td>
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<td></td>
</tr>
<tr>
<td>62</td>
<td>26-Jul-16</td>
<td>Corporate Risk Register</td>
<td>278/16</td>
<td>Future Board reports to include more detail regarding risks that had been removed since the last presentation at Board</td>
<td>ChN</td>
<td>25/10/2016 01/11/2016</td>
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<td>Open</td>
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<tr>
<td>64</td>
<td>26-Jul-16</td>
<td>Review of Board Planner</td>
<td>284/16</td>
<td>Progress with winter planning to be reported to Board</td>
<td>COO</td>
<td>26-Sep</td>
<td>see log item 75 below</td>
<td>Recommend to close</td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>30-Aug-16</td>
<td>Action Log</td>
<td>314/16</td>
<td>Mortality data - position to be confirmed to QAC</td>
<td>MD</td>
<td>To be discussed at October QAC</td>
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<td>Open</td>
<td></td>
</tr>
<tr>
<td>68</td>
<td>30-Aug-16</td>
<td>Report from CEO</td>
<td>316/16</td>
<td>Members to contact CoSec should they require more detailed information pertaining to strategic objectives tracker</td>
<td>All</td>
<td>No requests received</td>
<td></td>
<td>Recommend to close</td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>30-Aug-16</td>
<td>Report from CEO</td>
<td>316/16</td>
<td>Any information available from national exercise for Carter to be shared with Finance and Performance Committee</td>
<td>DoF</td>
<td>Agenda item for the September F&amp;P Committee</td>
<td></td>
<td>Recommend to close</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>30-Aug-16</td>
<td>Workforce Report</td>
<td>317/16</td>
<td>Information on key issues relating to junior doctors industrial action to be shared with the Board</td>
<td>DoW</td>
<td>Report provided in part 1</td>
<td></td>
<td>Recommend to close</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>30-Aug-16</td>
<td>Finance Report</td>
<td>371/16</td>
<td>Clarity to be provided to Finance and Performance Committee in relation to reserves movements</td>
<td>DoF</td>
<td>Details provided within the September Finance report to the F&amp;P Committee</td>
<td></td>
<td>Recommend to close</td>
<td></td>
</tr>
<tr>
<td>72</td>
<td>30-Aug-16</td>
<td>Finance Report</td>
<td>371/16</td>
<td>Requirement to ensure that the discussions with the CCG at the Board to Board harness their support for delivery of the quarter 2 STP target</td>
<td>Chair</td>
<td>07-Sep</td>
<td></td>
<td>Recommend to close</td>
<td></td>
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<tr>
<td>73</td>
<td>30-Aug-16</td>
<td>Register of Interest</td>
<td>319/16</td>
<td>Director of Corporate Trustees to be added to entry for Exec Directors</td>
<td>CoSec</td>
<td>Completed</td>
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<td>Recommend to close</td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>30-Aug-16</td>
<td>Register of Interest</td>
<td>319/16</td>
<td>Any further amendments to be informed to CoSec via e-mail</td>
<td>All</td>
<td>No amendments requested</td>
<td></td>
<td>Recommend to close</td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>30-Aug-16</td>
<td>Review of Board Annual Planner</td>
<td>320/16</td>
<td>September Operational Report to include progress on winter planning, with the final document to be submitted to the November Board meeting.</td>
<td>COO</td>
<td>Progress reported in item 353/16(b). Final plan submitted in November.</td>
<td></td>
<td>Open</td>
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</tbody>
</table>
Report: Report from the Chairman

Presented by: Martin Havenhand, Chairman
Author(s): Anna Milanec, Director of Corporate Affairs/ Company Secretary

Strategic Objective: Governance: Trusted, open governance

Regulatory relevance:
Monitor: Licence Condition FT4
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
BAF: All
Corporate Risk Register: N/A

Purpose of this paper:
This paper provides an overview of progress on key issues since my last report to the Board.

Summary of Key Points:
- The Rotherham Together Partnership (RTP) are continuing to develop their vision for the future of the Borough.
- The South Yorkshire and Bassetlaw Partnership (STP) have submitted a financial plan to the centre and the STP itself will be submitted on 21st October 2016.
- Details of meetings and activities I have taken part in since the last Trust Board Meeting.

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

This paper provides an overview of progress and activities on key issues since my last report to the Board.

2.0 The Rotherham Together Partnership

I attended a Rotherham Together Partnership (RTP) meeting and workshop on 14th September and the partnership are making good progress in delivering the 2016/17 Community Action Plan. Following the meeting the Partnership had a further facilitated workshop to continue its work on developing a compelling vision for the Rotherham Borough.

3. Acute Care Collaboration Vanguard (Working Together Partnership - Provider)

The Chief Executive and I attended the WTP-P Trust Chairs and Chief Executive meeting on 5 September, and there continues to be a strong commitment to the WTP and reconfiguring health services for our communities.

It was also excellent to see a Communications Plan that is currently being worked through, which includes publication of a monthly report that can be presented to each of the Trust Boards.

4.0 South Yorkshire and Bassetlaw STP

PWC have been commissioned to assist with the production of our financial plan which was submitted to the Centre on 16th September 2016.

The STP is still scheduled to be submitted on 21st October 2016.

On the 3rd October the WTP Chairs and Chief Executives are holding a workshop to further discuss the governance of the WTP and the STP along with the emerging themes for the STP work.

5.0 Chairman activities

The Chief Executive and I had our quarterly meeting with the Trust's Staff Governors earlier this month.

The Trust Board and Rotherham's CCG Governing Body met on 7 September and discussed issues that are pertinent to the two organisations, and the wider health economy. Issues of quality, performance, governance, finance and collaboration were discussed.

It was agreed that the two boards would meet again, after the STP submission has been made, which is due on 21 October.

The Chief Executive provided an overview of the Urgent and Emergency Care Work Stream that she is leading, with others leading on other topics.
5.5 I met with Councillor Roche, the Chair of the Health and Wellbeing Board, and I'm pleased to report that this Board is most pleased with the “Rotherham Place” collaboration and the progress of the Locality Pilot.

5.6 We are recruiting for a new Non-executive Director and interviews are being held in early October.

Martin Havenhand
Chairman
September 2016
Report: Report from the Chief Executive

Presented by: Louise Barnett, Chief Executive
Author(s): Louise Barnett, 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:
Monitor: Licence Condition FT4 / RAF
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
- BAF: All
- Corporate Risk Register: As appropriate.

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

Summary of Key Points:
- Progress being made against the Trust’s strategic objectives

Board action required:
This report is for noting.
1.0 Introduction

1.1 This paper outlines progress regarding a number of key strategic and operational issues and stakeholder engagement since the last Trust Board meeting.

2.0 Care Quality Commission (CQC)

2.1 As previously reported, the formal part of the CQC’s announced re-inspection of the Trust will begin on Tuesday 27 September 2016.

2.2 A series of engagement events are already underway at the Trust with the opportunity for colleagues, patients and the public to further engage through the social media coverage that has been in place for several weeks leading up to the inspection.

2.3 The re-inspection will provide the opportunity for colleagues to showcase the improvements that have been made to patient care over the last eighteen months, since the last inspection, whilst also recognising the ongoing the quality improvement work underway and the wider challenges that the Trust is facing. The Trust is committed to working effectively with the CQC, to embrace the feedback that this re-inspection will provide, which will further support the Trust in our quality improvement journey.

3.0 Strategic Issues

3.1 Progress against the strategic objectives for 2016/17 is summarised at Appendix A and should be considered alongside the Integrated Performance Report and quarterly Board Assurance Framework report.

3.2 Work is underway to review the Trust strategy which will support the preparation of the Trust two year operational plan for 2017-19. Partnership work through the South Yorkshire and Bassetlaw Vanguard, and the Sustainability and Transformation Plan (STP), is continuing to be further developed. Regular progress reports will be provided to the Board.

3.3 The Carter Review is gaining pace, with the increased collection and sharing of information to support the NHS to improve efficiency and productivity. The Trust has an underlying deficit and welcomes the opportunities that will be provided to benchmark information and identify and drive increased efficiency.

3.4 The Integrated Sexual Health Service and the 0-19 Integrated Public Health Nursing Service are currently delivered by the Trust and I can confirm that, the commissioners, Rotherham Metropolitan Borough Council, have recommended that the Trust should be re-awarded both contracts. This decision was ratified by the council’s cabinet on 12 September 2016, with the new contracts due to come into effect from April 2017.

3.5 As part of the new contracts, the existing Contraceptive and Sexual Health (CaSH) and Genito-Urinary Medicine (GUM) services will come together as the Integrated Sexual Health Service and be provided out of one location. This will give patients access to both services within one consultation.
3.6 The 0-19 Service aims to provide young people and families with a seamless and flexible needs-led service. A central part of this is working closely together with other services in the Trust as well as with our partners across the community. A major benefit to both patients and colleagues is that each family will have a named nurse providing tailored support when it is needed.

3.7 Further service developments will take place to further transform services for patients and service users.

4.0 Finance

4.1 The financial position continues to be challenging, with both the income and expenditure position and cost improvement programme adverse to plan at Month 5. Whilst there has been some reduction in the level of dependency on agency working during the last five months, the overall pay bill is in excess of the planned levels which is financially unsustainable. Strengthened controls have been implemented in September, with increased focus from corporate and divisional teams to identify and drive further CIP, but increased pace of implementation and delivery is required to achieve the plan. At this point in the year, the Trust is still forecasting to deliver the year end position, however this is not without significant risk.

4.2 Steps continue to be taken to achieve the quarter 2 STP financial and operational performance targets. However, as discussed previously, the diagnostics standards will not be achieved, with improvement activities underway to address this going forward.

5.0 Colleagues

5.1 The development of a new set of Trust Values and supporting behavioural framework is underway and will be launched in October. These Values form part of the strategy review work and be reinforced through the 2017/18 plan, with engagement sessions running throughout quarter 4.

5.2 I can confirm that Sarah Cooper has been appointed as Lead Speak-Up Guardian for the Trust. Sarah will commence her role on 1/10/2016 and this will be for two days per month initially.

5.3 Junior Doctor’s Industrial Action is planned for October, November and December 2016 and is due to go ahead as follows with a full withdrawal of labour from 0800 to 1700:

- 5, 6 and 7 October (weekend covered) and then 10 - 11 October (note NHS England are treating this as a 7-day period)
- 14 - 18 November
- 5 - 9 December

In order to prepare, regular planning meetings are being held and Divisions are in the process of drawing up plans for cover and possible cancellation of elective activity; those patients affected will be advised accordingly. Assurances of preparation for action will be required by NHS England in the period leading up to and over the days
of action, with a comprehensive assurance plan to be submitted by the Trust on 26 Sep 16.

6.0 Stakeholder Engagement

6.1 Rotherham partners continue to meet on a weekly basis to further develop and refine the Rotherham Place Plan and there continues to be strong focus on the development of the Sustainability and Transformation Plan, with a number of meetings and events taking place since the last board meeting, with partners and stakeholders from across the footprint.

6.2 A board to board meeting was held between the Trust and Rotherham Clinical Commissioning Group in September, which provided an opportunity to review progress and challenges for the Trust during the current financial year and the progress being made to support sustainability through the Rotherham Place Plan and development of the STP.

7.0 Conclusion

7.1 The Trust needs to continue to take mitigating actions to address the current and future risks of delivery against this year’s plan, with a focus on internal performance to ensure the delivery of high quality care, performance standards and financial targets this year, alongside transformation, place-based and wider collaboration to achieve improved resilience and sustainability of services for the population we serve.

Louise Barnett
Chief Executive
September 2016
## Board Priorities 2016/17

<table>
<thead>
<tr>
<th>Sheet</th>
<th>Detailed Priorities and Key Deliverables</th>
<th>New priority number</th>
<th>Board Priorities 2016/17</th>
<th>Lead Dir</th>
<th>Delivery Milestones</th>
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<tbody>
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<tr>
<td>PATIENTS</td>
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<td>A M J J A S O N D F M</td>
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<tr>
<td>2</td>
<td>Improve the quality of admission to discharge care planning</td>
<td>1</td>
<td>Improve the quality of admissions to discharge planning (over 17?)</td>
<td>COO</td>
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<tr>
<td>10</td>
<td>Reduce non clinical ward moves</td>
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<tr>
<td>1</td>
<td>Improve rates of harm free care and explain use of safety thermometer</td>
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<tr>
<td>6</td>
<td>Recognising and responding to the deteriorating patient</td>
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<td>4</td>
<td>Reduce the incidence of medication errors</td>
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<td>5</td>
<td>Prevent missed or delayed diagnosis</td>
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<td>7</td>
<td>Improve mortality rates (reduce HMR and SHM)</td>
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<td>3</td>
<td>Improve responsiveness to complaints</td>
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<tr>
<td>8</td>
<td>Improve patient experience of our clinical administration systems (e.g. outpatient booking systems)</td>
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<tr>
<td>11</td>
<td>Develop new models of care supported by the Trust's clinical strategy, and consistent with the STP and Vanguard</td>
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<tr>
<td>13</td>
<td>Removal of unnecessary clinical variation to support the Trust's strategy</td>
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<tr>
<td>14</td>
<td>Clinically led estates plan and strategy in place to support the Trust's strategy</td>
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<tr>
<td>15</td>
<td>Clinically led IT plan and strategy in place to support the Trust's strategy</td>
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<tr>
<td>COLEAGUES</td>
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<td>A M J J A S O N D F M</td>
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<tr>
<td>18</td>
<td>Implement demand and capacity led job planning</td>
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<tr>
<td>19</td>
<td>Improved short and long term workforce planning</td>
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<tr>
<td>20</td>
<td>Attract, recruit and retain the right colleagues to provide the capability and capacity to deliver the operational plan and strategy</td>
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<tr>
<td>25</td>
<td>Right colleagues in the right place at the right time (E-rostering and roster management)</td>
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<tr>
<td>26</td>
<td>Improve medical engagement</td>
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<tr>
<td>22</td>
<td>To create a culture where our colleagues are engaged and accountable</td>
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<tr>
<td>24</td>
<td>To improve the health and wellbeing of our workforce - to be happy, healthy and here</td>
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<tr>
<td>21</td>
<td>Provide training, education and development for colleagues</td>
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<tr>
<td>36</td>
<td>Develop senior leadership development programmes</td>
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<td>GOVERNANCE</td>
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<td>A M J J A S O N D F M</td>
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<tr>
<td>16</td>
<td>Implement effective emergency preparedness and business resilience planning</td>
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<tr>
<td>30</td>
<td>Work with regulator regarding outstanding enforcement actions and address where possible</td>
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<tr>
<td>53</td>
<td>Implementation of audit recommendations – none outstanding over 3 months old, with 90% completed within original deadline. Non compliance reported to TMC and Audit Committee, alongside &quot;lessons learnt&quot; actions</td>
<td></td>
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<tr>
<td>54</td>
<td>Delivery of annual audit plan to agreed timescales</td>
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<tr>
<td>33</td>
<td>Strengthen risk management</td>
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<tr>
<td>32</td>
<td>Enhance governance arrangements from ward to board</td>
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<td>34</td>
<td>Strengthen the BAF</td>
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<td>35</td>
<td>Develop board leadership development programmes</td>
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<tr>
<td>42</td>
<td>Increased transparency and board visibility</td>
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<td>41</td>
<td>Enhance stakeholder governance</td>
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<td>38</td>
<td>Improve compliance with IG Toolkit</td>
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<td>39</td>
<td>Improve IG compliance culture / awareness</td>
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<td>31</td>
<td>Effective use of business intelligence and performance management frameworks</td>
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<td>40</td>
<td>Improve data quality</td>
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<td>FINANCE</td>
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<td>A M J J A S O N D F M</td>
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<tr>
<td>43</td>
<td>Deliver the 2016/17 financial plan</td>
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<tr>
<td>55</td>
<td>2016/17 Capital programme approved by the BoD</td>
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<tr>
<td>44</td>
<td>Reduce the underlying deficit within the 2016/17 financial year and then subsequent years</td>
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<tr>
<td>45</td>
<td>Deliver the 2016/17 CIP programme</td>
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<tr>
<td>46</td>
<td>Draft CIP plans for 2017/18 to come to TMC/F/P from October onwards</td>
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**Notes:**
- ✔️ Indicates completion.
- ☑️ Indicates progress.
- 🔄 Indicates ongoing.
- 🔄 🔄 Indicates critical ongoing.
- 🔄 🔄 🔄 Indicates significant ongoing.
## Detailed Priorities and Key Deliverables

<table>
<thead>
<tr>
<th>Sheet</th>
<th>Detailed Priorities and Key Deliverables</th>
<th>New priority number</th>
<th>Board Priorities 2016/17</th>
<th>Lead Exec Director</th>
<th>Delivery Milestones</th>
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</tr>
<tr>
<td></td>
<td>Engagement in the Lord Carter Productivity Programme (monthly updates to TMCT 1/4ly T&amp;I)</td>
<td>50</td>
<td>Improvements to support the financial sustainability of TRFT</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Improve utilisation and efficiency of theatres and maximise use of day case services</td>
<td>17</td>
<td>COO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduction of premium pay</td>
<td>27</td>
<td>DoW</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monthly cash balance in line with the 2016/17 annual plan</td>
<td>47</td>
<td>Delivery of the monthly cash control totals</td>
<td>DoF</td>
<td>1/4ly SLR reports</td>
</tr>
<tr>
<td></td>
<td>Improved aged profile of debtors</td>
<td>46</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implementation of PLICs including 1/4ly SLR reports</td>
<td>49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Financial training implemented across TRFT to all budget holders (face to face and e-learning)</td>
<td>51</td>
<td>Improved financial acumen and reporting within TRFT</td>
<td>DoF</td>
<td>1/4ly SLR reports</td>
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<tr>
<td></td>
<td>Consultant finance and business sessions – 100% to be offered sessions by Q1, with 30% delivered by Q2 (to support medical engagement programme)</td>
<td>52</td>
<td></td>
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## Partners

<table>
<thead>
<tr>
<th>Sheet</th>
<th>Detailed Priorities and Key Deliverables</th>
<th>New priority number</th>
<th>Board Priorities 2016/17</th>
<th>Lead Exec Director</th>
<th>Delivery Milestones</th>
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<tbody>
<tr>
<td></td>
<td>Extend the scale and pace of transformation across both adult, and children and young people's services consistent with the principles of 7 day working and effective governance</td>
<td>12</td>
<td>Transformation across adult and children services (including emergency centre)</td>
<td>COO</td>
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<tr>
<td></td>
<td>Supporting closer health and social care integration</td>
<td>57</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>To develop a shared vision of services across the Rotherham Place and the South Yorkshire &amp; Bassetlaw Sustainability &amp; Transformation Plan including the acute care collaboration vanguard</td>
<td>58</td>
<td></td>
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</tbody>
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**Legend:**
- Red: Less than 20% of plan on track
- Orange: 20% - 40% of plan on track
- Yellow: 41% - 60% of plan on track
- Green: 61% - 80% of plan on track
- Deep Green: 81% - 100% of plan on track

**Time allowed before plan ends:**
- 1/4ly: Quarterly
- 1/2ly: Half yearly
- 1ly: Yearly
Purpose of this paper:

To provide to the board, for endorsement and support, a copy of Rotherham’s Local Digital Roadmap (LDR).

In October 2015, NHS England asked all CCGs to form themselves into digital health and social care footprint geographic areas and commence the construction of a digital IT strategy for the next 5 years, that meets local and national digital aspirations across the health and care system.

Further guidance was issued the Spring of 2016, by NHS England, as to the form and format for LDR submission, whilst in tandem work had commenced on formulating a South Yorkshire and Bassetlaw digital Sustainability and Transformation plan.

The diagram to the right, represents how the various digital strategies will align and the LDR was submitted to NHS England in June 2016 (as such some detail may now be out of date, including timetables for endorsement, and planned organisational names/forms)
Summary of Key Points:

The key points arising from the LDR are:

- All health and social care organisations across Rotherham have contributed, including:
  - Rotherham Metropolitan Borough Council
  - Rotherham Clinical Commission group
  - Rotherham Doncaster and South Humber NHS Foundation Trust
  - The Rotherham NHS Foundation Trust
  - Rotherham Hospice

- The vision, across Rotherham health and social care, is to support care closer to home and empower patients so they can better self-manage their own health and care through digital services.

- The Trusts own digital strategy will be key enabler for the wider LDR and STP digital strategies.

Board action required: For approval
<table>
<thead>
<tr>
<th>Section</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>3</td>
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<td>2. Vision</td>
<td>5</td>
</tr>
<tr>
<td>3. Baseline Position</td>
<td>15</td>
</tr>
<tr>
<td>4. Readiness</td>
<td>25</td>
</tr>
<tr>
<td>5. Capability Deployment</td>
<td>28</td>
</tr>
<tr>
<td>6. Universal Capabilities Delivery Plan</td>
<td>31</td>
</tr>
<tr>
<td>7. Information Sharing</td>
<td>32</td>
</tr>
<tr>
<td>8. Infrastructure</td>
<td>36</td>
</tr>
<tr>
<td>9. Minimising Risks Arising From Technology</td>
<td>38</td>
</tr>
<tr>
<td>10. Glossary</td>
<td>39</td>
</tr>
</tbody>
</table>
1. Introduction

The Rotherham Local Digital Roadmap (LDR) has been developed by the Rotherham Interoperability Group. This group has been established to support the development and delivery of the LDR and includes clinical and informatics representatives from all organisations identified in the Rotherham LDR footprint submission of October 2015. These organisations, which have all made a significant contribution to the development of the roadmap, are:

- Rotherham Clinical Commissioning Group (RCCG)
- Rotherham Hospice
- Rotherham Metropolitan Borough Council (RMBC)
- Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)
- The Rotherham NHS Foundation Trust (TRFT)

Lead individuals from all these organisations have met to understand the Digital Maturity Index and baseline position across Rotherham. A small multi-agency group has then collaboratively developed the plan for the next 5 years and shared the development of the LDR within their own organisation for comments and feedback. The LDR has been shared across the system in organisational meetings and also in system wide meetings to ensure that there is a broad understanding of the direction of travel, approval of the LDR content and ambition, and commitment at a very senior level to support the implementation of the LDR.

There are strong links between the development of the Rotherham LDR and the South Yorkshire and Bassetlaw (SY&B) Sustainability and Transformation Plan (STP). Rotherham CCG’s Chief Clinical Information Officer (CCIO), who Chairs Rotherham’s IT Strategy Group and is a member of the Interoperability Group, is the clinical lead for the STP Digital work stream. Other members of the Interoperability Group have participated in stakeholder engagement exercises supporting the development of the Digital Chapter. The Rotherham CCG lead for the LDR participates in the SY&B LDR leads group, which includes both of the Accountable Officer Leads for the Digital Health work stream of the STP. Through all of the above engagement there has been the opportunity for input into the STP Digital Health work stream and this has supported the alignment of the Rotherham LDR with the STP, which is reflected in the shared vision presented later in this document.

During development the LDR has been discussed in a number of forums for comment including the:

- Rotherham Health and Wellbeing Board
- Rotherham CCG Engagement and Communications Sub-Committee
- Rotherham CCG Governing Body
- Rotherham CCG Operational Executive
- Rotherham IT Strategy Group
- Rotherham Interoperability Group
- South Yorkshire and Bassetlaw LDR Development Group
- TRFT Corporate Informatics Committee
- TRFT Clinical Informatics Development Group
- TRFT Trust Board
- TRFT Trust Management Committee
- RDaSH Health Informatics sub-committee
- RDaSH Finance, Performance and Informatics Committee
- RDaSH Unity (EPR) Programme Board
- Rotherham Hospice Board of Trustees
- RMBC Digital Council Board

The Rotherham Local Digital Roadmap (LDR) has been endorsed by the multi-agency IT Strategy Group and Rotherham CCG’s Operational Executive. Following submission at the end of June it will be further endorsed as follows:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Endorsed by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham</td>
<td>Rotherham Health and Wellbeing Board</td>
<td>13\textsuperscript{th} July 2016</td>
</tr>
<tr>
<td>NHS Rotherham CCG</td>
<td>Governing Body</td>
<td>6\textsuperscript{th} July 2016</td>
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<tr>
<td>Rotherham Hospice</td>
<td>Board of Trustees</td>
<td>22\textsuperscript{nd} August 2016</td>
</tr>
<tr>
<td>The Rotherham NHS Foundation Trust</td>
<td>Trust Board</td>
<td>25\textsuperscript{th} August 2016</td>
</tr>
<tr>
<td>Rotherham Doncaster and South Humber NHS Trust</td>
<td>Finance, Performance and Informatics Committee</td>
<td>21\textsuperscript{st} July 2016</td>
</tr>
<tr>
<td>Rotherham Metropolitan Borough Council</td>
<td>Digital Council Board</td>
<td>26\textsuperscript{th} July 2016</td>
</tr>
</tbody>
</table>
2. Our Vision

Our vision supports Rotherham’s ambition to deliver care closer to home and out of hospital where possible. To enable the delivery of this ambition our roadmap will empower patients so that they can better self-manage their own health and care through digital services and support the transformation of our health and care services so that they can increasingly be delivered out in the community.

Productivity and Prevention.
In Rotherham, we know from a range of engagement activity over the last few years that patients are frustrated when communication between services and between services and patients fail – this also leads to waste in the system and poor experiences. Simultaneously, as growing numbers people have increasingly positive experiences of digital technology in everyday life, the disparity between commercial services and the health sector is becoming more and more apparent.

We are also starting to see examples of patients choosing to be digital innovators, and where this is right, safe and beneficial for the patient it can work extremely positively. We actively acknowledge that there is some hesitancy and concern within the community, especially older people; and that patients need to be assured that their data will be safe.

In addition, we have started to discuss these issues with a variety of stakeholders and a sample of their comments is shown below:

**The Vision for Rotherham Health and Care Services (Place Based Plan)**

Rotherham is a fully co-terminus health and social care community with a population of 260,000, which makes a perfect test bed for new innovations. We have developed very strong, credible, robust joint working across our local Health and Care system,
supported by cross stakeholder sign up to our place based plan. We are all committed to whole system partnership working and passionate about providing the best possible services and outcomes for our population and maximising the best value for of the Rotherham pound.

We have already made significant progress on delivery of the key enablers within of our place based plan. As a Health and Care Community with the additional support of transformational funding at a local place base level, we know that we can move further and faster to deliver the required transformation to support system sustainability. On our journey we are already delivering in the following areas:

- **An Accountable Care Organisation** jointly providing Acute, Community and Emergency Primary Care Services.

- **A fully integrated Multi-specialty Community Provider model (MCP)** for community based services, which maps resources to deprivation and is underpinned by comprehensive risk stratification. It encompasses the following services on a locality basis. This innovation is in its third year of development

  1. All GP practices
  2. Voluntary sector (Including the National Award Winning Rotherham Social Prescribing Service).
  3. Secondary Care Physicians
  4. Social Care
  5. Community Nursing
  6. Community Therapists
  7. Community Mental Health Services
  8. Hospice in the community
  9. Re-ablement services (including intermediate care).
  10. Fire Service
  11. Police

A video demonstrating Rotherham’s vision for the future of community-based healthcare can be accessed from the link below: https://www.youtube.com/watch?v=e2HlhcNI1jU

- **A new integrated Emergency Centre** due to open in spring 2017, delivering ground-breaking ‘next available clinician’ delivery model with innovative staffing solutions, hitting many of the requirements of the Keogh Review for Urgent Care.

- **A 24/7 Care Coordination centre and associated rapid response teams** which manages system capacity and advises on the most appropriate level of care for patients to avoid hospital admission wherever possible.

- **One Public Estate approach** for Rotherham
• **Integrated IT** across health, social care and care homes. Linking up Health and Care records is a must do and we have already made good progress. Our model of one provider for Health IT has facilitated a coordinated approach.

• **Further Development of our social prescribing service to cover mental health clients and facilitate earlier hospital discharge.** We already target the top 5% of patients at risk of hospitalisation using risk stratification and GP judgement. We have identified non-medical interventions for over 5000 patients with amazing success, saving money and improving outcomes for patients. We are further developing this approach and wish to move further and faster to develop more interventions for mental health clients and services to support early hospital discharge.

The overarching vision for our health and care services is for people to live independently in the community, with prevention and self-care at the heart of our delivery. Our Local Place Based Plan (CCG Commissioning Plan) supported by existing initiatives within our locally agreed Better Care Fund provides a real opportunity to improve the lives of the Rotherham population and some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better service and better quality of life.

We will work together to achieve the following objectives. These are aligned with the outcomes set out in Rotherham’s Health and Well Being Plan.

1. An integrated health and social care delivery system which promotes joint working
2. An integrated commissioning framework with joint outcomes and service specifications
3. More care and support provided in people’s homes
4. Integrated care planning that addresses physical and psychological wellbeing
5. Individuals and families taking more control of their health and care
6. Accurate identification and active case management of people at high risk of admission
7. Broader use of new technology to support care at home
8. A financially sustainable model that targets resources where there is greatest impact
9. Prevention, self-care and empowering citizens, communities and frontline staff will be at the heart of everything we do.

**The Rotherham Local Digital Roadmap Vision**

We have five major existing assets that can be utilized in the delivery of our digital roadmap:

• The local energy and enthusiasm of the people of Rotherham
• Established track record of working together and strong working relationships across the roadmap partners.
• There are already a large number of joint initiatives in progress.
The availability of a wide range of health apps and device technology that already exist
The variety of organisations that can help achieve the vision

Our objectives are that we will:
- Engage patients, staff and communities from the start, developing priorities through the eyes of those who use and pay for the NHS
- Develop services that reflect the needs of patients and improve outcomes by 2020/21 and, in doing so, help close the three gaps across the health and care system that were highlighted in the NHS 5 Year Forward View
- Mobilise local energy and enthusiasm around place-based systems of health and care, and develop the partnerships, governance and capacity to deliver
- Provide a better way of spreading and connecting successful local initiatives

Realisation of our digital roadmap vision will include:
- Access to shared records (by health professionals, carers and people themselves);
- Access to a directory of services
- Access to digital services (e.g. virtual clinics);
- Enabling digital transactions (e.g. booking of appointments);
- Access to virtual assistants
- Utilisation of personal device technology to manage wellbeing (exercise and fitness, medication compliance, managing mental illness, etc.)

In so doing we will create a community where the majority of health and wellbeing transactions are digital and these services will enable people and carers to care and be cared for in their homes.

A model of how digital care might be accessed is shown in the diagram below. It shows digital health supplementing face to face intervention and complementing the range of interventions available. In this model services will be accessed more easily and the process of making appointments in primary, secondary and community care will be facilitated and will be underpinned by access to a unified clinical record to which people can add information.
Rotherham is a leader in the delivery of social prescribing and we anticipate a range of social prescriptions being developed which will encourage the adoption of digital means of transaction, access to records and the acquisition data. Supplementary to the above model we expect that we will increasingly utilise the developments in genetics, data analytics, population health management and personalised medicine to enable a sharper focus on more effective treatments for the citizens of Rotherham.

The key building block that underpins progress is the existence of an integrated record, between the multiple agencies involved in care and in safeguarding, a particular emphasis in Rotherham, so that all involved can be party to the transactions of others and so that patterns of abuse and exploitation can be detected and dealt with earlier in the cycle. An objective is to improve the perception of Rotherham to that of a locality that is proactively dealing with issues such as safeguarding and protection in an effective way.

Good progress has already been made towards an integrated digital care record across health, social care, care homes and citizens/patients. There has been development of the Rotherham Clinical Portal (RCP) connecting information from disparate health systems and the population of Social Care systems with NHS Numbers in preparation for further connectivity. Our portal is a central and key element in moving forward and achieving our vision.

Our plan is to further integrate systems by engaging suppliers to use national technical standards across Health and Social care and using the RCP as a secure “window” into organisational systems, and to support self-care patients will be able to view and add their own data and interact with Health and Social care professionals using modern technology. Finally, we are also planning to ensure we share and exchange information with other providers outside of Rotherham.

There exists in our geography resourceful and significant organisations that can contribute to this challenge - they include local colleges (for example Hallam
University is one of the largest training organisations for nurse training) and educational establishments, small and medium size businesses. There are a significant number of technical start-up companies in the locality. Engaging these organisations in developing applications will enable access to an agile capacity that can respond to the market demand faster than the NHS. All of this will still require provider organisations to digitize applications such as e-prescribing, which will clearly save lives and staff rostering systems so that resources are well managed. It will also require providers to ensure that transactions between the different care settings and agencies are digitized so that they can become part of the integrated record that is already being built and used. It will require providers to develop virtual ward applications in which beds in people’s homes are part of the virtual ward so as to extend care and clinical responsibility.

There is a need to create the visibility of records and care pathways in the context of which will exist the data collected by people. There are already examples of these applications in the USA and of initiatives such as care navigators and care coordination that are focused on the individual not on the facility. These are initiatives are also being utilized in the NHS Vanguard sites for new care models.

The proposed change and shift of emphasis from the most expensive intervention to the most appropriate and cheaper intervention is evidenced in the new Emergency Care Centre project at Rotherham. This same shift is mirrored in the proposed changes to community care in Rotherham so that more is done in people’s homes, but key to that is their engagement, involvement and sense of control over what is being done to them by whom, why and in what context.

Through implementation of our digital roadmap we expect that the delivery of new models of care in Rotherham will be significantly enhanced by the development of the digital services envisaged, so that care becomes more based upon:

- Self-care
- Proactive care interventions
- More appropriate care interventions

The digital priorities for Rotherham fall within the wider vision set out in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan Digital Work Stream which is below.

**South Yorkshire and Bassetlaw Sustainability and Transformation Plan Digital Vision**

Our digital health strategy has three essential elements.

- Citizen and Patient Empowerment
- System integration and operational efficiency
- Strategic decision support
Our future technology enabled communities will therefore be characterised by:

- Enabling health and care providers’ access to all patient clinical electronic data across traditional boundaries, agnostic of staff employer or organisation. Having a Shared Care Record in place, accessible to clinical staff or those who need it wherever they are, is the single most important change we need to make. As we develop our plans for clinical services across the wider SYB footprint, we will inevitably see more patients moving between organisations to receive care. Therefore it makes sense that our ambition for shared care records extends across this larger footprint. Access to Shared Care Records is particularly important for urgent and emergency care, but such a system would have significant benefits for clinical care. This ambition:

  o will require up to date hardware and wireless networks so that access to data is fast and easy for our citizens, patients, carers, staff or wider health and care communities;
  o will require us to develop clear rules within which we operate to ensure appropriate governance and security for patient data as well as interoperability of systems and technologies now and into the future. Consequently data, data management and systems will be subject to agreed national and local standards supporting on-going interoperability;
  o will incorporate data from multiple sources (including NHS and social care as well as other public and voluntary or charitable organisations) and include citizen generated data from citizen controlled devices and innovations (e.g. Apps);
will means citizens and patients take greater ownership for their health and wellbeing. They will be supported to do this through technology which promotes risk prediction, prevention as well as self-care and management.

- Innovation and learning will be part of our DNA, translated into rapid deployment of technology (e.g. related to access, devices, apps etc.) and signposting where helpful to achieve improved health and wellbeing outcomes. This will need us to also concentrate on improving digital literacy so that interventions help to bridge, not exacerbate, the digital health divide and health inequalities across our broad socio-economic communities. Personal health and wellbeing digital data needs to be as ‘consumable’ for health and care professionals as for citizens and patients in order to maximise potential.

- Robust population based analytics, supporting risk stratification and system alerts which result in rapid response and appropriate interventions tailored to the individual’s needs.

Within the next five years our system will therefore deliver a new way of supporting and working in partnership with our communities to achieve improvement in health and wellbeing outcomes and address current health and care challenges.

<table>
<thead>
<tr>
<th>Gap</th>
<th>How we will address the Gap</th>
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</thead>
<tbody>
<tr>
<td>Care and quality</td>
<td>• Shared records offering increased access to relevant, real time, information about a patient by health and care providers as well as patient authorised viewers</td>
</tr>
<tr>
<td></td>
<td>• Improved interoperability to enable more effective and efficient transfer of care across providers (e.g. through e-referral and discharge processes) supporting reduced waiting times and access to appropriate support</td>
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<tr>
<td></td>
<td>• Promote mobile working of practitioners through Wi-Fi accessibility and roll-out of remote working solutions for practitioners</td>
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<tr>
<td></td>
<td>• Use population data to help identify and provide evidence for best practice and quantitatively assess quality outcomes</td>
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<td></td>
<td>• Ensure better informed clinical decisions enabling more appropriate cost effective and safe care (e.g. avoiding drug</td>
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<tr>
<td>contra-indications) as well as support for safeguarding</td>
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<td>---</td>
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<tr>
<td>Improved patient experience through not having to repeatedly provide clinical details and not having to undergo unnecessarily repeat clinical tests</td>
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</tbody>
</table>

**Health and wellbeing**

- Patients will have significantly more control over their care, and experience better outcomes through improved treatment and medication adherence as well signposting to appropriate services within their community

- Increased citizen, patient and carer awareness of, and involvement in, health and care support and delivery will result in better knowledge about condition management, better self-care and achievement of patient determined outcomes

- Increased interoperability and strategic system intelligence will support proactive care. This will reduce the frequency of exacerbation, and support co-ordination of care to address health and care needs holistically - including mental health

- Promotion of remote monitoring, new forms of consultation (e.g. video, phone) and mobile health (mHealth) will also support care based in the citizen's own home, reducing the burden of routine care on patients, their carers and families, and health professionals

**Finance and sustainability**

- We will develop combinatorial innovations (including technologies as well as service changes) to promote increased efficiency in the on-going care and management of patients

- Greater integration of care will mean increased opportunity for admission avoidance

- Increased reliance on validated risk stratification and population analytics will enable more efficient case finding and targeted
Remote monitoring and surveillance will mean earlier intervention to avoid unnecessary use of secondary care resources and effective use of community based resources.

Better tracking and scheduling of staff resources will enhance operational efficiencies.

Reduced DNAs through easy access to GP booking systems, reminders, patient self-reporting/recording and active self-management.

Clinicians able to use their time more effectively through the use of technology.
3. Baseline Position

In preparation for development of the Local Digital Roadmap the two secondary care providers in the Rotherham footprint carried out a Digital Maturity Assessment between in November 2015 – January 2016. A summary of the results from this initial assessment of the two providers is shown in the table below:

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<th>Section</th>
<th>Type</th>
<th>RDaSH</th>
<th>TRFT</th>
<th>National Average</th>
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<tbody>
<tr>
<td>Strategic Alignment</td>
<td>Readiness</td>
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<td>81</td>
<td>76</td>
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<td>Leadership</td>
<td>Readiness</td>
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<td>Resourcing</td>
<td>Readiness</td>
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<td>66</td>
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<tr>
<td>Governance</td>
<td>Readiness</td>
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<td>Information Governance</td>
<td>Readiness</td>
<td>75</td>
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<td>73</td>
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<tr>
<td>Records, Assessments &amp; Plans</td>
<td>Capabilities</td>
<td>68</td>
<td>41</td>
<td>44</td>
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<tr>
<td>Transfers Of Care</td>
<td>Capabilities</td>
<td>13</td>
<td>58</td>
<td>49</td>
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<tr>
<td>Orders &amp; Results Management</td>
<td>Capabilities</td>
<td>15</td>
<td>79</td>
<td>52</td>
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<tr>
<td>Medicines Management &amp; Optimisation</td>
<td>Capabilities</td>
<td>11</td>
<td>14</td>
<td>29</td>
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<tr>
<td>Decision Support</td>
<td>Capabilities</td>
<td>68</td>
<td>48</td>
<td>36</td>
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<tr>
<td>Remote &amp; Assistive Care</td>
<td>Capabilities</td>
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<td>33</td>
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<tr>
<td>Asset &amp; Resource Optimisation</td>
<td>Capabilities</td>
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<td>Enabling Infrastructure</td>
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<td>68</td>
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<td>Readiness Average</td>
<td>Readiness</td>
<td>81</td>
<td>79</td>
<td>73</td>
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<td>Capabilities Average</td>
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<tr>
<td>Enabling Infrastructure Average</td>
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</tbody>
</table>

As can be seen from the table above the assessment scores for the Rotherham footprint identify that our current level of development is consistent with the national position. A key insight is that organisational readiness is strong but capabilities still need to be developed. Nationally the capability areas where it has been identified that there is particular room for growth are medicines management, decision support and remote care. Our scores indicate that these with the exception of decision support are also key development areas for Rotherham along with transfers of care, orders and results management and asset and resource optimisation.

In addition to the above exercise Rotherham CCG has submitted a Digital Maturity Assessment for primary care and Rotherham Metropolitan Borough Council has completed a Digital Maturity Assessment via the Local Government Association. Analyses of the results for these assessments will be included in future developments of the LDR.
The health and care providers in Rotherham currently have multiple record systems and multiple departmental systems. The illustration below shows the overall position.

An overview of the current digital maturity of the primary, secondary and social care providers within the Rotherham LDR footprint along with a summary of their recent achievements and current initiatives is given below:

**Primary Care**

All of the general practices in Rotherham have implemented the latest version of their chosen GP clinical system and use either TPP SystmOne (68% practices) or EMIS Web (32% practices).

Key recent achievements within primary care include:

- e-discharge has been provided to all practices from secondary care
- NHS 111 ITK has been rolled out to 70% of practices
- Mobile devices (laptops with 4G and software to support connectivity over Wi-Fi) have been deployed to all GPs and registrars and appropriate practice nursing staff.
- 100% Practices have been switched on for patient online services
- 65% Practices are ETP enabled
- SystmOne Care Home module deployed in one care home

The key initiatives currently on-going in primary care are:
- Development of an improved and extended Wide Area Network that will connect all Rotherham practices to a set of IT systems and services
- The rollout of Wi-Fi networks into all practice premises is nearing completion
- A programme of work is underway that will help practices meet quality data quality standards for recording and sharing information and improve the utilisation of GP clinical systems and utilisation of universal and local capabilities.

The Rotherham NHS Foundation Trust (TRFT)
TRFT includes both acute hospital and community services. TRFT took a decision eight years ago to procure and implement an EPR system - Meditech. There is currently an initiative to optimize the utilization of the Meditech product and to rationalise applications onto the platform. For example the A&E department is being migrated from Symphony onto a Meditech module this summer. Community records are held on SystmOne The Rotherham Clinical Portal provides an overarching capability to view record across the Trust.
Significantly the development of the Rotherham Clinical Portal (RCP) has been a precursor to any single system and has demonstrated the benefits of having an integrated view across multiple systems. The system is being extended as GP practices make their data available in the portal view and as the number of systems whose data is capable of being viewed is increased. The portal will be a key part of enabling doctors in the new Emergency Centre (which opens in 2017) to view data from Out of Hours, Walk-in, NHS111, Ambulance, hospital and community systems. The Trust has completed a Digital Maturity Assessment which shows a high readiness, good capability but requires some improvement in the enabling infrastructure.
Key recent achievements at TRFT include:
- Integration of RCP and MT/S1 with rich clinical data
- Outpatients SNOMED compliant
- Small number of clinical specialties eNoting in Outpatients Clinics within EPR
- Small number surgical specialities documenting Operation notes within EPR
- Full Radiology Results & Reporting from within EPR
- RCP used as real-time patient flow
- MediTech & RCP Integration
- RCP and MIG Interoperability
- Heart Failure using Telehealth
- Regional Wide (7 Acute Providers) Results & Reporting integration using ICE
- Community services fully mobile

The key initiatives currently on-going at TRFT are:

<table>
<thead>
<tr>
<th>Project/Initiatives</th>
<th>Project Status (In Progress, Approved, Planning)</th>
<th>Who for</th>
<th>What (Capability)</th>
<th>Capability Group</th>
</tr>
</thead>
</table>

20

44
<table>
<thead>
<tr>
<th>Rotherham Clinical Portal</th>
<th>In Progress</th>
<th>Hospital &amp; Community &amp; GPs &amp; Social Services</th>
<th>Provide integrated view of clinical information across Rotherham Health and Social Care</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Yorkshire HIE</td>
<td>Planning</td>
<td>Hospital &amp; Community</td>
<td>Share detailed clinical information across all South Yorkshire health and social care</td>
<td>All</td>
</tr>
<tr>
<td>RCP (SEPIA) - Rotherham Health and Social Care capacity display</td>
<td>Planning</td>
<td>Hospital &amp; Community &amp; GPs &amp; Social Services</td>
<td>Rotherham wide view of all Healthcare &amp; social care beds/occupancy/patient</td>
<td>Asset and resource optimisation</td>
</tr>
<tr>
<td>eRostering</td>
<td>In Progress</td>
<td>Hospital</td>
<td>digital management of hospital nursing rotas</td>
<td>Asset and resource optimisation</td>
</tr>
<tr>
<td>SystmOne Mobile</td>
<td>Planning</td>
<td>Community</td>
<td>community nursing teams to have ability to interact with community EPR whilst &quot;offline&quot;</td>
<td>All</td>
</tr>
<tr>
<td>RCP (SEPIA) Patient flow</td>
<td>In Progress</td>
<td>Hospital &amp; Community</td>
<td>Clinical teams from any location on any device can manage and update patient flow across and outside of the hospital, supported by real-time patient notification</td>
<td>Asset and resource optimisation</td>
</tr>
<tr>
<td>NHSMail2 migration</td>
<td>Planning</td>
<td>Hospital &amp; Community</td>
<td>Secure email and messaging platform</td>
<td>Asset and resource optimisation</td>
</tr>
<tr>
<td>Business Intelligence and Intranet</td>
<td>In Progress</td>
<td>Hospital &amp; Community</td>
<td>Accurate and easily accessible hospital clinical and management information to support decision making and performance monitoring</td>
<td>Asset and resource optimisation</td>
</tr>
<tr>
<td>EPR Storage and Servers</td>
<td>In Progress</td>
<td>Hospital</td>
<td>Refresh 7+ year old EPR server and storage infrastructure</td>
<td>Asset and resource optimisation</td>
</tr>
<tr>
<td>Corporate Hardware Storage and Servers</td>
<td>Planning</td>
<td>Hospital &amp; Community</td>
<td>Ensure servers and storage systems are fit for purpose</td>
<td>Asset and resource optimisation</td>
</tr>
</tbody>
</table>

Rotherham and South Humber NHS Foundation Trust (RDaSH)
RDaSH’s current level of digital maturity for capabilities is consistent with the national average across secondary care providers. Their self-assessment indicates that growth is required in their capabilities for transfers of care, orders and results.
management, medicines management and optimisation and remote and assistive care.

RDaSH are addressing these growth areas through their 5 year strategy published in April 2016 “Information Communication and Technology Strategy – Towards a Digitally Integrated Healthcare Environment”. This ambitious strategy which will see all Trust services transferred onto a unified EPR system has the four key strategic aims identified below:

- Improving patient experience
- Supporting agile working
- Enabling paper-free care delivery
- Reducing administrative overheads

Key recent achievements at RDaSH include:

- Procurement for the new EPR is underway using the SBS framework and is therefore due to complete end of Q2 2016
- Implementation of the EPR is scheduled for completion Sept-Dec 2017
- Large remote sites have been moved on to the Yorkshire and Humber Public Sector Network
- An upgrade of the Trust’s core IT infrastructure upgrade was carried out during 2014-2016

The key initiatives currently on-going at RDaSH are:

- Procurement, configuration and implementation of a new EPR
- Development of an Agile working strategy
- A review of IT security and governance procedures
- A review of the Trust email services
- Investment in data warehouse capability

RMBC

RMBC are currently implementing a replacement social care system (Liquidlogic) across their adults and children’s services. It is anticipated that the system will be fully live by the end of 2016. It is expected that that data sharing will become much easier between health and social care services when the new system is in place.

Key recent achievements at RMBC include:

- All social workers have the ability to access systems and data when mobile.
- NHS number matching processes is in place and over 90% of open cases have the NHS number recorded (children’s and adults)
- New social care system procured and is being deployed, which will bring enhanced functionality.

The key initiatives currently on-going at RMBC are:

<table>
<thead>
<tr>
<th>Project/Initiatives</th>
<th>Project Status (In Progress, Approved, Planning)</th>
<th>Who for</th>
<th>What (Capability)</th>
<th>Capability Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replacement Social Care System</td>
<td>In Progress</td>
<td>Social Care Staff</td>
<td>Improvements to current social care system to underpin delivery of future integration with Health</td>
<td>Records, assessment and plans</td>
</tr>
<tr>
<td>Rotherham Clinical/Care Record Portal</td>
<td>Planning</td>
<td>All partners</td>
<td>A single secure website which will hold all appropriate health and social care data</td>
<td>All</td>
</tr>
<tr>
<td>e-Discharge</td>
<td>Planning</td>
<td>Social Care Staff</td>
<td>Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care</td>
<td>Transfers of care</td>
</tr>
<tr>
<td>Child Protection - Information Sharing</td>
<td>Approved</td>
<td>Social Care and emergency care</td>
<td>Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly</td>
<td>Decision Support</td>
</tr>
<tr>
<td>Initiative</td>
<td>Phase</td>
<td>Partner(s)</td>
<td>Description</td>
<td>Benefit</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------</td>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Shared HSC Wi-Fi</strong></td>
<td>In Progress</td>
<td>Social Care Staff</td>
<td>Giving NHS staff the ability to work from RMBC buildings (e.g. Care Homes) and vice versa</td>
<td>Asset and resource optimisation</td>
</tr>
<tr>
<td><strong>Mobile Working</strong></td>
<td>In Progress</td>
<td>Social Care Staff</td>
<td>Continuing to improve (e.g.) social worker access to systems and data from (e.g.) client homes</td>
<td>Asset and resource optimisation</td>
</tr>
<tr>
<td><strong>NHS Number Matching and Use</strong></td>
<td>In Progress</td>
<td>All partners</td>
<td>Underpins many other projects – the adoption of the NHS number as the unique ID for all clients.</td>
<td>All</td>
</tr>
<tr>
<td><strong>Overarching Information Sharing</strong></td>
<td>In Progress</td>
<td>All partners</td>
<td>To ensure all data exchange is legal and that clients are clear as to how their data is being used (includes the facility to opt out)</td>
<td>All</td>
</tr>
<tr>
<td><strong>Fax Elimination</strong></td>
<td>Planning</td>
<td>All partners</td>
<td>Digitising communication between organisations</td>
<td>Records, assessment and plans</td>
</tr>
</tbody>
</table>

**Rotherham Hospice**

Rotherham Hospice currently uses SystmOne as its main clinical system. For viewing of wider records it uses EMIS Web viewer, SWIFT (RMBC), The Rotherham Clinical Portal and ICE for results reporting.

Key recent achievements at Rotherham Hospice include:
• Implementation of the Rotherham Clinical Portal
• Provision of mobile devices for CNS/Community rapid response team and medics
• Implementation of the EMIS Web viewer.

The key initiatives currently on-going at Rotherham Hospice are:

• Preparation for migration of the TPP contract
• A review of IT Strategy and capabilities as a business

Out of Hours (OOH) Services

The OOH service is currently provided in Rotherham by Care UK and the system that they use is Adastra. Care UK will be moving to SystmOne during 2016/17. The data from OOH service will be integrated into the RCP as part of the development of the Emergency Centre Solution in 2017. Full integration will be sought when they have migrated to SystmOne.

Population Baseline

Our roadmap aspires to provide enhanced and increased digital services for the people of Rotherham. The information in this section provides the most recent information on the use of Internet services by the Rotherham population.

There are three main forms of access to digital services – the PC, Smartphone and Smart TV. In terms of local access to digital services, there is evidence of a local digital divide.

A recent statistical bulletin from ONS shows that the usage of the Internet in Barnsley, Doncaster and Rotherham is at one of the lowest rates in the country.

<table>
<thead>
<tr>
<th>Used in the last 3 months</th>
<th>Used over 3 months ago/Never used</th>
</tr>
</thead>
<tbody>
<tr>
<td>80.4</td>
<td>74.4</td>
</tr>
</tbody>
</table>

However statistics for phone ownership in the first quarter of 2014 and 2015 show that mobile phone ownership as a proportion of the population is high in the UK although smart phone ownership is lower.

Proportion of adults who personally own/use a mobile phone in the UK

93% (Q1 2014) 93% (Q1 2015)
Proportion of UK adults with a smartphone 61% (Q1 2014) 66% (Q1 2015)

The third means of access is smart TV and another OFCOM publication shows that over half of adults had a connected TV at the end of 2014 and evidence is that this will have increased.

Additionally access to Wi-Fi is an important enabler for smart phone access - a recent study shows that the UK had a Wi-Fi hotspot for every 11 people who were third behind the France and the US. The study predicted rapid growth in Wi-Fi hotspots between 2014 and 2018.

Access will be a key local issue that we will have to monitor so that the take up of digital services is not impeded. We will work closely with the Rotherham Digital Inclusion Network (RDIN) to encourage our citizens to get online and use digital services.

Rate Limiting Factors

There are a number of rate limiting factors in progressing paper free at point of care delivery across the Rotherham footprint. The key factors have been identified as:

- Unable to have coded data due to Clinical systems APIs not being available
- Feedback on capital funding bids delays ability to move forward with IT improvements and efficiencies
- Limited capacity to deliver in certain key areas (Project management, benefits management, Systems Architecture)
- Significant cuts in capital development
- In hospital Infrastructure near end of life
- MediTech currently does not support a "mobile interface"
- Lack of single clinical system across the Trust. Resulting in reduced functionality including the ability to share data.
- Lack of interoperability within the health and social care community
- Hospice still awaiting transfer onto their own ODS number, which may delay migration and risk access to SystmOne post 7th July
4. Readiness Assessment

As identified in section 1 we have established a new group, the Rotherham Interoperability Group, to support development and manage the delivery of our LDR. The group is chaired by the CCG Head of Health Informatics and has clinical and informatics representatives from all organisations. Clinical representation includes the CCG’s and TRFT’s Chief Clinical Information Officers. The seniority of the group membership helps to provide strong leadership and links back to LDR partner organisations.

The Interoperability group is accountable to the multi agency Rotherham IT Strategy Group, which is chaired by the CCG’s Deputy Chair and reports to the CCG Governing Body. The Interoperability Group also reports updates and progress to partner Informatics Boards, including TRFT’s Corporate Informatics Committee and RMBC’s Digital Council Board. This link helps to ensure that all partner organisations are clearly sighted and supportive of the roadmap objectives.

Progress on the delivery of the LDR will be reported to Interoperability Group and to existing provider informatics groups as per existing governance arrangements.

The current governance and programme structure for the Rotherham LDR is shown in the diagram below:

Interoperability group and make changes as required. We will also continue to participate in the development of potential programme/project resources at the SYB STP level, to identify where resources supporting the LDR could be best shared across the wider area.

There already exists across the Rotherham locality a significant informatics resource and capability with experience of delivering large informatics programmes including acute and community EPRs.
We are currently exploring the potential opportunity to engage an experienced programme lead, who works for the HSCIC, to work on our LDR programme during the remainder of 2016 to help establish our formal programme approach. Within our LDR footprint at present there isn’t a common change model or benefits management approach. Discussions at the Interoperability Group have identified that currently the approach to managing technology enabled change and benefits management at an organisational level does not follow a standard methodology. Our discussion on benefits management in particular has raised awareness that partner organisations may not currently have the required skills or resources to provide a formal benefits management programme. We are clear that to achieve benefits requires addressing three elements: people, process and technology. It also requires significant documentation of the baseline position so that variances from the baseline can be observed and accounted for. We will therefore identify appropriate change and benefits management’s models and implement them within our LDR community. These requirements have also been discussed at the South Yorkshire and Bassetlaw LDR Leads group and they were noted as a common requirement across several of the constituent LDR footprints. We will therefore seek to assess if these skills and resources could be provided and shared on a wider footprint. The existing budgets for IT Capital and Revenue are already over committed throughout Rotherham. It is therefore expected that to drive digital maturity further and faster we will need access to additional funding. We have identified the following potential sources for this:

- The Driving Digital Maturity Investment Fund
- The Estates and Technology Transformation Fund
- Sustainability and Transformation Plan Funding
- Prime Minister’s Access Fund
- Additional funding opportunities e.g. through Local Government and charities

Working together in partnership to deliver the LDR for Rotherham will enable and require much greater engagement, and co-working between the informatics departments across the footprint than before. It is expected that through this closer working we will be able to identify opportunities to share and rationalise systems, services, skills and resources for the benefit of the whole community.
5. Capability Deployment

Operating Paper-free at the Point of Care is about ensuring health and care professionals have access to digital information that is more comprehensive, more timely and better quality, both within and across care settings. Its scope is defined by the following seven groups of capabilities:

- Records, assessments and plans
- Transfers of care
- Orders and results management
- Medicines management and optimisation
- Decision support
- Remote care
- Asset and resource optimisation

The current level of maturity of Rotherham’s secondary care providers for the above groups of capabilities, as assessed by the digital maturity assessment, is detailed below:

<table>
<thead>
<tr>
<th>Group of Capabilities</th>
<th>The Rotherham NHS Foundation Trust</th>
<th>Rotherham and South Humber NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records assessments and plans</td>
<td>41</td>
<td>68</td>
</tr>
<tr>
<td>Transfers of care</td>
<td>58</td>
<td>13</td>
</tr>
<tr>
<td>Orders and results management</td>
<td>79</td>
<td>15</td>
</tr>
<tr>
<td>Medicines management and optimisation</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Decision support</td>
<td>48</td>
<td>68</td>
</tr>
<tr>
<td>Remote Care</td>
<td>33</td>
<td>25</td>
</tr>
<tr>
<td>Asset and resource optimisation</td>
<td>10</td>
<td>40</td>
</tr>
</tbody>
</table>

The above identifies that the level of maturity across our two providers for these capability groups is variable with some low levels of maturity for both providers in certain groupings. The assessment indicates that there is further work to be done across all capability groupings to enable Rotherham to realise the ambition of operating paper free at the point of care.
As described in our vision the partners in the Rotherham LDR footprint are committed to the further delivery of digitised and shared care records across Rotherham as these will be essential to the delivery of many of our strategic ambitions. We are also committed to working with our partners across the wider South Yorkshire and Bassetlaw STP footprint to deliver shared care records across the whole STP footprint.

To address the growth areas above we have identified a range of projects across the Rotherham LDR footprint that will support development of the necessary capability. The outputs from these projects have been captured in the Capability Deployment Schedule shown in Appendix 1. The deliverables for 2016/17 are based on in-flight projects that will delivered this year. Deliverables for future years are aspirational and will be dependent on approved business cases and funding. To deliver on our roadmap we will require finance and support and will make bids against the available technology funds for this.

Over the course of the next three years, as we deliver on the ambitions set out in this roadmap, our capabilities for the delivery of paper free care will be significantly increased. The estimated trajectories for the overall increase in the capabilities of our secondary care providers in shown in the Capability Trajectory score and diagram below (and in appendix 2):

<table>
<thead>
<tr>
<th>Capability group</th>
<th>Baseline score (Feb 16)</th>
<th>Target (end 16/17)</th>
<th>Target (end 17/18)</th>
<th>Target (end 18/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records, assessments and plans</td>
<td>54.5</td>
<td>60.0</td>
<td>80.0</td>
<td>85.0</td>
</tr>
<tr>
<td>Transfers of care</td>
<td>35.5</td>
<td>36.5</td>
<td>57.5</td>
<td>90.0</td>
</tr>
<tr>
<td>Orders and results management</td>
<td>47.0</td>
<td>47.5</td>
<td>77.5</td>
<td>85.0</td>
</tr>
<tr>
<td>Medicines management and optimisation</td>
<td>12.5</td>
<td>15.5</td>
<td>40.0</td>
<td>80.0</td>
</tr>
<tr>
<td>Decision support</td>
<td>58.0</td>
<td>60.0</td>
<td>75.0</td>
<td>85.0</td>
</tr>
<tr>
<td>Remote care</td>
<td>29.0</td>
<td>31.5</td>
<td>67.5</td>
<td>87.5</td>
</tr>
<tr>
<td>Asset and resource optimisation</td>
<td>25.0</td>
<td>45.0</td>
<td>47.5</td>
<td>80.0</td>
</tr>
</tbody>
</table>
6. Universal Capabilities Delivery Plan

The Rotherham health and care system will make progress on the 10 universal capabilities, listed below,

- Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
- Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)
- Patients can access their GP record
- GPs can refer electronically to secondary care
- GPs receive timely electronic discharge summaries from secondary care
- Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care
- Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
- Professionals across care settings made aware of end-of-life preference information
- GPs and community pharmacists can utilise electronic prescriptions
- Patients can book appointments and order repeat prescriptions from their GP practice

Our approach for addressing each of these capabilities is detailed in the Universal Capability Delivery Plan in appendix 3. The delivery plan details the baseline, ambition, key activities and approach to evidencing progress for each of the capabilities.
7. Information Sharing

A diagram showing how new information sharing capabilities will be deployed in Rotherham over the next 5 years and the corresponding solutions that will enable this information sharing are shown below (and in appendix 4):

The diagram above shows how we will optimize information from the variety of existing source systems via use of the Rotherham Clinical Portal to enable patients, GPs, providers and carers to get an integrated view of a patient record across multiple systems. The RCP is important in also enabling the capture and dissemination of end of life preferences and indeed will be linked up to the Rotherham Hospice early in the plan. The actions detailed in the Capability Deployment Plan (appendix 3) in 2016/7 and 2017/8 will underpin progress to achieving this vision.

Health and Care organisations in Rotherham are in the process of signing up to an existing Inter-Agency Information Sharing Protocol which has over 60 signatories from a variety of organisations across the Yorkshire and Humber region, including NHS Foundation Trusts, Clinical Commissioning Groups, Mental Health Trusts, Local Authorities, Ambulance Service, Voluntary Sector Organisations, Police and Fire Services. The protocol covers the sharing of person-identifiable confidential data where a legal basis exists to allow information sharing (where this is not the explicit consent of the individual, another legal or statutory basis for the sharing must be identified).

In Rotherham, Information Sharing Agreements have been developed to enable the sharing of records using the Rotherham Clinical Portal. The RCP allows health and
care organisations who are providing direct care to individuals a view of the clinical
records of patients held across a number of care settings, where the patient has
explicitly consented to this view at the point of care. It is anticipated that sharing
agreements will be in place between The Rotherham NHS Foundation Trust,
Rotherham, Doncaster and South Humber NHS Foundation Trust, GP Practices
under Rotherham CCG, Rotherham Hospice, Yorkshire Ambulance Service and
Rotherham Metropolitan Borough Council.
This will be supported by communications to the public across Rotherham, co-
ordinated by Rotherham CCG, to ensure that patients are made aware of the RCP,
how information will be shared and used and will allow patients the opportunity to
object to their record being made available to view within the RCP. The viewing of
the records within the Portal will be on explicit consent of the patient only. Access to
the Portal will only be available to Health and Social Care Professionals who have a
direct care relationship with the patient. In future the portal will also be made
available to patients and their carers.
Information Governance Leads from health and care organisations across
Rotherham (Acute, CCG, Mental Health and Local Authority) meet on a monthly
basis as an Information Governance Group to facilitate partnership working. This
group reports to the Rotherham Interoperability Group This approach ensures
consistency with regards to information sharing between the organisations and
allows for any concerns regarding the lawful basis for proposed information sharing
to be discussed and satisfied before sharing takes place.
The Information Governance Group will consider proposals for new projects which
require the sharing of information between the member organisations and will advise
on the appropriate requirements including the completion of privacy impact
assessments to ensure that information sharing is lawful and that due consideration
is taken regarding appropriate safeguards that should be in place to protect patient
information.
As part of our work within the wider SYB footprint we recognise the need to have a
shared approach to information sharing (through both an information governance
framework and technical solutions). Our intention is to engage in a wider joint
approach across all SYB (or wider) health and care organisations and we will be
seeking to take this work forward within the SYB STP governance arrangements. We
also recognise that we will need to develop an approach to appropriate information
sharing with other organisations including emergency services and the voluntary
sector.
The current level of adoption of the NHS Number across health and care providers in
Rotherham is shown in the table below:

<table>
<thead>
<tr>
<th>Provider</th>
<th>% records in key systems with NHS number</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRFT Meditech</td>
<td>Meditech (Acute EPR) - 99.8%</td>
<td>The A&amp;E department will migrate from the Symphony system to Meditech during 2016/17. This will facilitate improved NHS Number completion in A&amp;E</td>
</tr>
<tr>
<td></td>
<td>SystmOne (Community) EPR – 99.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symphony (A&amp;E) – 86.6%</td>
<td></td>
</tr>
<tr>
<td>RDaSH</td>
<td>99.9%</td>
<td>None required</td>
</tr>
<tr>
<td>Rotherham Hospice</td>
<td>A spine compliant system is used for Hospice records. Therefore very high NHS number completion is reported.</td>
<td>None required</td>
</tr>
</tbody>
</table>
RMBC has established a relationship with colleagues in TRFT Informatics and the CCG Business Intelligence Teams. RMBC now have an agreement with the Informatics Team whereby they will match records and assign NHS numbers. NHS Informatics uses their own routines to analyse the data and send back matched records. RMBC also receive analysis as to why any unmatched records have failed to achieve a match.

Business as usual NHS number assignment will become considerably easier after the new social care system goes live later in 2016. The new system includes the facility to integrate with the NHS ‘Patient Demographic Service’ (PDS) – which will deliver the ability to quickly look up NHS numbers on the NHS spine.

Whilst RMBC are waiting for that facility to go live they will add new NHS numbers manually and also continue to use the local Informatics’ team matching bureau for batch processing.

In order to extract the most value from the sharing of information, the SNOMED-CT and Dictionary of Medicines and Devices (dm+d) information coding standards will have to be rolled out across the local health and care system. Our plans and milestones for the adoption of these standards are summarised in the table below:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>SNOMED is already implemented in EMIS Web. The CCG will seek confirmation from the GPSoC programme of when it will be available in SystmOne.</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>dm+d</td>
<td>dm+d is already available in EMIS Web and SystmOne.</td>
</tr>
<tr>
<td>TRFT</td>
<td>SNOMED is within the acute EPR system. TRFT will continue to review when this functionality will be available for community SystmOne.</td>
</tr>
<tr>
<td>Rotherham Hospice</td>
<td>The hospice will continue to review when this will be available for SystmOne Hospice. dm+d is already available in SystmOne.</td>
</tr>
<tr>
<td>RDaSH</td>
<td>The implementation of SNOMED will be facilitated by the introduction of the new EPR system.</td>
</tr>
</tbody>
</table>
8. Infrastructure

The development of network connectivity between sites and mobile infrastructure has been progressed significantly in Rotherham over recent years. We have been working to rationalise and deploy network connections from the Yorkshire and Humber Public Sector Network (PSN) across primary care, secondary care and local authority sites for several years. These network connections are now fully deployed in RDaSH and RMBC and continue to be rolled out into TRFT and primary care, giving us increased capability to share information and services across providers. Rotherham has supported the development of the NHS Roam Wi-Fi solution, developed under the Working Together Partnership, and this has been implemented in sites at TRFT and RDaSH allowing staff to move and work across sites. In the future we aim to further develop this capability to allow seamless mobile working for health and care practitioners across all health and care sites in Rotherham.

A summary of the current mobile working capability in Rotherham and plans to develop this further is shown below:

| Primary Care | All GPs and Registrars within Rotherham practices have been allocated a laptop with mobile provision. The mobile connection is delivered by a solution that provides access over 4G and Wi-Fi networks helping to maintain a secure and reliable connection to system. To support mobile connectivity in GP practices we have invested in a GP practice Wi-Fi solution for all sites and this was deployed during 2015/16.

Wi-Fi connectivity is also available for GP connection at some care/nursing homes and this will be further rolled out to more sites over 2016/17. |
|---|---|
| TRFT | The majority of community teams have mobile devices. In the hospital site laptops on wheels are used. Wi-Fi is available across all key buildings and locations. The RCP is already accessible from any mobile device.

TRFT will deploy SystmOne mobile in 2016/17 to relevant teams and explore the suitability of alternative devices. In hospital, TRFT are exploring with their EPR supplier the ability to use handheld devices to interact with the patient record and add clinical data. The "Opening" of back office systems is also planned to enable access from any mobile device. |
| RDaSH | Infrastructure to facilitate mobile working (3G/4G plus VPN) is available. Staff have the ability to access this infrastructure depending on need. Wi-Fi is deployed to areas across the Trust.

A Mobile/Agile programme is now in place to support the Trust wide Transformation Programme. This will include extending Wi-Fi |
Rotherham Hospice

All community nurses and medics have ability for mobile working.

Rotherham Hospice is planning to develop their in-house IT service capability and capacity.

RMBC

All RMBC staff has access to their systems and information from any location where an internet connection can be established.

It is planned that more care home Wi-Fi will be enabled and Social workers are to be issued with tablet devices.

As detailed above the providers in Rotherham have implemented connectivity to a common wide area network infrastructure (PSN) and have discussed how this could be used to support collaboration and shared infrastructure in the future. There are currently discussions underway in the footprint regarding a shared data centre between TRFT and RMBC, an initiative to join-up active directories and the potential for BI tools and dashboards to be cloud hosted. We haven’t yet considered the implementation of tools to support collaboration across the Rotherham footprint but adoption of the NHSmail2 service is currently under consideration for primary care, TRFT, RDaSH and the CCG and we are keen to see how this development could support a future collaboration platform.

In Rotherham we have some areas of shared infrastructure in place across our organisations. TRFT provide an IT service that covers themselves, all General Practices and the CCG. This service has significant areas of shared infrastructure and this continues to develop as the IT services grow and are rationalised across our organisations.

As our LDR programme develops and the partner organisations develop their digital maturity we will use the opportunities provided by working in partnership to identify where infrastructure, systems and IT services could be shared across the Rotherham footprint or possibly wider across the STP or Working Together areas.
9. Minimising Risks Arising from Technology

All partners within the Rotherham LDR footprint have their own well established Information Governance functions and will remain responsible for minimising risks associated with data security, clinical safety, data quality, data protection, privacy, business continuity and disaster recovery.

The routine reporting of risks and issues has been established at the Rotherham Interoperability Group and we will use this process to ensure that key risks to LDR delivery and operation are communicated across the footprint and mitigated as appropriate. Within the Rotherham locality over the next three years there will be changes to core systems of several providers and we will monitor and review issues and risks associated with these developments through the Interoperability Group. In addition we have established a footprint wide Information Governance operating as sub-group to the Interoperability Group. We have also recognised that there is the opportunity for working more collaboratively on the wider STP footprint to support this agenda and we will continue to engage with partners across this wider area.

TRFT and RDASH are both developing plans for the GS1 standards. All TRFT systems procurements include reference to GS1 standard and they have completed a review of key patient ID systems and confirmed that they are GS1 compliant (track and trace, Patient ID).
<table>
<thead>
<tr>
<th><strong>Glossary</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A&amp;E (Accident and Emergency)</strong></td>
<td>A medical treatment facility specialising in acute care of patients who present without prior appointment.</td>
</tr>
<tr>
<td><strong>CCG (Clinical Commissioning Group)</strong></td>
<td>Clinical commissioning groups will cover the whole of England and will be responsible for commissioning the majority of healthcare for their local population. They will work with partners including NHS England and local authorities, who have responsibility for commissioning areas such as specialised services, primary care and public health, to commission integrated care for patients.</td>
</tr>
<tr>
<td><strong>DMA (Digital Maturity Assessment)</strong></td>
<td>The Digital Maturity Assessment measures the extent to which healthcare services in England are supported by the effective use of digital technology. It will help identify key strengths and gaps in healthcare providers’ provision of digital services at the point of care and offer an initial view of the current ‘baseline’ position across the country.</td>
</tr>
<tr>
<td><strong>EPS (Electronic Prescription Services)</strong></td>
<td>The Electronic Prescription Service is an NHS service that allows a GP to send prescriptions directly to a patient’s chosen pharmacy. This means that patients can choose to have a paper-free prescription.</td>
</tr>
<tr>
<td><strong>GP (General Practice)</strong></td>
<td>General practice (GP) General practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.</td>
</tr>
<tr>
<td><strong>GPsOC (GP Systems of Choice)</strong></td>
<td>GP Systems of Choice is a programme through which the NHS funds the provision of GP clinical IT systems in England.</td>
</tr>
<tr>
<td><strong>Local Digital Roadmap (LDR)</strong></td>
<td>Local health economies are required to produce Local Digital Roadmaps detailing the actions they will take to deliver the ambition of being paper-free at the point of care by 2020. Local Digital Roadmaps will generate momentum and drive transformation across local health economies, inform local investment priorities and support local benefit realisation strategies.</td>
</tr>
<tr>
<td><strong>NHS Digital (HSCIC)</strong></td>
<td>The national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care. NHS Digital (HSCIC) is an executive non-departmental public body, sponsored by the Department of Health.</td>
</tr>
<tr>
<td><strong>NHS e-RS (NHS e-Referral Service)</strong></td>
<td>NHS e-Referral Service replaced Choose and Book in 2015. This</td>
</tr>
<tr>
<td><strong>e-Referral Service)</strong></td>
<td><strong>Service</strong> is used to manage all appointments referred to secondary care from primary care</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>PF@POC (Paper Free at the Point of Care)</strong></td>
<td>Paper free at the point of care means that all authorised care givers can access a patient’s relevant digital records when and where they need them.</td>
</tr>
<tr>
<td><strong>PSN (Public Services Network)</strong></td>
<td>The Public Services Network (PSN) is the UK government’s high-performance network, which helps public sector organisations work together, reduce duplication and share resources.</td>
</tr>
<tr>
<td><strong>SCR (Summary Care Record)</strong></td>
<td>The Summary Care Record is an electronic record used to support patient care. The SCR is a copy of key information from a patient’s GP record, such as medication, allergies and adverse reactions. It provides authorised healthcare staff with faster, more secure access to essential patient information</td>
</tr>
<tr>
<td><strong>Social Care</strong></td>
<td>Social care in England is defined as the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.</td>
</tr>
<tr>
<td><strong>SNOWMED</strong></td>
<td>SNOMED CT (Systematized Nomenclature of Medicine -- Clinical Terms) is a standardized, multilingual vocabulary of clinical terminology that is used by physicians and other health care providers for the electronic exchange of clinical health information.</td>
</tr>
<tr>
<td><strong>Sustainability and Transformation Plan (STP)</strong></td>
<td>Local health and care blueprints for accelerating implementation of the Forward View.</td>
</tr>
<tr>
<td><strong>Working Together Programme (WTP)</strong></td>
<td>Working Together is a partnership involving seven hospital Trusts in South Yorkshire, Mid Yorkshire and North Derbyshire. Collaborating on a number of common issues will allow the Trusts to deliver benefits that they would not achieve by working on their own.</td>
</tr>
</tbody>
</table>
Integrated Performance Report
Board Meeting: 26 September 2016
Month 5 - Period ending 31 August 2016
Key

Reported to column:

P  Public Health England
N  NHS England (NHSE)
M  Monitor
CCG  Clinical Commissioning Group
INT  Internal (Board, Divisional)
NHFD  National Hip Fracture Database

Change from Prev Period column:

△  Improvement from last period
▽  Same as last period
▼  Worse than last period

Summary of Changes in Previous Period:

<table>
<thead>
<tr>
<th>Key</th>
<th>Aug-16</th>
<th>Jul-16</th>
<th>Jun-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAG</td>
<td>53</td>
<td>52</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>28</td>
<td>29</td>
</tr>
</tbody>
</table>

Key: Quality Assurance Level

* Through the detailed analysis of indicators included in the summary pages, variation in figures has been identified in some metrics where reporting windows vary between reports. For metrics where this has been identified an * has been included and a detailed data quality exercise is being accelerated in these areas.

5 to 6  To achieve a green rating the indicator requires a high level of granularity, is contemporaneous, complete, has been signed off and the system and data source is deemed to be of a robust nature, ideally automatically generated from source data. To achieve level 6 requires data to be audited by an external body within the last 12 months.

3 to 4  To achieve an amber rating it has to meet the immediate needs of the output requirement, data is available but isn't recorded in the recommended guideline timescales, the data is likely to change, data doesn’t have complete validation/scrutineering, local non robust tools utilised, audited by internal body in the last 12 months.

1 to 2  To achieve a rating of red there is insufficient detail, the data is incomplete and will change in the future, no sign off process, output is submitted with no validation or screening, it is a fully manual (paper based) process to capture and no audit has been performed.
Trust Integrated Performance Report Summary

Patients

Through the concerted efforts of the clinical and support teams, patient outcomes, as measured through mortality rates, healthcare associated infections and friends and family feedback, have continued to improve. However, there is concern in relation to the safety thermometer performance and particularly community acquired deep tissue pressure ulcers.

Patients

In August the Trust met the national standard for emergency access with 95.04% of patients being admitted, transferred or discharged from ED within four hours of arrival. Cancer access times for July also demonstrated excellence with all targets met and 6 of 9 indicators in the top quartile. However, waiting times for diagnostics increased significantly with 3.4% of patients waiting longer than 6 weeks.

Colleagues

Whilst August saw an increase in Bank and Agency use, other HR indicators were more positive. Sickness absence in month saw a slight reduction. MAST and PDR compliance increased whilst remaining just below target. For the first time in 6 months the number of starters within the nursing workforce was higher than the numbers leaving the Trust.

Finance

The Trust has seen performance on its income and expenditure account deteriorate further during August 2016. This primarily being driven by excess levels of pay expenditure and under-delivery of CIP requirements. Both of these areas will require increased rigour and focus in subsequent months along side general budget and cash management.
# Quality Summary

<table>
<thead>
<tr>
<th>Top Achievements</th>
<th>Most Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthcare associated infection rate</strong>&lt;br&gt;There continues to be 0 cases of MRSA bacteraemia and the incidence of C.Diff remains within target threshold and below year to date benchmarks.</td>
<td><strong>12 month rolling HMSR to March 2016 = 98.18</strong>&lt;br&gt;Relative risk adjusted mortality figures continue to be within national normal ranges. A significant improvement from last year.</td>
</tr>
<tr>
<td><strong>F&amp;F Positive Score - A&amp;E = 95% (Top Quartile), England performance = 86%</strong>&lt;br&gt;An improvement in response rate and scores is consistent with the proactive action of the A&amp;E patient champion.</td>
<td><strong>% seen by midwife before 12 weeks and 6 days of pregnancy = 94%, target 90%</strong>&lt;br&gt;The continued improvement is largely due to the introduction of evening clinics and a short notice (48hr) process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Concerns</th>
<th>Most Deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Safety Thermometer (% Harm Free Care) = 92%</strong>&lt;br&gt;Continued low performance is a cause for concern.&lt;br&gt;National average runs at approximately 94% with a target of 95%, IPR assess against a stretch target of 96%.&lt;br&gt;(see quality report for further detail)</td>
<td><strong>Medication Error (crude rate per 1000 bed days) = 9.07 (Target &lt;8.18)</strong>&lt;br&gt;Since April 2016 the medication error rate has risen from 6.25 per 1000 bed days to 9.07. This significant increase is believed to relate to improved reporting.</td>
</tr>
<tr>
<td><strong>Initial Health Assessment within 20 days - Looked After Children = 0%, Target = 95%</strong>&lt;br&gt;A task and finish group has been set up with both TRFT and RMBC to diagnose the problems, design solutions and deliver implementation.</td>
<td><strong>Number of Grade 3&amp;4, community acquired PU = 6 in month.</strong>&lt;br&gt;The number of reported grade 3&amp;4 PU has significantly increased from the same period last year when there were 4. This 50% rise has been present through most of 16/17 to date and is subject to further validation.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Reporting Period</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Number of reported cases of MRSA bacteraemia</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Number of reported cases of C.diff</td>
<td>Aug-16</td>
</tr>
<tr>
<td>HSMR (last rolling year)</td>
<td>Jun 15 - May 16</td>
</tr>
<tr>
<td>SHMI (Including out of hospital death - last rolling year)</td>
<td>Jan - Dec 15</td>
</tr>
<tr>
<td>*Crude Mortality - Number of in hospital deaths</td>
<td>Aug-16</td>
</tr>
<tr>
<td>*Weekend mortality (% of total in-hospital deaths occurring on weekend)</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Neonatal mortality (Labour Ward &amp; Neonatal Unit)</td>
<td>Aug-16</td>
</tr>
<tr>
<td>*Number of recorded patient safety incidents per 1,000 bed days</td>
<td>Aug-16</td>
</tr>
<tr>
<td>*Rate of patient safety incidents resulting in severe harm/death (NRLS)</td>
<td>Aug-16</td>
</tr>
<tr>
<td>*Serious Incidents per 1,000 bed days</td>
<td>Aug-16</td>
</tr>
<tr>
<td>*Never events</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Mixed Sex Accommodation Breaches</td>
<td>Aug-16</td>
</tr>
<tr>
<td>*Medication Errors (Crude rate per 1000 bed days)</td>
<td>Aug-16</td>
</tr>
<tr>
<td>%Age Average Fill Rate - Nursing Shifts to Plan (Nurses, Midwives &amp; HCA's)</td>
<td>Aug-16</td>
</tr>
<tr>
<td>*Local 'Never' event: a) x 1 RN on shift</td>
<td>Aug-16</td>
</tr>
<tr>
<td>*Number of Grade 3&amp;4, hospital acquired PU</td>
<td>Aug-16</td>
</tr>
<tr>
<td>*Number of Grade 3&amp;4, community acquired PU</td>
<td>Aug-16</td>
</tr>
<tr>
<td>NHS Safety Thermometer (%age ALL Harm Free Care)</td>
<td>Aug-16</td>
</tr>
</tbody>
</table>
### PATIENTS: Excellence in Healthcare

<table>
<thead>
<tr>
<th>Reported to:</th>
<th>Indicators</th>
<th>Reporting Month</th>
<th>Target Change from Prev Period</th>
<th>Actual</th>
<th>YTD</th>
<th>Trend</th>
<th>Consecutive Failures</th>
<th>Quality Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>N, CCG, INT</td>
<td>Percentage of all adult inpatients who have had a VTE risk assessment on admission to hospital.</td>
<td>Jul-16</td>
<td>&gt;= 95%</td>
<td>↓</td>
<td>97%</td>
<td>97%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>N, CCG, INT</td>
<td>Incidence of hospital-related venous thromboembolism (VTE)</td>
<td>Jul-16</td>
<td>= 0</td>
<td>↓</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>&quot;Complaints&quot;</td>
<td>Aug-16</td>
<td>&lt;= 50 per month</td>
<td>↓</td>
<td>29</td>
<td>111</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>&quot;Litigation claims&quot;</td>
<td>Aug-16</td>
<td>TBC</td>
<td>↓</td>
<td>4</td>
<td>11</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>Patients with dementia having Assessment/Investigation</td>
<td>Jul-16</td>
<td>&gt;= 90%</td>
<td>↑</td>
<td>91%</td>
<td>91%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>F&amp;F Positive Score - Inpatients &amp; Day Cases (% of patients extremely likely or likely to recommend the Trust to their family and friends)</td>
<td>Aug-16</td>
<td>&gt;= 95%</td>
<td>↓</td>
<td>97%</td>
<td>97%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>F&amp;F Positive Score - A&amp;E (% of patients extremely likely or likely to recommend the Trust to their family and friends)</td>
<td>Aug-16</td>
<td>&gt;= 85%</td>
<td>↑</td>
<td>95%</td>
<td>94%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>F&amp;F Positive Score - Maternity (% of patients extremely likely or likely to recommend the Trust to their family and friends)</td>
<td>Aug-16</td>
<td>&gt;= 95%</td>
<td>↓</td>
<td>98%</td>
<td>98%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>F&amp;F Positive Score - Outpatients (% of patients extremely likely or likely to recommend the Trust to their family and friends)</td>
<td>Aug-16</td>
<td>&gt;= 95%</td>
<td>↓</td>
<td>97%</td>
<td>97%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>N, CCG, INT</td>
<td>% women who have seen a midwife by 12 weeks and 6 days of pregnancy</td>
<td>Aug-16</td>
<td>&gt;= 90%</td>
<td>↓</td>
<td>94%</td>
<td>92%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>CCG</td>
<td>Proportion of patients aged over 18 with chronic condition ACS conditions admitted to hospital as an emergency.</td>
<td>Jul-16</td>
<td>&lt;=218 per month</td>
<td>↑</td>
<td>125</td>
<td>570</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>CCG</td>
<td>Emergency admissions for acute conditions not requiring hospital admission</td>
<td>Jul-16</td>
<td>&lt;= 223 per month</td>
<td>↓</td>
<td>235</td>
<td>954</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Breastfeeding Initiation within 48 hrs of delivery - the percentage of all deliveries</td>
<td>Aug-16</td>
<td>&gt;=66%</td>
<td>↓</td>
<td>55%</td>
<td>56%</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>The percentage of infants being exclusively breastfed at 6-8 weeks. This is part &quot;a&quot; of the PHE indicators.</td>
<td>Aug-16</td>
<td>&gt;=33.5%</td>
<td>↑</td>
<td>31.15%</td>
<td>30.00%</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Maternal smoking at delivery - % of mothers smoking at delivery</td>
<td>Aug-16</td>
<td>&lt;=19.3%</td>
<td>↓</td>
<td>12.56%</td>
<td>16.17%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Chlamydia Detection Rate - rate per 100,000 eligible population of 15 – 24 year olds</td>
<td>Aug-16</td>
<td>2400 - 3000</td>
<td>↑</td>
<td>2434</td>
<td>2066</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>N, CCG, INT</td>
<td>Chlamydia Detection Rate - Coverage - Percentage of population aged 15-24.</td>
<td>Aug-16</td>
<td>&gt;=70%</td>
<td>↑</td>
<td>77%</td>
<td>76%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>Initial Health Assessment within 20 days - Looked After Children</td>
<td>Jul-16</td>
<td>95%</td>
<td>↓</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>INT</td>
<td>Total number of CAMHs admissions</td>
<td>Aug-16</td>
<td>N/A</td>
<td>↑</td>
<td>0</td>
<td>15</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>% of CAMHs admissions assessed, and care plan in place within 24 hours of admission</td>
<td>Aug-16</td>
<td>100%</td>
<td>↓</td>
<td>no admissions</td>
<td>100%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>Health visitor numbers</td>
<td>Aug-16</td>
<td>54</td>
<td>↓</td>
<td>62.65</td>
<td>62.65</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
## Performance Summary

<table>
<thead>
<tr>
<th>Top Achievements</th>
<th>Most Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4 Hour Access</strong> = 95.04% (Target 95%)&lt;br&gt;Following a long period of focused attention performance against the 4 hour standard met national targets for the first time since June 2015.</td>
<td><strong>Cancer 14-day breast symptoms</strong> = 98% (Target 93%)&lt;br&gt;Following challenges earlier in the year relating to patient choice and work between the cancer team and RCCG, performance has returned to good levels.</td>
</tr>
<tr>
<td><strong>Cancer 62 day</strong> = 90.9% (July)&lt;br&gt;TRFT continues to consistently achieve top quartile performance in many of the cancer standards. Most notably the 62 Day Classic where TRFT is 22nd nationally.</td>
<td><strong>% Stroke patients supported by stroke skilled team</strong> = 29% (target 40%)&lt;br&gt;Whilst performance is yet to meet target levels there has been considerable progress made in the support we provide our patients that have experienced a stroke. This is an impact of a recently recruited team.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Concerns</th>
<th>Most Deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Waiting Times (DM01)</strong> = 3.4% (Target &lt;1%)&lt;br&gt;Performance on diagnostic waiting times has deteriorating in line with forecasts presented at August board. This is predominantly due to ongoing capacity issues in Endoscopy</td>
<td><strong>18 week incomplete</strong> = 93.4% (Target 92%)&lt;br&gt;Whilst performance continues to be better than national standard it is of concern than TRFT has fallen from an average of 96%.</td>
</tr>
<tr>
<td><strong>% Stroke patients admitted directly to a stroke bed within 4 hours</strong> = 57% (Target 90%)&lt;br&gt;Performance against this standard have been below target levels for 22 months.</td>
<td><strong>% Stroke patients scanned within 1 hour</strong> = 55.3% (down from 77.1%, Target 50%)&lt;br&gt;Following focused attention in June where performance climbed to excellent levels. The percentage of stroke patients scanned within an hour dropped back to typical levels. Whilst this is above local target, it is below levels required for SSNAP A rating.</td>
</tr>
</tbody>
</table>
### Indicators Reporting

<table>
<thead>
<tr>
<th>Reported to:</th>
<th>Indicators</th>
<th>Reporting Month</th>
<th>Target</th>
<th>Change from Prev Period</th>
<th>Actual</th>
<th>YTD</th>
<th>Trend</th>
<th>Consecutive Failures</th>
<th>Quality Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>N, M, CCG, INT</td>
<td>% of A&amp;E attendances seen within maximum waiting time of 4 hours from arrival to admission / transfer/ discharge</td>
<td>Aug-16</td>
<td>&gt;= 95%</td>
<td>↑</td>
<td>95.04%</td>
<td>91.73%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Number of pts spending 12 hours or more on a trolley in A&amp;E</td>
<td>Aug-16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>&quot;The number of handover delays longer than 30 minutes&quot;</td>
<td>Aug-16</td>
<td>0</td>
<td>↑</td>
<td>1</td>
<td>70</td>
<td>0</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>&quot;The number of handover delays longer than 60 minutes&quot;</td>
<td>Aug-16</td>
<td>0</td>
<td>↑</td>
<td>0</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 2 weeks: Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer</td>
<td>Jul-16</td>
<td>&gt;= 93%</td>
<td>↑</td>
<td>96%</td>
<td>95%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 2 weeks: Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected</td>
<td>Jul-16</td>
<td>&gt;= 93%</td>
<td>↑</td>
<td>98%</td>
<td>94%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 31 day: Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis</td>
<td>Jul-16</td>
<td>&gt;= 96%</td>
<td>↓</td>
<td>99%</td>
<td>99%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 31 day: Percentage of patients receiving subsequent treatment for cancer within 31-days from the decision to treat date - where that treatment is Surgery</td>
<td>Jul-16</td>
<td>&gt;= 94%</td>
<td>↑</td>
<td>100%</td>
<td>97%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 31 day: Percentage of patients receiving subsequent treatment for cancer within 31 days from the decision to treat date - where that treatment is an Anti-Cancer Drug Regime</td>
<td>Jul-16</td>
<td>&gt;= 98%</td>
<td>↓</td>
<td>100%</td>
<td>100%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 62 days: Percentage of patients receiving first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer</td>
<td>Jul-16</td>
<td>&gt;= 85%</td>
<td>↓</td>
<td>91%</td>
<td>92%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 62 days: Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service</td>
<td>Jul-16</td>
<td>&gt;= 90%</td>
<td>↑</td>
<td>100%</td>
<td>95%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>% of Admitted patients waiting less than 18 weeks from point of referral to treatment</td>
<td>Aug-16</td>
<td>&gt;= 90%</td>
<td>↓</td>
<td>84%</td>
<td>85%</td>
<td>7</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>% of Non Admitted patients waiting less than 18 weeks from point of referral to treatment</td>
<td>Aug-16</td>
<td>&gt;= 95%</td>
<td>↓</td>
<td>96%</td>
<td>96%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>% of patients waiting less than 18 weeks from point of referral to treatment on incomplete pathways</td>
<td>Aug-16</td>
<td>&gt;= 92%</td>
<td>↓</td>
<td>94%</td>
<td>95%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Number of patients waiting more than 52 weeks on a RTT pathway (incomplete)</td>
<td>Aug-16</td>
<td>= 0</td>
<td>↑</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>% of patients waiting 6 weeks or over for any of the 15 Key diagnostic tests</td>
<td>Aug-16</td>
<td>&lt;= 1%</td>
<td>↓</td>
<td>3.4%</td>
<td>1.5%</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Reported to:</td>
<td>Indicators</td>
<td>Reporting Month</td>
<td>Target</td>
<td>Change from Prev Period</td>
<td>Actual</td>
<td>YTD Trend Consecutive Failures</td>
<td>Quality Assurance</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of patients presenting with stroke with AF anti-coagulated on discharge</td>
<td>Aug-16</td>
<td>&gt;= 60%</td>
<td>100%</td>
<td>100.0%</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival</td>
<td>Aug-16</td>
<td>&gt;= 90%</td>
<td>57%</td>
<td>56%</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N, CCG, INT</td>
<td>Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit</td>
<td>Aug-16</td>
<td>&gt;= 80%</td>
<td>81%</td>
<td>84%</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of stroke patients scanned within one hour of hospital arrival</td>
<td>Aug-16</td>
<td>&gt;= 50%</td>
<td>55.3%</td>
<td>57.6%</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of stroke patients scanned within 24 hrs of hospital arrival</td>
<td>Aug-16</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.5%</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N, CCG, INT</td>
<td>Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (Trans Ischaemic Attack - mini stroke)</td>
<td>Aug-16</td>
<td>&gt;= 60%</td>
<td>91%</td>
<td>87%</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>% of patients who have a stroke who receive a follow up assessment between 4-8 months after initial admission</td>
<td>Aug-16</td>
<td>&gt;= 95%</td>
<td>100%</td>
<td>100%</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>% of patients who have had a stroke who are discharged from hospital with a joint health and social care plan</td>
<td>Aug-16</td>
<td>&gt;= 85%</td>
<td>100%</td>
<td>100%</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke</td>
<td>Aug-16</td>
<td>&gt;= 40%</td>
<td>100%</td>
<td>100%</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>% of patients who receive thrombolysis following an acute stroke</td>
<td>Aug-16</td>
<td>&gt;= 11%</td>
<td>8%</td>
<td>3%</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of patients supported by a stroke skilled ESD team</td>
<td>Aug-16</td>
<td>&gt;= 40%</td>
<td>29%</td>
<td>15%</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>% Out patient New to Follow up ratio</td>
<td>Aug-16</td>
<td>&lt;= 3.1</td>
<td>2.0</td>
<td>1.9</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>% Out patient DNA rates</td>
<td>Aug-16</td>
<td>&lt;= 7.7%</td>
<td>8.3%</td>
<td>7.9%</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Number of Cancelled Patient Appointments by Hospital</td>
<td>Aug-16</td>
<td>&lt; Prev Month</td>
<td>2380</td>
<td>10728</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Percentage of patients being admitted as an emergency within 28 days of discharge following an emergency admission</td>
<td>Aug-16</td>
<td>&lt; 12.5%</td>
<td>12.21%</td>
<td>13.57%</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Percentage of patients being admitted as an emergency within 28 days of discharge following a planned admission</td>
<td>Aug-16</td>
<td>&lt; 6%</td>
<td>4%</td>
<td>6%</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Average Length of Stay - Elective</td>
<td>Aug-16</td>
<td>&lt;= 3.05</td>
<td>2.96</td>
<td>2.96</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Average Length of Stay - Non-Elective</td>
<td>Aug-16</td>
<td>&lt;= 5.00</td>
<td>5.07</td>
<td>5.44</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### PATIENTS: Excellence in Healthcare

<table>
<thead>
<tr>
<th>Reported to:</th>
<th>Indicators</th>
<th>Reporting Month</th>
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<th>Actual</th>
<th>YTD</th>
<th>Trend</th>
<th>Consecutive Failures</th>
<th>Quality Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>N, INT</td>
<td>% of available beds occupied at midnight on a Thursday</td>
<td>Aug-16</td>
<td>&lt;=85%</td>
<td>↓</td>
<td>83%</td>
<td>85%</td>
<td><img src="chart1.png" alt="Graph" /></td>
<td>1</td>
<td><img src="red.png" alt="Red" /></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>% of patients cancelled on day of operation for non medical reasons</td>
<td>Aug-16</td>
<td>&lt;= 0.8%</td>
<td>↑</td>
<td>0.62%</td>
<td>0.80%</td>
<td><img src="chart2.png" alt="Graph" /></td>
<td>0</td>
<td><img src="green.png" alt="Green" /></td>
</tr>
<tr>
<td>N, CCG, INT</td>
<td>Percentage of patients whose transfer of care from hospital was delayed.</td>
<td>Aug-16</td>
<td>&lt;= 3.5%</td>
<td>↓</td>
<td>2.40%</td>
<td>2.06%</td>
<td><img src="chart3.png" alt="Graph" /></td>
<td>0</td>
<td><img src="green.png" alt="Green" /></td>
</tr>
<tr>
<td>INT</td>
<td>Theatre Session Utilisation (DS)</td>
<td>Aug-16</td>
<td>&gt;=85%</td>
<td>↑</td>
<td>86%</td>
<td>85%</td>
<td><img src="chart4.png" alt="Graph" /></td>
<td>0</td>
<td><img src="green.png" alt="Green" /></td>
</tr>
<tr>
<td>INT</td>
<td>Theatre Session Utilisation (MT)</td>
<td>Aug-16</td>
<td>&gt;=91%</td>
<td>↓</td>
<td>92%</td>
<td>93%</td>
<td><img src="chart5.png" alt="Graph" /></td>
<td>0</td>
<td><img src="green.png" alt="Green" /></td>
</tr>
<tr>
<td>INT</td>
<td># NOF - Time to surgery within 36hrs (refer to national definition) - taken from the National Hip Database - not including full BPT criteria</td>
<td>Aug-16</td>
<td>TBC</td>
<td>↓</td>
<td>84.62%</td>
<td>81.37%</td>
<td><img src="chart6.png" alt="Graph" /></td>
<td>0</td>
<td><img src="green.png" alt="Green" /></td>
</tr>
<tr>
<td>INT</td>
<td># NOF - Time to surgery within 48hrs</td>
<td>Aug-16</td>
<td>100%</td>
<td>↑</td>
<td>92%</td>
<td>91%</td>
<td><img src="chart7.png" alt="Graph" /></td>
<td>15</td>
<td><img src="red.png" alt="Red" /></td>
</tr>
</tbody>
</table>
## Workforce Summary

<table>
<thead>
<tr>
<th>Most Improved</th>
<th>Top Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Job Plans Completed = 91%</td>
<td>Reduced Usage of bank and agency</td>
</tr>
<tr>
<td>Through the continued efforts of all divisions over 90% of consultant job plans have been completed. The highest percentage recorded.</td>
<td>Over the last couple of month the systems have been substantially improved, resulting in more controlled use of bank and agency.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Concerns</th>
<th>Most Deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAST = 76%</td>
<td>12 month Rolling Sickness Absence</td>
</tr>
<tr>
<td>Completion rates remain lower than expected position at 76%. This is a key concern and action plans are in progress to rapidly improve compliance.</td>
<td>Rates have increased from 4.2% to 4.4%. However, in month during August saw a slight reduction from 4.49% to 4.37%.</td>
</tr>
<tr>
<td>Indicators</td>
<td>Reporting Month</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Variable Pay: Consultants Job Plans excluding Associate Specialists etc</td>
<td>Aug-16</td>
</tr>
<tr>
<td>MAST: Mandatory &amp; Statutory Training - overall compliance</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Employee Relations: Total active employee relations cases at month end</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Employee Engagement: Staff Survey - engagement score</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Employee Engagement: PDR's</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Recruitment and Retention: Total staff in post - headcount</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Recruitment and Retention: Total staff in post - FTE</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Recruitment and Retention: Starters in month - headcount</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Recruitment and Retention: Starters in month - FTE</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Recruitment and Retention: Leavers in month - headcount</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Recruitment and Retention: Leavers in month - FTE</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Recruitment and Retention: Exit Interviews - issued to leavers</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Recruitment and Retention: Exit Interviews - Returned</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Recruitment and Retention: Rolling Turnover Rate in month - FTE</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Recruitment and Retention: Average time from Successful Candidate to Hire (weeks)</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Health and Wellbeing: Sickness absence rate in month %</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Health and Wellbeing: Rolling sickness absence rate %</td>
<td>Aug-16</td>
</tr>
<tr>
<td>Health and Wellbeing: Completed return to work %</td>
<td>Aug-16</td>
</tr>
</tbody>
</table>
## Health and Wellbeing

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Reporting Month</th>
<th>Target</th>
<th>Change from Prev Period</th>
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<th>Consecutive Failures</th>
<th>Quality Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness Estimated Costs in month</td>
<td>Aug-16</td>
<td>N/A</td>
<td>↑</td>
<td>£408,356</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness Attendance - Short Term % (&lt;21 days) FTE</td>
<td>Aug-16</td>
<td>&lt;= 1%</td>
<td>↓</td>
<td>0.97%</td>
<td>1.11%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Sickness Attendance - Long Term % (&gt;21 days) FTE</td>
<td>Aug-16</td>
<td>&lt;= 3%</td>
<td>↑</td>
<td>3.39%</td>
<td>3.12%</td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Total number of referrals to Health &amp; Wellbeing</td>
<td>Aug-16</td>
<td>N/A</td>
<td>↑</td>
<td>141</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Internal referrals</td>
<td>Aug-16</td>
<td>N/A</td>
<td>↑</td>
<td>92</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External referrals</td>
<td>Aug-16</td>
<td>N/A</td>
<td>↑</td>
<td>49</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>External income</td>
<td>Aug-16</td>
<td>N/A</td>
<td>↓</td>
<td>£2,023</td>
<td>N/A</td>
<td></td>
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</table>
### Finance Summary

<table>
<thead>
<tr>
<th>Most Improved</th>
<th>Top Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank and agency expenditure continues on a downward trend in both absolute cost and percentage terms, with figures for August 2016 indicating that it now represents only 8.5% of the total pay cost in month. The Trust is £393K ahead of its trajectory for reducing total agency costs by £5,439K in year.</td>
<td>Other operating income across the Trust has shown an improvement in month of £103K and is now over 5% ahead of plan year to date (+£258K). This is being driven by a reassessment of income covered by service level agreements (£58K) together with other pay and non-pay recharges (£62K).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Concerns</th>
<th>Most Deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td>The annual plan includes delivery of £10,500K cost improvement target. The Trust is behind plan by £2,204K at 31st August 2016. Significant improvements need to be made and much of this must be targeted at the Trust’s pay budgets.</td>
<td>Medicine division has shown a significant deterioration its performance against budget during August 2016 by £769K. Most worryingly whilst income was adverse to plan by £122K, expenditure was over-spent by £647K driven by undelivered CIPs £306K and £237K non-excluded drugs.</td>
</tr>
</tbody>
</table>
## FINANCE: Strong financial foundations

<table>
<thead>
<tr>
<th>Reported to:</th>
<th>Indicators</th>
<th>Reporting Month</th>
<th>In month</th>
<th>Year to Date</th>
<th>Trend</th>
<th>Quality Assurance</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Plan £000</td>
<td>Actual £000</td>
<td>Variance £000</td>
<td>Plan £000</td>
</tr>
<tr>
<td>INT</td>
<td>Income &amp; Expenditure</td>
<td>Aug-16</td>
<td>533</td>
<td>(233)</td>
<td>(766)</td>
<td>1,421</td>
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<tr>
<td>INT</td>
<td>Cash Flow</td>
<td>Aug-16</td>
<td>(18)</td>
<td>1,750</td>
<td>1,768</td>
<td>2,117</td>
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<td>INT</td>
<td>Continuity of Service Risk Rating (COSR)</td>
<td>Aug-16</td>
<td>3</td>
<td>2</td>
<td>(1)</td>
<td>3</td>
</tr>
<tr>
<td>INT</td>
<td>Capital Programme</td>
<td>Aug-16</td>
<td>1,073</td>
<td>1,486</td>
<td>413</td>
<td>5,638</td>
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<td><strong>Income</strong></td>
<td>Elective Activity Income</td>
<td>Aug-16</td>
<td>1,212</td>
<td>1,146</td>
<td>(77)</td>
<td>5,971</td>
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<td>INT</td>
<td>Day Case Activity Income</td>
<td>Aug-16</td>
<td>1,859</td>
<td>1,956</td>
<td>97</td>
<td>9,062</td>
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<tr>
<td>INT</td>
<td>A&amp;E Activity Income</td>
<td>Aug-16</td>
<td>742</td>
<td>713</td>
<td>(29)</td>
<td>3,662</td>
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<tr>
<td>INT</td>
<td>Non Elective Activity Income</td>
<td>Aug-16</td>
<td>4,563</td>
<td>4,304</td>
<td>(259)</td>
<td>22,025</td>
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<td>INT</td>
<td>New Outpatients Income</td>
<td>Aug-16</td>
<td>1,025</td>
<td>1,075</td>
<td>50</td>
<td>5,251</td>
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<tr>
<td>INT</td>
<td>Follow Up Outpatients Income</td>
<td>Aug-16</td>
<td>1,429</td>
<td>1,484</td>
<td>55</td>
<td>7,104</td>
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<tr>
<td>INT</td>
<td>Other Clinical Income</td>
<td>Aug-16</td>
<td>8,470</td>
<td>8,493</td>
<td>23</td>
<td>43,000</td>
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<td>INT</td>
<td>Education &amp; Training income</td>
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<td>525</td>
<td>534</td>
<td>9</td>
<td>2,625</td>
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<td>INT</td>
<td>Other non clinical income</td>
<td>Aug-16</td>
<td>1,083</td>
<td>1,238</td>
<td>155</td>
<td>4,937</td>
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<tr>
<td><strong>Expenditure (Operating)</strong></td>
<td>Pay Costs</td>
<td>Aug-16</td>
<td>13,382</td>
<td>13,657</td>
<td>(275)</td>
<td>67,702</td>
</tr>
<tr>
<td>INT</td>
<td>Non Pay Costs</td>
<td>Aug-16</td>
<td>6,779</td>
<td>7,522</td>
<td>(743)</td>
<td>33,988</td>
</tr>
<tr>
<td><strong>Agency Costs</strong></td>
<td>Total Pay spend</td>
<td>Aug-16</td>
<td>13,382</td>
<td>13,657</td>
<td>(275)</td>
<td>67,702</td>
</tr>
<tr>
<td>Monitor</td>
<td>Agency Spend</td>
<td>Aug-16</td>
<td>915</td>
<td>791</td>
<td>124</td>
<td>5,139</td>
</tr>
<tr>
<td>Monitor</td>
<td>Percentage</td>
<td>Aug-16</td>
<td>6.84%</td>
<td>5.79%</td>
<td>1.05%</td>
<td>7.59%</td>
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</table>
## FINANCE: Strong financial foundations

<table>
<thead>
<tr>
<th>Activity</th>
<th>Reporting Month</th>
<th>Elective Activity</th>
<th>Day Case Activity</th>
<th>A&amp;E Activity</th>
<th>Non Elective Activity</th>
<th>New Outpatients</th>
<th>Follow Up Outpatients</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Aug-16</td>
<td>491</td>
<td>2,945</td>
<td>6,522</td>
<td>2,312</td>
<td>7,634</td>
<td>17,525</td>
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<tr>
<td></td>
<td></td>
<td>366</td>
<td>2,964</td>
<td>6,316</td>
<td>2,295</td>
<td>7,246</td>
<td>15,792</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(125)</td>
<td>19</td>
<td>(206)</td>
<td>(17)</td>
<td>(388)</td>
<td>(1,733)</td>
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<td></td>
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<tr>
<td>Year to Date</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Key
- **Variance**
  - Worse than plan
  - In line with plan / better than plan

### Activities
- **INT Elective Activity**
- **INT Day Case Activity**
- **INT A&E Activity**
- **INT Non Elective Activity**
- **INT New Outpatients**
- **INT Follow Up Outpatients**

### Consecutive Failures
- **Consecutive Failures**
  - Worst than plan
  - In line with plan / better than plan
## APPENDIX A - Breakdown of 62 day Performance by Tumour Site - Month 4

<table>
<thead>
<tr>
<th>Tumour Site</th>
<th>62 Day from 2ww (*)</th>
<th>62 day CUG</th>
<th>62 Day Screening</th>
<th>31 Day 1st Treatment</th>
<th>31 Day Subsequent</th>
<th>2WW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Median Wait Days (Treating Hospital)</td>
<td>%</td>
<td>Median Wait Days (Treating Hospital)</td>
<td>%</td>
<td>Median Wait Days (RFR)</td>
</tr>
<tr>
<td>Acute Leukaemia</td>
<td>100.0</td>
<td>6 (RFR)</td>
<td>100.0</td>
<td>31 (RFR)</td>
<td>100.0</td>
<td>20</td>
</tr>
<tr>
<td>Brain/CNS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>100.0</td>
<td>40 (RFR) 37 (RHQ)</td>
<td>100.0 35 (RFR)</td>
<td>100.0 31 (RFR)</td>
<td>100.0</td>
<td>1</td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>87.5</td>
<td>55 (RFR) 67 (RHQ)</td>
<td>100.0 38 (RFR)</td>
<td></td>
<td>100.0</td>
<td>13</td>
</tr>
<tr>
<td>Haematological</td>
<td>100.0</td>
<td>33 (RFR)</td>
<td>85.7 35 (RFR)</td>
<td></td>
<td>100.0</td>
<td>1</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>66.7</td>
<td>21 (RFR) 81 (RHQ)</td>
<td>0.0 84 (RHQ)</td>
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<td>100.0</td>
<td>3</td>
</tr>
<tr>
<td>Lower GI</td>
<td>100.0</td>
<td>29 (RFR) 52 (RHQ)</td>
<td>100.0 21 (RFR) 44 (RHQ)</td>
<td>100.0 53 (RFR)</td>
<td></td>
<td>87.5</td>
</tr>
<tr>
<td>Lung</td>
<td>50.0</td>
<td>66 (RHQ)</td>
<td>90.9 18 (RFR) 42 (RHQ)</td>
<td></td>
<td>100.0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarcoma</td>
<td>0.0</td>
<td>103 (RHQ)</td>
<td>100.0 47 (RFR)</td>
<td></td>
<td>100.0</td>
<td>12</td>
</tr>
<tr>
<td>Skin</td>
<td>100.0</td>
<td>16 (RFR)</td>
<td>100.0 13 (RFR)</td>
<td></td>
<td>100.0</td>
<td>10</td>
</tr>
<tr>
<td>Testicular</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper GI</td>
<td>100.0</td>
<td>49 (RFR) 57 (RHQ)</td>
<td>100.0 12 (RFR) 52 (RHQ)</td>
<td></td>
<td>100.0</td>
<td>4</td>
</tr>
<tr>
<td>Urological</td>
<td>90.9</td>
<td>39 (RFR) 64 (RHQ)</td>
<td>86.4 30 (RFR) 62 (RHQ)</td>
<td></td>
<td>100.0</td>
<td>3</td>
</tr>
<tr>
<td>All</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RFR = Rotherham FT  
RHQ = Sheffield Teaching Hospitals FT  
RRS = Leeds Teaching Hospitals NHS Trust  
(*) Performance includes reallocations
## Rotherham CCG Admitted <18Wks 18Wks+ %<18Wks

<table>
<thead>
<tr>
<th>Specialty</th>
<th>&lt;18Wks</th>
<th>18Wks+</th>
<th>%&lt;18Wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>155</td>
<td>28</td>
<td>84%</td>
</tr>
<tr>
<td>Urology</td>
<td>84</td>
<td>25</td>
<td>77%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>193</td>
<td>36</td>
<td>84%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>33</td>
<td>6</td>
<td>86%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>209</td>
<td>3</td>
<td>96%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>15</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>19</td>
<td>2</td>
<td>90%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>14</td>
<td>3</td>
<td>82%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>20</td>
<td>1</td>
<td>95%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>3</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>3</td>
<td>1</td>
<td>75%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>2</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>151</td>
<td>35</td>
<td>81%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>904</td>
<td>143</td>
<td>86%</td>
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</tbody>
</table>

## Rotherham CCG Non Admitted <18Wks 18Wks+ %<18Wks

<table>
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<th>18Wks+</th>
<th>%&lt;18Wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>339</td>
<td>14</td>
<td>96%</td>
</tr>
<tr>
<td>Urology</td>
<td>166</td>
<td>6</td>
<td>96%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>455</td>
<td>6</td>
<td>98%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
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<td>10</td>
<td>97%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>630</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
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<td>96%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>49</td>
<td>2</td>
<td>96%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>71</td>
<td>20</td>
<td>78%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>108</td>
<td>43</td>
<td>71%</td>
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<tr>
<td>Dermatology</td>
<td>281</td>
<td>15</td>
<td>94%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>66</td>
<td>6</td>
<td>91%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>162</td>
<td>6</td>
<td>96%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>67</td>
<td>4</td>
<td>94%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>328</td>
<td>5</td>
<td>98%</td>
</tr>
<tr>
<td>Other</td>
<td>232</td>
<td>2</td>
<td>99%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3394</td>
<td>139</td>
<td>96%</td>
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## Rotherham CCG Incomplete <18Wks 18Wks+ %<18Wks

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<th>18Wks+</th>
<th>%&lt;18Wks</th>
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<tbody>
<tr>
<td>General Surgery</td>
<td>1078</td>
<td>87</td>
<td>92%</td>
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<td>633</td>
<td>37</td>
<td>94%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>1308</td>
<td>102</td>
<td>92%</td>
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<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>1085</td>
<td>64</td>
<td>94%</td>
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<td>946</td>
<td>6</td>
<td>99%</td>
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<tr>
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<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>261</td>
<td>5</td>
<td>98%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>619</td>
<td>22</td>
<td>96%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>490</td>
<td>62</td>
<td>96%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>777</td>
<td>71</td>
<td>98%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>317</td>
<td>1</td>
<td>99%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>359</td>
<td>24</td>
<td>93%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>117</td>
<td>6</td>
<td>96%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>946</td>
<td>64</td>
<td>93%</td>
</tr>
<tr>
<td>Other</td>
<td>358</td>
<td>14</td>
<td>96%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9274</td>
<td>565</td>
<td>94%</td>
</tr>
</tbody>
</table>

### Admitted

- **Total Admitted** = 1122
- **Non Admitted** = 204
- **Incomplete** = 83

### Targets

- **Admitted** = 90%
- **Non Admitted** = 95%
- **Incomplete** = 92%
Report: Quality Report

Presented by: Tracey McErlain-Burns, Chief Nurse and Dr Conrad Wareham, Medical Director

Author(s): As above

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

Regulatory relevance:
Monitor: Licence Condition FT4
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
BAF: B1, B5, B8
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.

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

- Harm Free Care and Looked After Children Assessment performance are concerns.

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

1.1 The Quality Report is presented to the Board of Directors to complement the information presented in the Integrated Performance Report.

1.2 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. As an overview to overall quality performance, the quadrant view from the Integrated Performance Report is replicated below:

<table>
<thead>
<tr>
<th>Top Achievements</th>
<th>Most Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare associated infection rate</td>
<td>12 month rolling HMSR to March 2016 = 98.18</td>
</tr>
<tr>
<td>There continues to be 0 cases of MRSA bacteraemia and the incidence of C.Diff remains within target threshold and below year to date benchmarks.</td>
<td>Relative risk adjusted mortality figures continue to be within national normal ranges. A significant improvement from last year.</td>
</tr>
<tr>
<td><strong>F&amp;F Positive Score - A&amp;E = 95% (Top Quartile), England performance = 86%</strong></td>
<td>% seen by midwife before 12 weeks and 6 days of pregnancy = 94%, target 90%</td>
</tr>
<tr>
<td>An improvement in response rate and scores is consistent with the proactive action of the A&amp;E patient champion.</td>
<td>The continued improvement is largely due to the introduction of evening clinics and a short notice (48hr) process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Concerns</th>
<th>Most Deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Safety Thermometer (% Harm Free Care) = 92%</strong></td>
<td>Medication Error (crude rate per 1000 bed days) = 9.07 (Target &lt;8.18)</td>
</tr>
<tr>
<td>Continued low performance is a cause for concern. National average runs at approximately 94% with a target of 95%, IPR assess against a stretch target of 96%.</td>
<td>Since April 2016 the medication error rate has risen from 6.25 per 1000 bed days to 9.07. This significant increase may relate to improved reporting.</td>
</tr>
<tr>
<td><strong>Initial Health Assessment within 20 days - Looked After Children = 0%, Target = 95%</strong></td>
<td>Number of Grade 3&amp;4, community acquired PU = 6 in month.</td>
</tr>
<tr>
<td>A task and finish group has been set up with both TRFT and RMBC to diagnose the problems, design solutions and deliver implementation.</td>
<td>The number of reported grade 3&amp;4 PU has significantly increased from the same period last year when there were 4. This 50% rise has been present through most of 16/17 to date and is subject to further validation.</td>
</tr>
</tbody>
</table>

2. **Healthcare Associated Infections**

2.1 Year-to-date, against a trajectory of 14 cases for the end of September, the Trust has reported seven (7) cases of Hospital Acquired Clostridium-difficile. The seventh case was reported mid-September.

2.2 Of the seven cases of C-diff year to date, four have so far been subject to post-infection-review with the Clinical Commissioning Group. In two cases there were no lapses in care. In the other two cases there were identified lapses in care. The lapses were associated with, delay in time of sample being obtained, poor completion of the stool chart and Gentamycin levels not taken correctly.

2.3 None of the first six cases are thus far linked and all have originated in different
clinical locations the seventh case occurred this weekend and the investigation has commenced. The Ribotypes thus far are 050, 220, 023, 078 and 020.

2.4 At the beginning of September in-patient capacity was slightly reduced on ward A3 due to a number of patients experiencing diarrhoea. The picture was similar to the recent events of ward B4 whereby no organisms were identified.

3. **Harm Free Care**

3.1 After improvements last month the results of the Classic Safety Thermometer have deteriorated again in August by 0.4% to 92.33%.

3.2 The Hospital Harm Free Care rate was 95.50% and the community rate was 90.22%. The consistent issue for the past five months has been the increase in new pressure ulcers identified in the community. In addition to revisiting the STOP Pressure campaign the teams are implementing the React to Red campaign at the end of September. This will involve working with Care Homes to detect early signs of pressure damage.

3.3 Rates of falls resulting in harm are 0.12% against a national average of 0.56%.

3.4 All data for catheter related urinary tract infections has been reviewed and validated by the infection prevention and control team. Our rates of new catheter related UTI are 1.38% against a national average of 1.2%. Because they are small in number there is some month-on-month volatility. Based on data validation and case review the infection prevention team are reviewing antibiotic prescribing practice.

3.5 The physical harm free care rate in maternity services has remained above national averages at 80.49% compared with 70.27%. The only indicator adverse to the national picture across a range of 10 indicators measured in the maternity safety thermometer is the one measuring post-partum haemorrhage greater than 1000mls. For 16 months the Trust rates have been below the national rates. This month our rates were above the national rate. The position will be reviewed by the Division of Family Health noting that this is point prevalence.

3.6 The Quality Assurance Committee has had sight of the Children and Young People's Safety Thermometer. Only two months of data is available at the moment and it is too early to comment albeit the results indicate the need to review completion of early warning scores and this is being picked up by the Division of Family Health.

4. **Complaints**

4.1 The trust received 30 formal complaints in August which is an increase from the previous month of three (3). Seventy Nine (79) concerns were received for the month, which is a reduction of 12 on the previous month.

4.2 Improvement continues in relation to our timely response to complaints. Last month 60% of responses were issued within agreed timescales.

4.3 There are currently 6 cases under investigation with the Parliamentary Health Service Ombudsman (PHSO). One new request was received and one case was closed within August. The latter was not upheld by the PHSO.

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1 The Board should note that whilst the data for Classic Safety Thermometer is August 2016 the data for maternity and paediatrics is July 2016. The latter will always be a month behind due to the release dates.
5. **Friends and Family Test (FFT)**

5.1 For August, Emergency Medicine and Maternity have fallen below target for response rates. The Emergency Department have fallen to 8% against a target of 15% and Maternity has a response rate of 35% against a target of 40%. This is the second consecutive month for both areas. The position is being reviewed by the Deputy Chief Nurse and recovery plans are being developed through the FFT Steering Group. Specifically response rates within the Delivery Suite and Wharncliffe Ward remain high. The reduction has been seen in the out-patient and antenatal services.

5.2 Overall the positive response scores remain above target. Specifically the response scores for the Emergency Department are at 95% compared with a target of 85%.

5.3 The Emergency Department have met to discuss their response rates and will be introducing a slightly different process to enhance the current process that is in place, by introducing the forms at the beginning of the ED pathway.

6. **Mortality**

6.1 The most recent HSMR is 98.18 and has been below 100 for the last five months reported. The number of uncoded episodes is of a sufficiently low level that there is confidence that the HSMR reported is an accurate reflection and will not change following further coding.

6.2 Whilst SHMI is no longer significantly outside of the normal range it remains above 100 due to the older figures reported in the calculation. SHMI is reported as 105 again this month as it only recalculated on a quarterly basis.

6.3 The crude rate of mortality continues to be reported as similar to last month with nearly high levels of activity and 6000 admissions and discharges in the month of July. This gives a three month crude rate of 1.60%

6.4 Weekend crude mortality rate is double the rate of all crude mortality and may be explained by the differing case mix that occurs at weekends. But this has reduced slightly since last reported.

6.5 The HSMR admissions for particular days of the week is not significantly different or outlying the normal range but at present but Sunday still may be trending upwards. This will be monitored closely through the mortality committee.

6.6 The diagnosis groups which have triggered are being scrutinised by the mortality and quality alerts group and work is ongoing with these to determine where improvements can be made.

6.7 Cancer of the colon mortality is still showing statistical significance with a higher than expected HSMR. A verbal assurance has been provided to the mortality committee that there are no clinical concerns and a written report is to follow. Cancer of the rectum and anus is one of the lowest diagnosis codes featured in the report.

6.8 Congestive heart failure is no longer significant in respect to HSMR. A review of this diagnosis code has been undertaken and presented by the cardiology department following the previously significant high HSMR. The mortality committee were assured that there are no significant issues with this but there are some ongoing practice improvement with respect to the identification of patients with heart failure, timely investigations (collaborative work with echocardiography) and specialist involvement with patients with this condition.
6.9 Work is beginning on reducing clinical variation in practice with initially five main diagnosis codes acute coronary syndrome/myocardial infarction, urinary tract infection, stroke, pneumonia, heart failure.

6.10 There continues to be collaborative working within the secondary care setting and the community regarding advance care planning and the mortality within 24 hours of admission. As seen in this report work should extend to first 48 hours. This may be due to issues with patient transfers between wards and work may focus on this to determine the level of concern. There is to be a new working party between primary and secondary care.

6.11 In conclusion:

- HSMR continues to remain low.
- SHMI is no longer significant but remains high.
- The diagnosis codes which have raised concerns have and will be reviewed further for conclusions.
- Congestive heart failure has been reported on and although there are a few improvement practices ongoing the mortality committee is satisfied there is not a significant issue.

7 Nurse Staffing Report

7.1 The headlines for August 2016 are that Registered Nurse (RN) shift fill rates (daytime) were 91.8% compared to 91.6% in July and 97.2% on nights compared to 97.7%. Healthcare Support Worker (HCSW) fill rates marginally increased to 103.9% on days from a position of 102.5% in July and reduced to 96.7% from 97.3% on nights.

7.2 Nine in-patient areas had Registered Nurse fill rates (days) below 90%. These were: A1, A2, A4, A5, AMU, B4, Fitzwilliam, Critical care and the Stroke Unit. Of these, five had a day time shift fill rate less than 85% and these were; AMU at 83.7% as compared with 83% in July; A4 at 82.1% compared with 90.3%; Critical care at 83% compared with 79.5% in July and the Stroke Unit and B4 (see below).

7.3 Two areas had a Registered Nurse fill rate below 80% on days these were Stroke Unit at 78.5% as compared with 83.6% in July and B4 at 79.8% compared with 78.2% in July.

7.4 Three areas had a Registered Nurse shift fill rate (nights) below 90% and these were B5, Critical Care and Keppel Ward.

7.5 There were two ‘internal never event’ shifts in August, these were on the Stroke Unit for a period of 1½ hours and B11. There were no patient harm events reported for the same locations and shift times when 1 RN was reported.

7.6 There were 28 shifts in the month with over 50% of RNs on duty being within the 12 month preceptorship period compared with 24 shifts in July.

7.7 There has been a reduction in the percentage use of Agency Nurses and HCSW’s, with an increase in flexible staffing (internal bank) in August.

7.8 There was a reduction in the number of shifts with more than 50% of RNs being flex (bank) or agency. Where these did occur, these shifts were in the Division of Medicine with 81 shifts compared with 112 in July.

7.9 In the community there was a deficit of 3.4% of nursing against plan representing deterioration on previous months. This is accounted for by increased annual leave
during the summer holiday period, together with vacancies. These vacancies have been recruited to, with successful candidates due to start in post.

7.10 Ward A3, our ‘winter escalation ward’ closed on 29 July. The substantive RN and HCSW colleagues from this ward have been transferred to other wards within the Trust.

7.11 From June 2016 the Trust (and all others nationally) has been collecting Care Hours per Patient Day (CHpPD) data. This metric identifies the number of care contact hours patients receive from nursing staff, both Registered Nurses and HCSW. It is understood that NHS Improvement will review this metric in October.

7.12 Last month the Board was advised that the Chief Nurse team would be seeking benchmarking data to compare the TRFT CHpPD with those of other organisations in order to start to make meaning of the data.

7.13 The information in the table below has been accessed via The Centre of Study of Policy and Practice in Health and Social Care, University of West London (2016), and the Trust is grateful to them for allowing access and use of their research data.

7.14 The data has been generated from 208 best practice wards / specialities across the United Kingdom and it allows a comparison at speciality level.

<table>
<thead>
<tr>
<th>TRFT ward / National Speciality</th>
<th>TRFT</th>
<th>Average from Best Practice Ward / Speciality across UK.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 / Medicine</td>
<td>5.3</td>
<td>5.64</td>
</tr>
<tr>
<td>A2 / Medicine</td>
<td>10.9</td>
<td>5.64</td>
</tr>
<tr>
<td>A4 / Medicine</td>
<td>4.8</td>
<td>5.64</td>
</tr>
<tr>
<td>A5 / Medicine</td>
<td>5.2</td>
<td>5.64</td>
</tr>
<tr>
<td>A7 / Oncology &amp;/ or Haematology</td>
<td>6.1</td>
<td>8.05</td>
</tr>
<tr>
<td>AMU / AMU</td>
<td>7.5</td>
<td>7.08</td>
</tr>
<tr>
<td>CCU / CCU</td>
<td>11.3</td>
<td>14.45</td>
</tr>
<tr>
<td>Stroke Unit / Stroke Unit</td>
<td>5.7</td>
<td>5.51</td>
</tr>
<tr>
<td>B4 / Surgery</td>
<td>5.0</td>
<td>6.6</td>
</tr>
<tr>
<td>B5 / Surgery</td>
<td>5.3</td>
<td>6.6</td>
</tr>
<tr>
<td>Sitwell / Surgery</td>
<td>6.4</td>
<td>6.6</td>
</tr>
<tr>
<td>Fitz / Trauma</td>
<td>6.2</td>
<td>6.45</td>
</tr>
<tr>
<td>Keppel / Orthopaedics</td>
<td>5.7</td>
<td>6.21</td>
</tr>
<tr>
<td>B11 / Gynae</td>
<td>7.2</td>
<td>5.74</td>
</tr>
<tr>
<td>Children’s wards / Children’s ward</td>
<td>21.9</td>
<td>10.19</td>
</tr>
</tbody>
</table>

7.15 Trust data is largely comparable. Two areas stand out as having the greatest variance; Ward A2 and Children’s Ward. Based on August data it is possible the A2 position may be explained by the fact that a bed capacity was reduced (whilst the ward was on A3), as described in the healthcare associated infection section of this report. The position in relation to Children’s Ward needs to be understood.

7.16 Both A4 and B4 that are cited in para 7.2 above have lower ChpPD than the best practice wards whilst the AMU and Stroke Unit also cited in paragraph 7.2 have higher CHpPD.
7.17 Over the next few weeks this information also needs to be reviewed alongside information arising from the Carter [efficiency] Review.

7.18 Finally for this section of the report the Board is asked to note that the first cohort on the Adult Compass Programme commences on 19 September. The programme is unique to TRFT and is designed to attract recruits and nurture talent. The second cohort will commence in March alongside a programme designed for Children’s services.

8 **Medical Staffing Report**

8.1 This summarises the main priorities at this current time for the M&D workforce.

8.2 The following table gives a high level overview of M&D staffing across the Trust as at 12 Sep 16:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Establishment</th>
<th>Vacancies</th>
<th>This Month</th>
<th>Last Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>168.7</td>
<td>16.65</td>
<td>9.87%</td>
<td>12.61%</td>
</tr>
<tr>
<td>SAS Grades</td>
<td>61.52</td>
<td>9</td>
<td>14.63%</td>
<td>21.13%</td>
</tr>
<tr>
<td>Training Grades</td>
<td>150</td>
<td>8</td>
<td>5.33%</td>
<td>6.00%</td>
</tr>
<tr>
<td>Non-Training Grades</td>
<td>27</td>
<td>12</td>
<td>44.44%</td>
<td>42.31%</td>
</tr>
<tr>
<td>Totals</td>
<td>407.22</td>
<td>45.65</td>
<td>11.21%</td>
<td>13.36%</td>
</tr>
</tbody>
</table>

8.3 The training grade total includes posts managed by Lead Units, namely STH, SCH and DBHT; TRFT only employs Foundation and GPVTS posts directly. We remain concerned around the non-training grade posts at lower level in both Surgery and T&O, who account for 8 of the 12 vacancies at this level. Recruitment is on-going and posts filled with agency locum staff as an interim measure.

8.4 The consultant vacancy figure includes locums, both NHS and Agency, on fixed term contracts. In terms of substantive vacancies there are currently 31.65; recent appointments are summarised below:

8.5 The Head of Medical Workforce has met with the BMJ to look at innovative and alternative methods of advertising to attract individuals to work at the Trust; these will be out in place going forward as part of our recruitment strategy. In addition, a meeting has been arranged on 22 Sep 16 with Gatenby Sanderson who will look to offer targeted support in recruitment of consultants.

8.6 Issues continue with the Junior Doctor Contract following the announcement by the BMA of extended strike action. The planned action from 12 – 16 Sep 16 was suspended due to patient safety concerns being raised by NHS leaders, Royal Colleges and, in particular, the GMC. Strike action planned for October, November and December (all over 5 days with full withdrawal of labour between 0800 and 1700) remains a distinct possibility. Planning is well underway and the Trust will be required to provide necessary assurance and staffing returns to NHS England as previously. Internal planning meetings will commence later in September but, in the interim, communications will be sent out by the Head of Medical Workforce.

8.7 Red Flag shifts reported (Appendix 1) note there were no cases of staffing difficulties resulting in adverse instances of patient care.

8.8 Whilst a significant number of vacancies persist there is no ongoing evidence of direct risk as a consequence.
The fifth ‘Day to Celebrate’ was held on Thursday 8 September 2016 and focused on developments and innovations following our CQC Inspection in February 2015.

The event provided a further fantastic opportunity to showcase innovation and improvement being led by nurses, midwives and allied health professionals here in Rotherham.

As with previous events this was a two and a half hour showcase event consisting of 7 short presentations. A number of CQC related posters were on display throughout the event. Sadly only 30 colleagues attended this event. For Nurses and Midwives participation can contribute to NMC revalidation participatory practice hours.

The presentations covered; the role of the TRFT Pride Makers; the improvements made within the Oakwood Community Unit with a focus on the new Elm Unit; the Allied Health Professional review of the Stroke Pathway; the development of the Discharge Lounge; the new Children’s Service models of care and the significant progress being made in relation to managing Deprivation of Liberty Safeguards and Mental Capacity Act assessments.

The next Day to Celebrate event is planned for Thursday 12 January 2017 when the focus will be on the nursing, midwifery and AHP contribution to achieving our Quality Improvement Priorities.

During the past month the Chief Nurse team have been seeking peer review of a number of aspects of practice. Specifically in relation to the prevention of Pressure Ulcers the Trust has been in contact with Barnsley NHS Foundation Trust. This contact was generated following reference to Barnsley at a recent conference. Furthermore the team have invited peer scrutiny of our Pressure Ulcer Review Panel by way of seeking assurances that decisions around avoidability or otherwise are robust. That input will take place later in September and is being provided by Doncaster and Bassetlaw NHS Foundation Trust.

Some Trusts use ‘safety clocks’ at the patient bedside to indicate the time the patients ‘next turn’ (to prevent pressure damage) is due. Before considering whether TRFT should trial this, acknowledging that pressure ulcer prevention in the hospital is generally well managed, the Lead Nurse for Dementia is researching experience in the Trusts that use such clocks to understand how they have prevented place and time disorientation when patients in bays are faced with 6 clocks, plus the wall clock, all telling a different time?

The Chief Nurse has been in contact with a number of Trusts to discuss their quality improvement journey and specifically visited Hinchinbrook Hospital.
## Medical Red Flag Shifts - August 2016

<table>
<thead>
<tr>
<th>ID</th>
<th>Incident date</th>
<th>CSU/OSU</th>
<th>Location</th>
<th>Description</th>
<th>Mitigation</th>
<th>Degree of Harm</th>
<th>Approval status</th>
</tr>
</thead>
<tbody>
<tr>
<td>70569</td>
<td>01/08/2016</td>
<td>General Medicine</td>
<td>AMU / (formerly Ward B1)</td>
<td>Vacant ST1-2 medical red flag on call shift was left vacant due to lack of internal/locum cover</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td>Finally approved</td>
</tr>
<tr>
<td>70563</td>
<td>01/08/2016</td>
<td>General Medicine</td>
<td>AMU / (formerly Ward B1)</td>
<td>On call ST1-2 night shift was not covered due to lack of internal cover/locum cover</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td>Finally approved</td>
</tr>
<tr>
<td>70567</td>
<td>01/08/2016</td>
<td>General Medicine</td>
<td>AMU / (formerly Ward B1)</td>
<td>Vacant F1 red flag medical on call shift was not filled due to lack of internal/locum cover</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td>Finally approved</td>
</tr>
<tr>
<td>70575</td>
<td>02/08/2016</td>
<td>General Medicine</td>
<td>AMU / (formerly Ward B1)</td>
<td>Vacant red flag medical on call shift was unfilled due to lack of internal/locum cover</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td>Finally approved</td>
</tr>
<tr>
<td>70576</td>
<td>02/08/2016</td>
<td>General Medicine</td>
<td>AMU / (formerly Ward B1)</td>
<td>Vacant F1 red flag medical on call shift was uncovered due to lack of internal/locum cover</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td>Finally approved</td>
</tr>
<tr>
<td>70578</td>
<td>02/08/2016</td>
<td>General Medicine</td>
<td>AMU / (formerly Ward B1)</td>
<td>Vacant red flag medical on call shift was uncovered due to lack of internal/locum cover</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td>Finally approved</td>
</tr>
<tr>
<td>70580</td>
<td>03/08/2016</td>
<td>General Medicine</td>
<td>AMU / (formerly Ward B1)</td>
<td>Vacant red flag on call shift was uncovered due to lack of internal/locum cover</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td>Finally approved</td>
</tr>
<tr>
<td>70582</td>
<td>03/08/2016</td>
<td>General Medicine</td>
<td>AMU / (formerly Ward B1)</td>
<td>Vacant red flag medical on call shift was uncovered due to lack of internal/locum cover</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td>Finally approved</td>
</tr>
<tr>
<td>70585</td>
<td>03/08/2016</td>
<td>General Medicine</td>
<td>AMU / (formerly Ward B1)</td>
<td>Vacant red flag medical on call ST1-2 shift was unfilled by either internal/locum staff</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td>Finally approved</td>
</tr>
<tr>
<td>70588</td>
<td>03/08/2016</td>
<td>General Medicine</td>
<td>AMU / (formerly Ward B1)</td>
<td>Vacant ST1-2 red flag medical on call shift was uncovered due to lack of internal/locum cover</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td>Finally approved</td>
</tr>
<tr>
<td>No.</td>
<td>Date</td>
<td>Area</td>
<td>Reason</td>
<td>Impact</td>
<td>Resolution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70568</td>
<td>04/08/2016</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle grade vacancy remained unfilled due to lack of internal cover and/or locum cover</td>
<td>Workload distributed to rest of team</td>
<td>Finally approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70590</td>
<td>04/08/2016</td>
<td>General Medicine</td>
<td>Vacant ST1-2 red flag medical on call shift was uncovered due to lack of internal/locum cover.</td>
<td>On call team shared workload with consultant support</td>
<td>No harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70571</td>
<td>05/08/2016</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade vacancy remained unfilled due to lack of internal cover and/or locum cover</td>
<td>Workload distributed to rest of team</td>
<td>Finally approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70574</td>
<td>06/08/2016</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade vacancy remained unfilled due to lack of internal cover and/or locum cover</td>
<td>Workload distributed to rest of team</td>
<td>Finally approved</td>
<td></td>
<td></td>
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<tr>
<td>70577</td>
<td>07/08/2016</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade shift remained unfilled due to lack of internal cover and/or locum cover</td>
<td>Workload distributed to rest of team</td>
<td>Finally approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70579</td>
<td>10/08/2016</td>
<td>Accident and Emergency</td>
<td>2000-0800 Middle Grade shift remained unfilled due to lack of internal and/or locum cover</td>
<td>Consultant had to cover the shift due to both 2200-0800 Middle Grade shifts remaining unfilled</td>
<td>No harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70581</td>
<td>10/08/2016</td>
<td>Accident and Emergency</td>
<td>Both 2200-0800 Middle Grade shifts remained unfilled due to lack of internal and/or locum cover</td>
<td>Consultant had to cover the shift due to both 2200-0800 Middle Grade shifts remaining unfilled</td>
<td>No harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70582</td>
<td>11/08/2016</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade shift remained unfilled due to lack of internal and/or locum cover</td>
<td>Workload distributed to rest of team</td>
<td>Finally approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70584</td>
<td>12/08/2016</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle grade shift remained unfilled due to lack of internal and/or locum cover</td>
<td>Workload distributed to rest of team</td>
<td>Finally approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70586</td>
<td>12/08/2016</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade shift remained unfilled due to lack of internal and/or locum cover</td>
<td>Workload distributed to rest of team</td>
<td>Finally approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70587</td>
<td>13/08/2016</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade shift remained unfilled due to lack of internal and/or locum cover</td>
<td>Workload distributed to rest of team</td>
<td>Finally approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70589</td>
<td>14/08/2016</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade shift remained unfilled due to lack of internal and/or locum cover</td>
<td>Workload distributed to rest of team</td>
<td>Finally approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70591</td>
<td>17/08/2016</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade shift remained unfilled due to lack of internal and/or locum cover</td>
<td>Workload distributed to rest of team</td>
<td>Finally approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Date</td>
<td>Department</td>
<td>Sub-Department</td>
<td>Description</td>
<td>Outcome</td>
<td>Approval</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>----------</td>
<td>--------------------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>70594</td>
<td>18/08/2016</td>
<td>Accident and Emergency</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade shift remained unfilled due to lack of internal and/or locum cover</td>
<td>No harm</td>
<td>Finally approved</td>
<td></td>
</tr>
<tr>
<td>70595</td>
<td>22/08/2016</td>
<td>Accident and Emergency</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade shift remained unfilled due to lack of internal and/or locum cover</td>
<td>No harm</td>
<td>Finally approved</td>
<td></td>
</tr>
<tr>
<td>70597</td>
<td>25/08/2016</td>
<td>Accident and Emergency</td>
<td>Accident and Emergency</td>
<td>Second 2200-0800 Middle Grade shift remained unfilled due to lack of internal and/or locum cover</td>
<td>No harm</td>
<td>Finally approved</td>
<td></td>
</tr>
</tbody>
</table>
Board Meeting: 26 September 2016

Agenda item: 353/16(b)

Report: Operational Performance Update

Presented by: Chris Holt, Chief Operating Officer
Author(s): Chris Holt, Chief Operating Officer
Tom Ridgeway, Head of Performance

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:
Monitor: Licence Condition FT4
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
BAF: B1, B10, B20
Corporate Risk Register: As appropriate.

Purpose of this paper:
This paper provides, for each key operational indicator, an overview of performance in August 16’, summarising headline progress and actions being taken to address on-going issues.

Summary of Key Points:

- In August, 95.04% of patients were admitted, transferred or discharged from A&E within four hours of arrival, above the 95% standard and the strongest performance since June 2015.
- The 18 week Incomplete pathways continues to deliver above national standard, however there is concern relating to the increasing number of patients waiting over 18 weeks.
- Performance against the 62-day cancer standard in July continued to be strong at 90.9%, placing TRFT 22nd of all NHS acute providers.
- 6 week wait diagnostics in August was significantly below standard with 3.4% of patients waiting longer than 6 weeks, forecast ranking of 160th of 177 NHS providers.
- The Trust did not meet the STP trajectory for 18-week Incomplete or DM01 in August. However neither of these under performance challenges will impact STP funding.

Board action required:
For noting
## 1.0 Introduction

### 1.1 This paper provides, for each key operational indicator, an overview of performance in August'16, summarising headline progress and actions being taken to address areas of concern and deliver continuous improvements.

### 1.2 As an overview to overall operational performance, the quadrant view from the Integrated Performance Report is replicated below:

<table>
<thead>
<tr>
<th>Top Achievements</th>
<th>Most Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Hour Access = 95.04% (Target 95%)</td>
<td>Cancer 14-day breast symptoms = 98% (Target 93%)</td>
</tr>
<tr>
<td>Following a long period of focussed attention performance against the 4 hour</td>
<td>Following challenges earlier in the year relating to patient choice and work</td>
</tr>
<tr>
<td>standard met national targets for the first time since June 2015.</td>
<td>between the cancer team and RCCG, performance has returned to good levels.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 62 day = 90.9% (July)</td>
<td>% Stroke patients supported by stroke skilled team = 29% (target 40%)</td>
</tr>
<tr>
<td>TRFT continues to consistently achieve top quartile performance in many of the</td>
<td>Whilst performance is yet to meet target levels there has been considerable</td>
</tr>
<tr>
<td>cancer standards. Most notably the 62 Day Classic where TRFT is 22nd nationally.</td>
<td>progress made in the support we provide our patients that have experienced a</td>
</tr>
<tr>
<td></td>
<td>stroke. This is an impact of a recently recruited team.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Concerns</td>
<td>Most Deteriorated</td>
</tr>
<tr>
<td>Diagnostic Waiting Times (DM01) = 3.4% (Target &lt;1%)</td>
<td>18 week incomplete = 93.4% (Target 92%)</td>
</tr>
<tr>
<td>Performance on diagnostic waiting times has deteriorating in line with forecasts</td>
<td>Whilst performance continues to be better than national standard it is of</td>
</tr>
<tr>
<td>presented at August board. This is predominantly due to ongoing capacity issues</td>
<td>concern than TRFT has fallen from an average of 96%.</td>
</tr>
<tr>
<td>in Endoscopy</td>
<td></td>
</tr>
<tr>
<td>% Stroke patients admitted directly to a stroke bed within 4 hours = 57% (Target</td>
<td>% Stroke patients scanned within 1 hour = 55.3% (down from 77.1%, Target 50%)</td>
</tr>
<tr>
<td>90%)</td>
<td>Following focused attention in June where performance climbed to excellent</td>
</tr>
<tr>
<td>Performance against this standard have been below target levels for 22 months.</td>
<td>levels. The percentage of stroke patients scanned within an hour dropped back</td>
</tr>
<tr>
<td></td>
<td>to typical levels. Whilst this is above local target, it is below levels</td>
</tr>
<tr>
<td></td>
<td>required for SSNAP A rating.</td>
</tr>
</tbody>
</table>
2.0 **4hr emergency access target**

2.1. There were 6,144 attendances to the Emergency Department (ED) in August 2016, an average of 198 patients per day. This was 3.5% below (Sustainability and Transformation Plan) STP trajectory and contracted activity levels.

2.2. In August, 95.04% of patients were admitted, transferred or discharged from ED within four hours of arrival. Achieving the national performance standard for the first time since June 2015.

2.3. The key factors which resulted in the Trust achieving the 4hr standard in August can be summarised as:
   - Low demand (less than 200 per day)
   - Good staffing levels (low annual leave)
   - Fewer admissions into the hospital

2.4. Admissions into the hospital via the Emergency department reduced from an average of 55 per day in July (25.2%) to 48 per day in August (24.3%).

2.5. The strong performance across emergency pathways was also seen in a decreased number of ambulance handover delays greater than 30 minutes (1, down from 12 last month).

### National Performance Comparisons

2.6. In comparing performance against the national position for July (which is released a month behind), TRFT fell out of the top 50 Type 1 Providers being placed 55th.
2.7. National performance in July against the 4-hour standard continued at 85.4%, as set in Q1 16/17.

National performance against 4hr emergency access

<table>
<thead>
<tr>
<th>Period</th>
<th>TRFT Performance</th>
<th>TRFT Rank (of 140)</th>
<th>England Avg (Type 1)</th>
<th>No. of Trusts &gt;95% (Type 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>95.7%</td>
<td>23</td>
<td>91.1%</td>
<td>44</td>
</tr>
<tr>
<td>Q2</td>
<td>92.1%</td>
<td>79</td>
<td>91.4%</td>
<td>43</td>
</tr>
<tr>
<td>Q3</td>
<td>90.5%</td>
<td>58</td>
<td>87.4%</td>
<td>12</td>
</tr>
<tr>
<td>Q4</td>
<td>83.8%</td>
<td>59</td>
<td>81.8%</td>
<td>4</td>
</tr>
<tr>
<td>Year 15/16</td>
<td>90.5%</td>
<td>53</td>
<td>87.8%</td>
<td>10</td>
</tr>
<tr>
<td>April</td>
<td>92.9%</td>
<td>27</td>
<td>84.8%</td>
<td>8</td>
</tr>
<tr>
<td>May</td>
<td>90.1%</td>
<td>50</td>
<td>85.4%</td>
<td>10</td>
</tr>
<tr>
<td>June</td>
<td>91.9%</td>
<td>41</td>
<td>85.8%</td>
<td>13</td>
</tr>
<tr>
<td>Q1</td>
<td>91.6%</td>
<td>38</td>
<td>85.4%</td>
<td>8</td>
</tr>
<tr>
<td>July</td>
<td>89.1%</td>
<td>55</td>
<td>85.4%</td>
<td>12</td>
</tr>
</tbody>
</table>

2.8. In comparison to local trusts, TRFT performance in July was not as relatively good with both Barnsley and Doncaster showing stronger performance.

Local Type 1 performance against 4hr emergency access

<table>
<thead>
<tr>
<th>Trusts</th>
<th>May</th>
<th></th>
<th>June</th>
<th></th>
<th>July</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Perf.</td>
<td>Rank (of 140)</td>
<td>Perf.</td>
<td>Rank (of 140)</td>
<td>Perf.</td>
<td>Rank (of 140)</td>
</tr>
<tr>
<td>Barnsley</td>
<td>95.4%</td>
<td>8</td>
<td>95.5%</td>
<td>7</td>
<td>91.4%</td>
<td>30</td>
</tr>
<tr>
<td>Doncaster</td>
<td>91.5%</td>
<td>39</td>
<td>90.3%</td>
<td>52</td>
<td>92.8%</td>
<td>36</td>
</tr>
<tr>
<td>TRFT</td>
<td>90.1%</td>
<td>50</td>
<td>91.9%</td>
<td>41</td>
<td>89.1%</td>
<td>55</td>
</tr>
<tr>
<td>Chesterfield</td>
<td>87.1%</td>
<td>69</td>
<td>82.1%</td>
<td>102</td>
<td>87.9%</td>
<td>62</td>
</tr>
<tr>
<td>Sheffield TH</td>
<td>80.0%</td>
<td>108</td>
<td>73.8%</td>
<td>132</td>
<td>86.5%</td>
<td>129</td>
</tr>
</tbody>
</table>

2.9. At the time of writing, 4-hour performance for September is better than STP trajectory, with current month to date performance at 92.9%. Whilst many actions outlined in last month’s board paper continue to positively contribute to improved delivery, it is clear that a return to higher levels of attendances is challenging our ability to maintain >95% performance. Average daily attendances are running at 211.

2.10. As such, whilst key actions continue to be taken to secure strong emergency department staffing and excellent patient flow, this re-emphasises the need to continue our focus with the CCG on maintaining lower attendance volumes.

2.11. As presented last month the results of recent forecasting, presented below, demonstrate how vital this work is if TRFT is to sustainably deliver the 4-hour access standard. If trends continue at current and historic rates, the forecasts predict up to 234 attendances and 60 admissions per day by the end of the financial year.
2.12. Further to the forecasting analysis presented above, there has also been an in depth review of performance weak spots. Presented below is a table depicting performance by two-hour time bands for attendances in quarter one of 2016/17. This highlights the relative challenges overnight.

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 2</td>
<td>73.08%</td>
<td>65.81%</td>
<td>76.03%</td>
<td>63.11%</td>
<td>73.28%</td>
<td>74.47%</td>
<td>84.89%</td>
</tr>
<tr>
<td>2 to 4</td>
<td>72.00%</td>
<td>61.04%</td>
<td>65.75%</td>
<td>59.38%</td>
<td>77.78%</td>
<td>62.77%</td>
<td>73.73%</td>
</tr>
<tr>
<td>4 to 6</td>
<td>80.82%</td>
<td>65.33%</td>
<td>84.85%</td>
<td>69.49%</td>
<td>77.14%</td>
<td>78.46%</td>
<td>64.47%</td>
</tr>
<tr>
<td>6 to 8</td>
<td>98.00%</td>
<td>88.74%</td>
<td>99.11%</td>
<td>93.20%</td>
<td>98.57%</td>
<td>94.96%</td>
<td>91.10%</td>
</tr>
<tr>
<td>8 to 10</td>
<td>94.94%</td>
<td>93.42%</td>
<td>97.88%</td>
<td>94.80%</td>
<td>96.44%</td>
<td>95.12%</td>
<td>92.66%</td>
</tr>
<tr>
<td>10 to 12</td>
<td>93.84%</td>
<td>91.33%</td>
<td>96.87%</td>
<td>94.62%</td>
<td>93.37%</td>
<td>94.12%</td>
<td>94.29%</td>
</tr>
<tr>
<td>12 to 14</td>
<td>90.68%</td>
<td>94.12%</td>
<td>95.05%</td>
<td>95.54%</td>
<td>92.45%</td>
<td>94.91%</td>
<td>91.67%</td>
</tr>
<tr>
<td>14 to 16</td>
<td>88.37%</td>
<td>92.05%</td>
<td>94.57%</td>
<td>95.64%</td>
<td>94.31%</td>
<td>95.77%</td>
<td>89.71%</td>
</tr>
<tr>
<td>16 to 18</td>
<td>91.47%</td>
<td>89.17%</td>
<td>91.37%</td>
<td>92.84%</td>
<td>93.96%</td>
<td>94.36%</td>
<td>88.51%</td>
</tr>
<tr>
<td>18 to 20</td>
<td>88.10%</td>
<td>91.64%</td>
<td>90.00%</td>
<td>93.09%</td>
<td>92.75%</td>
<td>93.77%</td>
<td>90.93%</td>
</tr>
<tr>
<td>20 to 22</td>
<td>88.93%</td>
<td>84.87%</td>
<td>86.56%</td>
<td>90.91%</td>
<td>92.13%</td>
<td>95.47%</td>
<td>90.09%</td>
</tr>
<tr>
<td>22 to 24</td>
<td>93.40%</td>
<td>87.03%</td>
<td>90.20%</td>
<td>97.51%</td>
<td>93.58%</td>
<td>96.45%</td>
<td>91.33%</td>
</tr>
</tbody>
</table>
2.13. Initial analysis indicates that a contributing factor to the increased performance challenges during overnight periods relates to a higher acuity of patients as measured through financial coding. During the overnight hours of 21:00 to 08:00 21% of patients were recorded in the high acuity codes, compared to 17% during day time hours.

2.14. The increased understanding that the above analysis provides is assisting in the review and redesign of staffing rotas, which have previously been based on activity volume analysis.

3.0 Cancer

3.1. In July, all cancer standards were met with 6 being in the national top quartile.

3.2. For July TRFT met both national and STP 62-day cancer waiting time targets, with 90.9% of patients beginning a first definitive treatment within 62 days from an urgent GP referral for a suspect cancer (Target 85%).

3.3. The achievement of 90.9% for July places TRFT 22\textsuperscript{nd} of all acute NHS providers for timeliness of cancer treatment.

3.4. The forecasted performance for Q2 is to be achieving all targets. However, performance on the 62-day classic pathway is not as strong as last quarter. This decline in performance is largely due to increased patient choice breaches during the summer holiday period.

### TRFT Cancer Performance July and Forecast August & Q2

<table>
<thead>
<tr>
<th>Target</th>
<th>Standard</th>
<th>July 2016 Confirmed</th>
<th>August 2016 Validation Ongoing</th>
<th>Q2 Forecast Validation Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2ww</td>
<td>93</td>
<td>95.9</td>
<td>94.9</td>
<td>94.7</td>
</tr>
<tr>
<td>2ww Breast Symptoms</td>
<td>93</td>
<td>97.9</td>
<td>94.9</td>
<td>94.4</td>
</tr>
<tr>
<td>62 Day from GP</td>
<td>85</td>
<td>90.9</td>
<td>87</td>
<td>86.4</td>
</tr>
<tr>
<td>62 Day Consultant Upgrade</td>
<td>No Target</td>
<td>92.4</td>
<td>89.3</td>
<td>90.7</td>
</tr>
<tr>
<td>62 Day from Screening</td>
<td>90</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>31 Day First Treatment</td>
<td>96</td>
<td>98.7</td>
<td>100</td>
<td>99.4</td>
</tr>
<tr>
<td>31 Day Subs Treatment for Chemotherapy</td>
<td>98</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>31 Day Subs Treatment for Palliative Care</td>
<td>No Target</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>31 Day Subs Treatment for Surgery</td>
<td>94</td>
<td>100</td>
<td>88.9</td>
<td>95.7</td>
</tr>
</tbody>
</table>

*\(\star\) = Top Quartile Performance

4.0 18 week RTT Incomplete

4.1. 93.4% of patients on the waiting list at the end of August 2016 had been waiting less than 18 weeks, compliant with National target but below our STP trajectory of 94.1%. This performance will position TRFT 76\textsuperscript{th} of 186 providers nationally. England performance is currently being reported at 91.3%.
4.2. It is of concern that the incomplete performance has continued to deteriorate and is the lowest recorded, with 752 patients waiting over 18 weeks. The graph presented below shows 18 week Incomplete performance for the last 12 months.

4.3. It is of particular concern that three specialties, Oral Surgery, Cardiology and Dermatology did not meet the national standard. However, progress in Oral Surgery and Cardiology is in line with trajectory. A remedial action plan is in progress with these specialties to secure future delivery and improve the overall Trust position.

18 week RTT Incomplete Performance August'16

<table>
<thead>
<tr>
<th>Trust Total Incomplete</th>
<th>% &lt;18Wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>92.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>94.0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>92.5%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>93.9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>99.4%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>86.8%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>98.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>96.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>87.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>91.6%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>99.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>93.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>95.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>93.5%</td>
</tr>
<tr>
<td>Other</td>
<td>96.1%</td>
</tr>
<tr>
<td>Total</td>
<td>93.4%</td>
</tr>
</tbody>
</table>

4.4. In terms of the overall Trust position, and the deterioration in performance, the core issue is the deficit in capacity in a number of specialties. This deficit is also driving the challenges being experienced in waiting list increases for both new referrals (via Choose & Book) and review patients who require a planned follow up. All of these issues are in turn largely driven by workforce challenges of both a short and medium/long term nature. There are approximately 8 specialties affected and each specialty has a recovery plan in place with an agreed trajectory, and it is anticipated that the worsening performance will begin to improve as early as next month.
5.0 6 week wait diagnostic tests

5.1 As per the forecast presented in July Board report, 3.4% of the patients waiting at the end of August had been waiting six weeks or longer for one of the 15 key diagnostic tests, worse than the national standard (1%) and outside our STP trajectory.

TRFT 6 week wait diagnostic performance August’16

<table>
<thead>
<tr>
<th>Test</th>
<th>&lt;6 weeks</th>
<th>&gt;6 weeks</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnetic Resonance Imaging</td>
<td>392</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Computed Tomography</td>
<td>367</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Non-obstetric ultrasound</td>
<td>829</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Barium Enema</td>
<td>9</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>DEXA Scan</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Audiology - Audiology Assessments</td>
<td>342</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Cardiology - echocardiography</td>
<td>219</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Cardiology - electrophysiology</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Neurophysiology - peripheral neurophysiology</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Respiratory physiology - sleep studies</td>
<td>113</td>
<td>3</td>
<td>2.6%</td>
</tr>
<tr>
<td>Urodynamics - pressures &amp; flows</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>156</td>
<td>41</td>
<td>20.8%</td>
</tr>
<tr>
<td>Flexi sigmoidoscopy</td>
<td>74</td>
<td>14</td>
<td>15.9%</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>91</td>
<td>6</td>
<td>6.2%</td>
</tr>
<tr>
<td>Gastroscopy</td>
<td>241</td>
<td>35</td>
<td>12.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2833</strong></td>
<td><strong>99</strong></td>
<td><strong>3.4%</strong></td>
</tr>
</tbody>
</table>

5.2 Compared to National benchmarks, performance for July’16 placed TRFT 98th out of 177 NHS providers. Early indications suggest that performance for August’16 will place TRFT approximately 160th.

5.3 It is forecast that the performance against the 6 week wait for diagnostics will continue to not meet national standard in September 2016. The cause of this deterioration in performance relates to the Endoscopy department not having sufficient capacity to meeting ongoing demand.

5.4 Through quarter one premium additional payments were being offered to successfully ensure delivery of national waiting times. These above policy additional payments ceased in July, resulting in less additional capacity being available.

5.5 Short and long term capacity solutions are being reviewed to recover performance. However, it is expected that performance will be significantly under national standard until late in quarter three.
Winter Planning Preparation

6.1 Winter planning preparation is now well underway and the full plan will be presented to Trust Board in October. The winter plan will be structured around two core areas:

6.1.1 System responsibility and requirements: this will outline the actions and schemes that the wider Rotherham health economy will be taking to support the winter period. This will include primary care, CCG, RMBC, YAS and other key partners. The actions that will underpin these schemes will be expected to include areas such as the provision of intermediate care beds, discharge to assess beds and other appropriate capacity provision, appropriate social worker cover for peak periods of demand and holiday periods, the availability of additional enablement, domiciliary care, social packages of care and urgent primary care access.

6.1.2 TRFT planning and implementation: this will include the actions and schemes that are to be taken internally within the Trust to manage the winter period. This will include plans to ensure appropriate staffing is in place for peak periods, targeted clinical input into key areas such as ward rounds, how bed capacity is to be used and deployed, the management of elective pathways and demand along with daily support and changes to ‘business as usual’ working. There will also be the seasonal flu-vaccination programme.

6.2 A focus will also be applied to establish an escalation system for the Rotherham borough, which will see the deployment of the Escalation Management System (EMS) that has been in use within TRFT during 2016. This tool has been agreed to be adopted by all key partners via agreement at the A&E Delivery Board (formerly System Resilience Group) and this will allow all partners to have visibility of increasing emergency pressure within the system, underpinned by appropriate actions to take.

6.3 We are also undertaking analysis on how to best use the bed base and the management of flexible beds as well as looking at the use of additional beds external to the Trust. A number of audits have been undertaken, which will be triangulated with the analysis, to identify potential cohorts of patients whose care could be continued in an alternative setting prior to being suitably returned home. Discussions are also underway in parallel with various partners on where this care could be provided and how it could be funded with the aim of having additional capacity in place prior to the winter period.

7.0 Conclusion

6.1. Achievement against the 4hr access standard is a significant success for the Trust, which demonstrates our ability to be a national top performer. A key factor in delivering >95.0% performance was the low volume of attendances. The focus remains on a combination of short term and medium term actions, with particular focus being placed on working with RCCG to manage demand.

6.2. The Trust performance against the 18-week incomplete and Cancer standards continues to be above national standard. However, the strength of performance for 18 weeks has noticeably deteriorated for which we are providing focused attention on local action plans.
6.3. A key area of concern for the Trust is the increasing number of patients waiting longer than 6 weeks for their diagnostic tests. These issues are predominantly in endoscopy. Solutions are being reviewed to recover performance including a business case for adjusting the skill mix of staff.

6.4. Overall for the month of August, our performance can be represented in the table below, which provides a compliance status not only against the national standard, but also the STP monthly trajectory and National top quartile.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>TRFT Performance against:</th>
<th>National standard</th>
<th>STP Trajectory</th>
<th>Top Quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>4hr emergency access</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 62 day waits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 week RTT Incompletes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 week wait diagnostics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key to table above

- Confirmed Under Performance
- At risk or TBC
- Confirmed Achievement

6.5. A key ambition at the outset of the 16/17 financial year was to work toward achieving national top quartile across the key four access standards. Based on the results for August it is clear that whilst there is much work to do, TRFT is capable of achieving this ambitious goal in 4-hour access, Cancer 62 day and 18 week RTT. However, for 6 week wait diagnostics (DM01) this is unlikely to be achievable in 16/17 due to ongoing capacity challenges. All efforts will continue to be made to delivery excellent waiting times across all domains with robust long term recovery plans being implemented in the areas of key challenge.

Chris Holt
Chief Operating Officer

Tom Ridgeway
Head of Performance

September 2016
Report: Workforce Report

Presented by: Cheryl Clements – Director of Workforce
Author(s): Cheryl Clements – Director of Workforce

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:
Monitor: Licence Condition FT4
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
BAF: B5, B6
Corporate Risk Register: N/A

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

Summary of Key Points:
- For the first time within the last 6 months numbers of starters within nursing workforce are higher than leavers.
- Currently there are 42 Qualified Nurses at various stages of the recruitment process.
- Sickness absence has reduced by 0.12% to 4.37% from 4.49% in July.
- Mandatory training compliance continues to rise overall 77.12%. The target is 80%.

Board action required:
For noting
1.0  **Bank & Agency Usage**

1.1 The Trust needs to reduce the current level of pay spend to ensure delivery of the key financial targets. The Trust will be held to account for delivering 2016/17 agency expenditure for all staff in line with their expenditure ceiling.

1.2 Agency costs for August 2016 were £1,162K (previous month £877K) while the cost of bank staff was £389K (previous month £308K).

2.0  **Turnover**

2.1 Medical workforce has seen a spike in starters and leavers over the past 2 months this is due to annual rotation of medical trainees.

2.2 For the first time within last 6 months the numbers of starters within the Nursing workforce are higher than leavers.

2.3 Allied Health Professional, Professional technical & Scientific and Admin & Clerical starters continue to remain well above leavers.

2.4 Annual turnover by staff group highlighted in the table below (local organisations to June 2016)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Add Prof Scientific &amp; Technic</th>
<th>Additional Clinical Services</th>
<th>Administrative &amp; Clerical</th>
<th>Allied Health Professionals</th>
<th>Estates &amp; Ancillary</th>
<th>Healthcare Scientists</th>
<th>Medical &amp; Dental</th>
<th>Nursing &amp; Midwifery</th>
<th>Organisation Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnsley Hosp</td>
<td>6.62%</td>
<td>10.05%</td>
<td>11.16%</td>
<td>13.16%</td>
<td>12.77%</td>
<td>7.78%</td>
<td>10.53%</td>
<td>10.07%</td>
<td>9.42%</td>
</tr>
<tr>
<td>Doncaster &amp; B’law</td>
<td>15.47%</td>
<td>10.71%</td>
<td>13.93%</td>
<td>17.12%</td>
<td>13.19%</td>
<td>11.93%</td>
<td>10.11%</td>
<td>8.95%</td>
<td>10.15%</td>
</tr>
<tr>
<td>Rotherham</td>
<td>23.79%</td>
<td>11.26%</td>
<td>8.61%</td>
<td>13.83%</td>
<td>34.31%</td>
<td>6.49%</td>
<td>12.81%</td>
<td>10.65%</td>
<td>10.34%</td>
</tr>
<tr>
<td>Sheffield Childrens</td>
<td>11.38%</td>
<td>14.51%</td>
<td>9.85%</td>
<td>8.51%</td>
<td>7.99%</td>
<td>11.63%</td>
<td>6.06%</td>
<td>9.58%</td>
<td>8.84%</td>
</tr>
<tr>
<td>Sheffield Teach Hosp</td>
<td>8.93%</td>
<td>11.41%</td>
<td>8.54%</td>
<td>8.76%</td>
<td>10.36%</td>
<td>5.43%</td>
<td>5.21%</td>
<td>9.16%</td>
<td>7.99%</td>
</tr>
<tr>
<td>Staff Group Total</td>
<td>10.20%</td>
<td>10.90%</td>
<td>9.30%</td>
<td>9.75%</td>
<td>13.16%</td>
<td>7.03%</td>
<td>7.51%</td>
<td>8.24%</td>
<td>8.96%</td>
</tr>
</tbody>
</table>

3.0  **Recruitment and Retention**

3.1 Currently there are 42 Qualified Nurses going through the Recruitment Process.

3.2 The Recruitment Team are currently dealing with a high volume of Recruitment due to the amount of vacancies within the Trust. There are approx. 208 applicants currently receiving pre-employment checks and a further 60 applicants over 5 campaigns.

3.3 Employee Relations team have developed a leaver’s policy which includes a revised exit interview/questionnaire process resulting in an exit questionnaire issued at the point of resignation (earlier than current process). The policy was agreed at JPG in July 2016 and a supporting toolkit has been developed for managers which will be endorsed at the JPF on 15 September 2016.

4.0  **Sickness Absence**

4.1 Surgery and Family Health have seen a slight increase in absence. All other Divisions have seen a fall in absence.
4.2 In comparison to Local NHS organisations the Trust continue to improve since January 2016, however sickness remains above target.

4.3 Rolling absence September 2015 to August 2016 increased slightly to 4.41%.

4.4 Return to work interviews carried out continue to increase on previous month to 63.48%.

4.5 The estimated cost for sickness has reduced to £408,356 for August 2016 - estimated cost data has been taken from ESR and does not include any bank/agency cover or addition shifts/overtime worked.

4.6 Short term sickness has reduced slightly this month to 0.97 %. Long term sickness has seen a slight increase over the last 4 months to 3.39 %.

4.7 Sickness absence, in month, has reduced by 0.12% to 4.37% (July – 4.49%)

4.8 Sickness absence by division last 12 months

5.0 MAST Training

5.1 Mandatory training compliance continues to rise (overall 77.12%).

5.2 Clinical Support Services, Emergency Care, Family Health, Medicine and Surgery have increased compliance across all subject areas.

5.3 Both Clinical Support Services and Corporate Operations remain above Trust 80% Target for overall compliance relating to the subject areas signed off under the MAST Project.

5.4 Work is continuing to align MAST competency requirements with job roles.

5.5 Mandatory training by division at 31 August 2016
6.0 Employee Engagement

6.1 Departments have continued support from HR and Workforce Intelligence (ESR) teams to ensure PDR information has been entered onto the system in a timely manner. All areas have improved compliance rates.

<table>
<thead>
<tr>
<th>Division</th>
<th>Conflict Resolution</th>
<th>Dementia Awareness - No Renewal</th>
<th>Equality &amp; Diversity</th>
<th>Fire Safety - 1 Year</th>
<th>Hand Hygiene - 1 Year</th>
<th>Information Governance - 1 Year</th>
<th>PREVENT No Renewal</th>
<th>Safeguarding Adults L2 &amp; Above</th>
<th>Safeguarding Children L2 &amp; Above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>90.11%</td>
<td>86.69%</td>
<td>90.81%</td>
<td>90.34%</td>
<td>79.36%</td>
<td>98.46%</td>
<td>89.16%</td>
<td>87.75%</td>
<td>93.20%</td>
</tr>
<tr>
<td>Corporate Operations</td>
<td>86.88%</td>
<td>93.95%</td>
<td>89.83%</td>
<td>92.25%</td>
<td>86.30%</td>
<td>88.62%</td>
<td>68.11%</td>
<td>84.62%</td>
<td>73.08%</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>80.88%</td>
<td>72.06%</td>
<td>83.82%</td>
<td>83.82%</td>
<td>74.35%</td>
<td>80.88%</td>
<td>81.99%</td>
<td>56.10%</td>
<td>62.75%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>61.08%</td>
<td>61.08%</td>
<td>77.83%</td>
<td>68.47%</td>
<td>45.81%</td>
<td>66.50%</td>
<td>49.75%</td>
<td>51.61%</td>
<td>62.83%</td>
</tr>
<tr>
<td>Family Health</td>
<td>84.47%</td>
<td>79.91%</td>
<td>82.95%</td>
<td>61.19%</td>
<td>65.91%</td>
<td>82.04%</td>
<td>82.34%</td>
<td>67.54%</td>
<td>82.78%</td>
</tr>
<tr>
<td>Medicine</td>
<td>76.73%</td>
<td>72.48%</td>
<td>72.62%</td>
<td>72.60%</td>
<td>62.42%</td>
<td>73.04%</td>
<td>69.13%</td>
<td>62.15%</td>
<td>69.48%</td>
</tr>
<tr>
<td>Surgery</td>
<td>79.16%</td>
<td>75.42%</td>
<td>83.92%</td>
<td>81.65%</td>
<td>68.52%</td>
<td>76.56%</td>
<td>73.39%</td>
<td>77.56%</td>
<td>70.46%</td>
</tr>
</tbody>
</table>

7.0 Diversity

7.1 The annual Workforce Race Equality Scheme (WRES) data collection has been submitted by the Trust, August 2016.

7.2 The table below shows a breakdown of Disciplinary cases during the period April 2015 to March 2016 by WRES Ethnicity category – data as at 30 June 2016.

7.3 A new Equality & Diversity Group has been established and held its inaugural meeting on 08 September 2016 to scope out the key actions that will form the work plan going forward for the rest of 2016/17; as well as agree the constitution of the group.

7.4 WRES Disciplinary split by Ethnicity April 2015 to March 2016

Cheryl Clements
Director of Workforce
September 2016
BOARD MEETING: 26 September 2016

Agenda item: 353/16(d)

Report: Finance Report - Month 5

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:
Monitor: Licence Condition FT4
CQC Domain: Effective/responsive/well-led

Risk Reference:
BAF: B10, B11
Corporate Risk Register: 4357, 4364, 4366, 4371, 4374,

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

- Delivery against the planned income and expenditure surplus;
- Delivery against the capital programme;
- The financial sustainability risk rating.

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

- £204K surplus to the end of August 2016, which is £1,216K adverse to the planned surplus.
- Financial sustainability risk rating of 2 against the plan of 3.
- An under-spend against the capital programme of £505K compared to the plan of £5,638K as at the end of August 2016.
- It is vital that the recovery actions described in section 5 are implemented to ensure the Trust gets back on plan with its financial trajectory

Board action required: for noting
1. **Introduction and Context**

1.1 This paper provides the Board of Directors with an update on performance against the Trust's key financial duties, namely:

- Delivery against the planned income and expenditure surplus;
- Delivery against the capital programme;
- The financial sustainability risk rating.

2. **Key Financial Duties**

2.1 The following table summarises the financial position:

<table>
<thead>
<tr>
<th>Financial Duty</th>
<th>August Plan £K</th>
<th>August Actual £K</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering the Planned Surplus</td>
<td>1,421</td>
<td>204</td>
<td>R</td>
</tr>
<tr>
<td>Cash</td>
<td>2,117</td>
<td>2,836</td>
<td>R</td>
</tr>
<tr>
<td>Achieving the Capital Plan</td>
<td>5,638</td>
<td>5,133</td>
<td>A</td>
</tr>
</tbody>
</table>

2.2 The consultation on the single oversight framework (SOF) closed on 4 August 2016, and the new regulatory framework document was published on 13 September 2016 and will come into force from 1 October 2016. This will mean that the Trust will be providing performance data to NHSI under the requirements of the new SOF from 1 October 2016 although the existing Monitor and TDA templates for collection of data will continue into 2016/17. We will report against both the current metrics and new metrics from the September (month 6) reports.

**Key issues**

- £204K surplus to the end of August 2016, which is £1,216K adverse to the planned surplus.
- Financial sustainability risk rating of 2 against the plan of 3.
- An under-spend against the capital programme of £505K compared to the plan of £5,638K as at the end of August 2016.
3. Financial Position (Month 5 – August 2016)

3.1 The month 5 results may be summarised as follows. In month the Trust delivered a deficit of £233K against a planned surplus of £533K; an adverse variance of £765K. Cumulatively this results in a surplus of £204K; adverse to plan by £1,216K, as summarised in the table below.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Actual</th>
<th>Better (Worse) than Plan</th>
<th>Description</th>
<th>Plan</th>
<th>Actual</th>
<th>Better (Worse) than Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>£K</td>
<td>£K</td>
<td>£K</td>
<td>Income</td>
<td>£K</td>
<td>£K</td>
<td>£K</td>
</tr>
<tr>
<td>18,514</td>
<td>18,322</td>
<td>(192)</td>
<td>Clinical</td>
<td>92,171</td>
<td>92,625</td>
<td>454</td>
</tr>
<tr>
<td>874</td>
<td>850</td>
<td>(24)</td>
<td>Excluded Drugs</td>
<td>4,459</td>
<td>4,775</td>
<td>317</td>
</tr>
<tr>
<td>544</td>
<td>604</td>
<td>60</td>
<td>Research &amp; Development &amp; Educ</td>
<td>2,719</td>
<td>2,832</td>
<td>113</td>
</tr>
<tr>
<td>1,065</td>
<td>1,168</td>
<td>103</td>
<td>Other</td>
<td>4,843</td>
<td>5,101</td>
<td>258</td>
</tr>
<tr>
<td><strong>20,997</strong></td>
<td><strong>20,944</strong></td>
<td><strong>(53)</strong></td>
<td>TOTAL INCOME</td>
<td><strong>104,192</strong></td>
<td><strong>105,333</strong></td>
<td><strong>1,142</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
<th>Actual</th>
<th>Better (Worse) than Plan</th>
<th>Description</th>
<th>Plan</th>
<th>Actual</th>
<th>Better (Worse) than Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>£K</td>
<td>£K</td>
<td>£K</td>
<td>Expenditure</td>
<td>£K</td>
<td>£K</td>
<td>£K</td>
</tr>
<tr>
<td>13,408</td>
<td>13,657</td>
<td>(249)</td>
<td>Pay</td>
<td>67,199</td>
<td>68,967</td>
<td>(1,767)</td>
</tr>
<tr>
<td>6,022</td>
<td>6,746</td>
<td>(724)</td>
<td>Non Pay</td>
<td>29,927</td>
<td>32,295</td>
<td>(2,368)</td>
</tr>
<tr>
<td><strong>19,430</strong></td>
<td><strong>20,403</strong></td>
<td><strong>(973)</strong></td>
<td>TOTAL EXPENDITURE</td>
<td><strong>97,126</strong></td>
<td><strong>101,262</strong></td>
<td><strong>(4,136)</strong></td>
</tr>
<tr>
<td>(276)</td>
<td>0</td>
<td>276</td>
<td>Reserve Movements</td>
<td>(1,806)</td>
<td>0</td>
<td>1,806</td>
</tr>
<tr>
<td><strong>1,291</strong></td>
<td><strong>541</strong></td>
<td><strong>(750)</strong></td>
<td>EBITDA</td>
<td><strong>5,259</strong></td>
<td>4,071</td>
<td><strong>(1,188)</strong></td>
</tr>
<tr>
<td>(758)</td>
<td>(773)</td>
<td>(15)</td>
<td>Financing Costs</td>
<td>(3,838)</td>
<td>(3,867)</td>
<td>(29)</td>
</tr>
<tr>
<td><strong>533</strong></td>
<td><strong>(233)</strong></td>
<td><strong>(765)</strong></td>
<td>SURPLUS/(DEFICIT)</td>
<td><strong>1,421</strong></td>
<td>204</td>
<td><strong>(1,216)</strong></td>
</tr>
</tbody>
</table>

3.2 The attached graph shows how the Trust’s continues to under-perform on its income and expenditure account in the first five months of the financial year, as it struggles to manage pay expenditure overall as well as failing to deliver cost improvements to the required levels.

3.3 Income performance has been consistently better than plan in the first four months, although threshold adjustments have had an adverse impact in July. August has seen a £200k adverse position to plan for clinical income with a greater adverse, £450k, worse than the trend. This position, along with shortfalls in CIP and the monthly surplus increasing in line with the plan, has resulted in the adverse position to plan in month.
3.4 The key reasons for the variances are:

**Income**

- Patient care income is £216K worse than plan in month but is still and £771K better than plan cumulatively. In month performance is being driven by decreased non-elective activity (£251K) offset by improved performance in outpatients (£105K). However, there is also a net improvement within non-PbR (locally priced) activity most notably in GP direct access (+£125K); unbundled diagnostics (+£85K) and critical care (-£63K).

The increased non elective income, as noted, takes the Trust above the threshold for non-elective income whereby the Trust only receives 70% of the appropriate tariff. The remaining 30% is held by the CCG to re-invest in alternative provisions of care, in theory, to reduce the demand of this activity on providers. The Trust will be raising this issue with Rotherham CCG in order to seek re-investment of this income with the Trust for 2016/17.

- Cumulatively, elective activity is less just over 1% behind plan (-£162K) whereas non-elective activity is 3.6% above plan (+£837K): both of these figures include non-PBR activity. Conversely, outpatients is now just over 1% behind plan which is resultant of non-payment for over 5,000 follow up attendances above agreed ratios amounting to a reduction in income of £418K.

- Non-PbR income continues to see an over-recovery of excluded drugs: +£317K year to date. Other areas are now over-performing including GP direct access and unbundled diagnostics (£199K) and best practice tariff in Children’s services (£114K) although this is being offset to some extent by under-performance in other areas including critical care (-£108K)

**Pay**

- Pay costs are again above budget in August 2016 (£249K) and year to date (£1,767K). This continued level of over-spend is as a consequence of two factors namely; continuing reductions in budgets for cost improvement targets together with increased levels of expenditure on temporary staffing.

  - The Trust continues to see bank and agency costs being incurred throughout the Trust. However, whilst substantive staffing levels have increased throughout the Trust at an average increase of c. £102K per month since April, it is encouraging to note that the run rate on both bank and agency staff has been decreasing at a much greater rate during the same period c. £400K per month. This trend must continue in order for the financial plan to be delivered.

  - Medical staffing costs are now being maintained within budget overall year to date, despite incurring agency costs of £2,688K. Non-recurrent funding was added into these areas during June 2016 to recognise the significant cost pressures being experienced. However, it should be noted that there were the equivalent of 44.66 WTE substantive vacancies within this staff group during August 2016, which represented over 11% of establishment. There are still a number of key vacant posts that are being filled by agency staff.

  - Nursing staff, including healthcare assistants and other support staff are now over-spending year to date (£247K – less than 1%). As such, the Trust has placed restrictions on the use of healthcare assistants with effect 1 September.

  - Performance for the first five months of 2016/17 show that bank and agency expenditure has been on a downward trend in both absolute cost and percentage
terms, with figures for August 2016 indicating that it now only represents 8.5% of the total pay cost in month. However, the general trend direction is downwards and hence, is very encouraging, but it must still be recognised that there is a lot of further work to be done to reduce its current 12-months rolling average percentage of 10.9%.

The Trust has initially been set a target by Monitor (now NHS Improvement) to reduce its agency expenditure for nursing staff to 6% and latterly to reduce its overall agency expenditure by 35%, below levels experienced in the last financial year. This represents an overall reduction in expenditure of £5,439K, which whilst challenging, is essential if the Trust is to have any real chance of delivering its planned surplus in year. The table below shows the Trust is £393k ahead of this trajectory at the end of August.

<table>
<thead>
<tr>
<th>Month</th>
<th>Plan £K</th>
<th>Actual £K</th>
<th>Better (Worse) than Plan £K</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>1,169</td>
<td>1,203</td>
<td>(34)</td>
<td>-2.89%</td>
<td>-2.89%</td>
</tr>
<tr>
<td>May</td>
<td>1,082</td>
<td>935</td>
<td>147</td>
<td>13.54%</td>
<td>5.01%</td>
</tr>
<tr>
<td>June</td>
<td>1,020</td>
<td>973</td>
<td>47</td>
<td>4.63%</td>
<td>4.89%</td>
</tr>
<tr>
<td>July</td>
<td>953</td>
<td>844</td>
<td>109</td>
<td>11.47%</td>
<td>6.38%</td>
</tr>
<tr>
<td>August</td>
<td>915</td>
<td>791</td>
<td>124</td>
<td>13.55%</td>
<td>7.65%</td>
</tr>
<tr>
<td></td>
<td>5,139</td>
<td>4,746</td>
<td>393</td>
<td>7.65%</td>
<td>7.65%</td>
</tr>
</tbody>
</table>

**Non-Pay**

Non-pay costs are £32,295K against a budget of £29,927K resulting in a £2,368K adverse position for the year to date and £724K in month.

- The key areas contributing to this overspend are:
  - The drugs budget has over-spent in month by £149K and is over-spending by £706K year to date of which £317K is being offset by increased income from excluded drugs recharged to commissioners. It is inevitable that there will still be a residual over-spend on the drugs budget given the increased activity overall being experienced within the Trust. However, it is a concern, that whilst clinical income has remained relatively static in month the level of non-excluded drugs has increased significantly and will need to be investigated further.
Expenditure on clinical supplies and services has shown a significant over-spend in month (£112K) which is consistent with the trend of previous months leading to a cumulative over-spend of £611K. Cumulatively, this over-spend is primarily manifesting itself within medical and surgical supplies (£251K) and patients appliances (£118K). The former can be linked to increased activity, although there are various levels of over-spends across many areas of the Trust. The latter also reflects demands being placed on the services (including patient wheelchairs) and the Trust needs to consider approaching commissioners for additional funding to be provided in this area. However, in month there has been an increase in the costs for prostheses above budget (£60K) as consequence of the Orthopaedics service unit having a positive month for activity, but also an increase in bought in clinical support services (£41K), which is now resulting in a cumulative over-spend in this area of £22K.

Establishment expenditure is better than plan, both in month (£27K) and year to date (£224K). This is a mixture primarily of telephony costs (£138K); training costs (£72K) and travel (£44K).

4. Cost Improvement Programme

4.1. The Trust set a 2016/17 Cost Improvement Programme (CIP) target of £10.5m which is approximately 5% of controllable costs. This level of CIP is far in excess of the inbuilt implied efficiency level within the 2016/17 national tariff of 2%. This stretched target relates to the Trust having an underlying deficit position.

4.2. Performance to date against the CIP is disappointing and is summarised in the tables below at a Divisional level, for the year to date position and year end.

<table>
<thead>
<tr>
<th>Service</th>
<th>Year to Date</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>341</td>
<td>0</td>
<td>-341</td>
</tr>
<tr>
<td>Family Health</td>
<td>467</td>
<td>320</td>
<td>-147</td>
</tr>
<tr>
<td>Surgery</td>
<td>1,322</td>
<td>886</td>
<td>-436</td>
</tr>
<tr>
<td>Medicine</td>
<td>1,034</td>
<td>233</td>
<td>-801</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>795</td>
<td>537</td>
<td>-259</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>416</td>
<td>137</td>
<td>-278</td>
</tr>
<tr>
<td>Total</td>
<td>4,375</td>
<td>2,113</td>
<td>-2,262</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Forecast Out-Turn</th>
<th></th>
<th></th>
<th>Full Year Effect</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>817</td>
<td>0</td>
<td>(817)</td>
<td>817</td>
<td>0</td>
<td>(817)</td>
</tr>
<tr>
<td>Family Health</td>
<td>1,122</td>
<td>769</td>
<td>(353)</td>
<td>1,122</td>
<td>770</td>
<td>(352)</td>
</tr>
<tr>
<td>Surgery</td>
<td>3,173</td>
<td>2,558</td>
<td>(615)</td>
<td>3,173</td>
<td>2,785</td>
<td>(388)</td>
</tr>
<tr>
<td>Medicine</td>
<td>2,482</td>
<td>853</td>
<td>(1,629)</td>
<td>2,482</td>
<td>794</td>
<td>(1,688)</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>1,909</td>
<td>1,220</td>
<td>(689)</td>
<td>1,909</td>
<td>1,255</td>
<td>(654)</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>998</td>
<td>591</td>
<td>(407)</td>
<td>998</td>
<td>583</td>
<td>(415)</td>
</tr>
<tr>
<td>Central</td>
<td>750</td>
<td>750</td>
<td></td>
<td>1,000</td>
<td>1,000</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10,500</td>
<td>6,741</td>
<td>(3,760)</td>
<td>10,500</td>
<td>7,187</td>
<td>(3,314)</td>
</tr>
</tbody>
</table>
4.3. As with the year to date performance, the year-end forecast is off plan. To ensure delivery of the financial plan and to improve the underlying financial position it is vital that the organisation closes the current gap. Specific areas of focus are;

- Ensure all pay opportunities are reflected recurrently in the CIPs and any risks identified.
- Additional schemes, as discussed at the Finance & Performance Committee and Board Seminar session are implemented and profiled for the Q2 reporting cycle.
- Theatres action plan is quantified with realistic timescales
- Outpatients improvement plan is updated and savings quantified
- Medicines management schemes, particularly around drugs changes, are implemented as soon as possible following clinical engagement.
- All schemes to have gone through the Quality Impact Assessment by the end of Q2 – currently this is approximately 75%.

5. Financial Forecast and Action

5.1. As part of the normal reporting cycle from Q1 onwards all the Divisions and Corporate Directorates have produced year end forecasts. These have been produced in the month 5 reporting cycle within these respective areas with a mutli-disciplinary approach involving finance, service and general managers.

5.2. Whilst the year-end forecast for the Trust of the £6.6m surplus is very challenging it is still achievable. In order to deliver the year-end target a number of actions need to happen with immediate effect, along- side continued focus on the Cost Improvement Programme. These actions are a mixture of stopping / reducing certain types of expenditure and recurrent cost improvement. The main themes are as follows, and will be discussed in detail at the Finance & Performance Committee on 23 September 2016.

- Reducing pay costs – maintaining current run rate and then reducing costs
- Cost Improvement Programme, particularly Theatres, Outpatients and the workforce. We must deliver against the £10.5m target both in year and recurrently
- Continued progress against the procurement and medicines management schemes
- Implementation on an internal bank to support the reduction on agency spend
- Continued restrictions on discretionary spend
- Securing additional income from CCG for activity levels delivered
- Delivering against the CQUIN targets.

5.3. These actions predominately focus around our pay expenditure, as a consequence of the excessive costs currently being incurred and the benchmarking position of the Trust against other organisations and peers.

- Non clinical agency restriction
- Enhanced vacancy controls
- No Healthcare assistant agency spend
- Targeted reductions on medical and qualified nursing agency spend via daily approval meetings
- Revised bank arrangements and remuneration rates for all clinical staff

5.4. These enhanced controls have been implemented and will run alongside and complement the current Cost Improvement Programme. As well as ensuring delivery of these actions it is vitally important the Trust continues to deliver against the activity plan, including the CQUIN indicators. To support this, the Medical Director, with support from colleagues, is chairing a monthly meeting to ensure delivery.
5.5. There will also be additional “Financial Scrutiny” meetings held with Divisions, Directorates and Services to ensure delivery against plans. Where current performance is off track a financial recovery plan has been produced to identify the key actions to bring performance in line with plan. These recovery actions will all be risk assessed.

5.6. In addition to the financial scrutiny meetings, and to support the significant challenge and focus on financial performance;

- Financial performance at the top of the agenda on divisional performance meetings.
- Formal performance management for corporate services
- Weekly CIP meetings with divisions/services to review progress.

5.7. For the month 5 reporting cycle the Trust is forecasting delivery of the year end control total. This is predicated on delivery against the actions described above. Any delays in implementation of the schemes and/or reductions in values will seriously jeopardise the Trust’s ability to deliver the year end control total.

6. **Working Capital and Cash**

6.1. The chart below shows the latest cash position against the plan; £2,836K out-turn compared to a plan of £2,117K. Clearly, the Trust’s under-performance on its income and expenditure account is adversely affecting the overall level of cash balances held, which is being offset by the under-spend on capital expenditure (see Section 7 below).

6.2. Additionally, the Trust’s working capital debtor balance is being adversely affected by the level of outstanding sustainability and transformation funding that is accruing (£1,083K) and accruals for in-year over-performance on activity and other adjustments (£3,121K).

![Planned Cash Versus Actual Cash Balance](chart.png)

6.3. The Trust has now received a response to last year’s application to the Independent Trust Financing Facility (ITFF) regarding the consolidation of the Trust’s existing loan portfolio. Unfortunately, this is not favourable in that considerable redemption penalties would be required on existing loans to enable consolidation, which is clearly not affordable given the Trust’s current income and expenditure and cash position.

6.4. Subsequently, the Trust has applied for a working capital facility via the ITFF, which has recently been approved up to a maximum value of £10,000K. To date the Trust has drawn down £6,000K of this facility to help manage its ongoing relationships with suppliers.

7. **Capital**

7.1 Performance for August 2016 and year to date against the capital plan is summarised in the table below, which shows a cumulative under-spend of £505K (9%). This is primarily due to slippage on Estates maintenance and information technology schemes.
<table>
<thead>
<tr>
<th></th>
<th>In Month Plan</th>
<th>Actual</th>
<th>(Above) Below Plan</th>
<th>Description</th>
<th>Year To Date Plan</th>
<th>Actual</th>
<th>(Above) Below Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>£K</td>
<td>£K</td>
<td>£K</td>
<td></td>
<td></td>
<td>£K</td>
<td>£K</td>
<td>£K</td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>25</td>
<td></td>
<td>Pharmacy Aseptic Suite</td>
<td>440</td>
<td>321</td>
<td>120</td>
</tr>
<tr>
<td>914</td>
<td>1,167</td>
<td>(253)</td>
<td></td>
<td>Emergency Care Centre</td>
<td>3,586</td>
<td>3,839</td>
<td>(253)</td>
</tr>
<tr>
<td>0</td>
<td>4</td>
<td>(4)</td>
<td></td>
<td>Other</td>
<td>0</td>
<td>9</td>
<td>(9)</td>
</tr>
<tr>
<td>926</td>
<td>1,158</td>
<td>(232)</td>
<td></td>
<td>Total Estates Strategy</td>
<td>4,026</td>
<td>4,168</td>
<td>(142)</td>
</tr>
<tr>
<td>93</td>
<td>42</td>
<td>51</td>
<td></td>
<td>Total Estates Maintenance</td>
<td>592</td>
<td>236</td>
<td>356</td>
</tr>
<tr>
<td>57</td>
<td>165</td>
<td>(222)</td>
<td></td>
<td>Total Information Technology</td>
<td>702</td>
<td>458</td>
<td>244</td>
</tr>
<tr>
<td>111</td>
<td>121</td>
<td>(11)</td>
<td></td>
<td>Total Medical &amp; Other Equipment</td>
<td>319</td>
<td>271</td>
<td>48</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td>Total Contingency</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1,073</td>
<td>1,486</td>
<td>(414)</td>
<td></td>
<td>Total Capital Expenditure Programme</td>
<td>5,638</td>
<td>5,133</td>
<td>505</td>
</tr>
</tbody>
</table>

7.2 Estates maintenance has been delayed pending the review of the Emergency Care Centre scheme and the increased expenditure approved by the Board, some of which has to be funded via slippage in these maintenance schemes. Budgets have now been realigned to account for this fact and expenditure will now be progressed in line with budgetary expectations.

7.3 IT schemes are being progressed satisfactorily, with the main scheme (Meditech SAN/server replacement), which is currently under-spending by £262K, exploring options for the timing of the replacement and different financing options cognisant with the Trust's current cash position. A revised business case is expected to be presented to Business Investment Committee during October 2016.

8. Risks

8.1 As at the end of August 2016 the risks within the financial position are as follows;

- **Clinical Coding**

  Whilst clinical coding was a major area of concern during last financial year, significant progress has been made over recent months to ensure all activity is coded within national deadlines to ensure recorded activity values can be billed to commissioners. However, the Trust currently has a reliance on agency staffing within this area and must look to recruit substantively to establishment as quickly as possible to reduce this additional financial overhead on the Trust. Additionally, the Trust must aspire to further improve the timeliness of its clinical coding to be more in line with its financial reporting timetable in order to improve the accuracy and reliability of estimates included therein. There are still significant challenges within this business critical function.

- **Divisional Monthly performance**

  The month 5 performance of the Divisions and Corporate Services is an area of ongoing concern, given that all areas of the Trust are adverse to plan to greater or lesser degrees. This will have been discussed in detail with Divisions at the performance meetings held on 22nd September 2016.
• **Premium Pay**

The current level of premium pay spend is unsustainable and therefore, it is vitally important that appropriate controls are established, reviewed and enhanced, as appropriate. The Trust also needs to be mindful of NHS Improvement’s expectations that agency expenditure will be reduced by 35%, which represents a financial challenge of £5,439K although it is encouraging to note the reduction in this area during these first five months of 2016/17. However, further central measures and controls will be necessary to provide greater assurance that this target can be achieved by 31st March 2017.

• **Cost Improvement Delivery**

Delivery of the financial plan is predicated on delivering the £10,500K cost improvement target.

• **Unforeseen Events**

There may well be unknown events which may impact on the Trust’s financial position.

• **Liquidity**

Managing the Trust’s cash position will be challenging throughout the whole of the financial year. The plan has a forecast cash balance fluctuating between a high of £2,632K in April 2016 and a low of £2,097K in December 2016. Current financial performance, underlying non-delivery of cost improvement targets and an increase in outstanding debt represents a significant risk to this position in the short and medium term. This can and has been alleviated by use of the Trust’s recently approved working capital facility, but all of these factors need to significantly improve throughout the remainder of this financial year.

9. **Next Steps and Recommendations**

The Board of Directors is recommended to:

• **Note** the contents of this report
Report: Governance Report

Presented by: Lisa Reid, Head of Governance
Author(s): Anna Milanec, Director of Corporate Affairs/ Company Secretary

Strategic Objective: Governance: Trusted, open governance

Regulatory relevance:
Monitor: Licence Condition FT4 /
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
BAF: B7, B8
Corporate Risk Register: -

Purpose of this paper:
This paper intends to provide the Board with details of progress against various governance issues, and highlights other governance based matters that may be pertinent to the Board.

Summary of Key Points:

- NHSI has published the ‘Single Oversight Framework’ guidance which went out to consultation during the summer – the five themes upon which the guidance are based, together with details of ‘support’ which will be available to providers, is outlined overleaf, with more details available via the link in the report;
- Several additional documents and sets of guidance have been published – all available via a link in this report – including the NHSI toolkit for increasing staff engagement and leadership, and guidance for public consultation following STP publication and prior to submission of operational plans.

Board action required:
For noting.
1.0 Introduction

1.1 This report provides an update on board governance, and regulatory matters affecting board governance, to the end of August / beginning of September 2016.

2.0 Information Governance

2.1 Appendix 1 provides information relating to numbers of FOIs, ICO issues, IG training, etc. in month.

3.0 NHSI Improvement – Single Oversight Framework

3.1 The consultation on the single oversight framework (SOF) closed on 4 August 2016, and the new regulatory framework document was published on 13 September 2016 and will come into force from 1 October 2016.

3.2 This will mean that the Trust will be providing performance data to NHSI under the requirements of the new SOF from 1 October 2016 although the existing Monitor and TDA templates for collection of data will continue into 2016/17.

3.3 Once the data for October has been collected, NHSI will carry out an initial segmentation exercise in November based on the data received. Regulatory interventions and the basis of NHSI ‘support’ to be provided to trusts – whether mandated or not - will be established. Until the point of the first segmentation exercise, regard will continue to be paid to the former Risk Assessment Framework (RAF) and TDA Accountability Framework.

3.4 However, significant changes have been made to the document since the consultation was launched in June 2016 and NHSI invited views on the changes, to be received by them by 23 September 2016.

3.5 One of the major changes that has been made since the consultation was published, is the introduction of agency spend into the ‘finance and use of resources’ score from 1 October 2016, rather than at a later date with a shadow period as previously anticipated. NHSI advise that they consider that, having monitored agency spend for the last 12 months, they are able to calibrate thresholds now and hence, implement the measure earlier, rather than waiting until 2017/18.

3.6 NHSI also plans to use income and expenditure (I&E) margin rather than the current EBITDA margin to monitor efficiency.

3.7 The new performance framework, which is based on the principle of earned autonomy, is based on five themes:

- **Quality of care**: (safe, effective, caring and responsive) using the CQC most recent assessments. Will also include delivery against the four priority standards for 7-day hospital services;
- **Finance and use of resources**: progress in meeting providers’ financial control total – this approach is being developed in conjunction with the CQC;
- **Operational performance**: NHS constitution standards, and others such as A&E waiting times, RTT’s, etc.
• **Strategic change**: how well are providers developing the strategic changes set out in the 5YFV;
• **Leadership and improvement capability** (well-led): a shared system view with the CQC of what good governance and leadership looks like, including the organisation’s ability to learn and improve.

3.8 Should a CQC assessment identify a provider as ‘inadequate’ or ‘requires improvement’ against any of the safe, effective, caring or responsive KLOE’s, this will trigger a potential support need.

3.9 Financial metrics will be used to measure sustainability, efficiency and compliance with other controls, such as agency staffing and capital expenditure. Together with the CQC, NHSI are developing a framework to assess and rate how well a Trust uses its resources – this will built on the measures being introduced from 1 October.

3.10 Providers will be scored on a scale from 1 to 4 against each metric used, and scores will be derived from an average score from all financial metrics. Where providers score 3 or 4, this will trigger a potential support need, as will if any provider scores 4 against any individual metric.

3.11 NHSI may also use some broader metrics if there is any evidence of whether a provider is failing to operate effective systems for financial management and control.

3.12 To determine whether providers require support, the following will be considered:
- the **extent** to which the provider is triggering an SOF measure under one, or more, of the five themes
- any **associated circumstances** the provider is facing
- the degree to which the provider **understands what is driving the issue**
- the provider’s **capability** and the **credibility of plans it has developed** to address the issue
- the extent to which the provider is **delivering against a recovery trajectory**

3.13 Providers will be segregated into one of four segments, each of which will be determined by a judgment on how much support should be provided to providers by NHSI.

3.14 Descriptions of the four segments which will be allocated to providers appear below:

<table>
<thead>
<tr>
<th>Allocated Segment</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td><strong>Providers with maximum autonomy</strong> – no potential support needs identified across our five themes – lowest level of oversight and expectation that provider will support providers in other segments</td>
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<td>2</td>
<td><strong>Providers offered targeted support</strong> – potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not needed</td>
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<td>3</td>
<td><strong>Providers receiving mandated support for significant concerns</strong> – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)</td>
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<tr>
<td>4</td>
<td><strong>Special measures</strong> – the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean that they are in special measures.</td>
</tr>
</tbody>
</table>
3.15 Where providers have a potential support need, based on the triggers, NHSI will consider the circumstances to determine the level of support required:

<table>
<thead>
<tr>
<th>Segment</th>
<th>Levels of support</th>
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</thead>
</table>
| 1       | **Universal** support  
|         | - e.g. tools, guidance, benchmark information  
|         | - made available for providers to access |
| 2       | **Universal** support (as for segment 1)  
|         | **Targeted** support as agreed with the provider  
|         | - to address issues and help move the provider to segment 1  
|         | - either offered to provider (and accepted voluntarily) or requested by provider |
| 3       | **Universal** support (as for segment 1)  
|         | **Targeted** support as agreed with the provider (as for segment 2)  
|         | **Mandated** support as determined by NHS Improvement  
|         | - to address specific issues, help move the provider to segment 2 or 1  
|         | - compliance required |
| 4       | **Universal** support (as for segment 1)  
|         | **Targeted** support as agreed with the provider (as for segment 2)  
|         | **Mandated** support as determined by NHS Improvement  
|         | - to help minimise the time the provider is in segment 4  
|         | - compliance required |

3.16 The legal obligations to Monitor and the TDA continue, so the requirements of the licensing regime continue. Whereas non-FT’s are not subject to the licensing regime in the same way as FT’s, the SOF has been devised in such a manner that non-FT’s will need to comply with the same level of diligence.

3.17 At the time of writing, there are also suggestions that new ‘special measures’ may be introduced for those trusts which do not perform against national operational targets, with the 95% A&E access target being highlighted. It is anticipated that the regulator will make a decision by the week commencing 26 September.

4. NHSI – Misc.

4.1 This month, NHSI have published the first of its *Culture and Assessment tools* to support its objective for building higher levels of staff engagement and leadership in the NHS.

4.2 The toolkit has been trialled and piloted in partnership with some early adopter trusts and is based on national and international evidence that categorises providers’ current culture by using existing data, board, staff and stakeholder perceptions and workforce analysis.

4.3 The Director of Workforce is reviewing the toolkit.
5. Other publications and guidance to note

5.1 NHS England has published *The Multispecialty Community Provider (MCP) emerging care model and contract framework* which brings together features and lessons learned from the 14 MCP vanguards.

5.2 The logic of the care model is to create more efficient, joined up pathways that focus on preventative care, and reducing avoidable hospital admissions and elective activity by transferring care out of hospitals and into the community.

5.3 The publication is not definitive guidance, but rather a useful guide which provides insight into potential opportunities for new models of care in the community and may be a useful source of reference information for the Trust to consider with regard to further developing its community care models.

5.4 As an aside, for those of us who work with acute care collaboration vanguards, there is an opportunity to meet German hospital chain chief executives in London on 6 October to learn more about hospital chain models. The NHS European Office is hosting this open session in London in collaboration with the NHS Confederation.

5.5 *Social Care for Older People: home truths* has been published by The Kings Fund and highlights the impact of the shrinkage of social care provision. The report suggests that hospital transfers associated with social care shortages have doubled in just two years. It is also suggested that the funding outlook for the next five years looks bleak, and that the gap between social needs and resources will continue to widen.

5.6 Last week, NHS England published its guidance, *Engaging Local People*, following media coverage in recent weeks regarding the extent of the perceived secrecy surrounding STPs. The new guidance also comes after a debate in the Commons last week, organised by Labour MPs when several MPs raised concerns about STPs and the process.

5.7 Following publication in June 2016 of the *Six Principles for Engaging People and Communities*, by the People and Communities Board, the new guidance goes further to lay out what is expected, and the legal requirements of various parties to the STPs of the need to engage publically.

5.8 It is proposed that each of the STPs in every part of the country should have started to consult with the public about their plans by the end of October / November 2016. And whilst individual organisations such as CCGs, foundation trusts, etc. have legal obligations to consult on commissioning and provision of services, it is proposed that joint communications from STPs, would be more efficient. However, the relevant statutory duties for each type of organisation will also need to be considered – appendix A to the publication provides an excellent summary of the different legal consultation requirements.

5.9 The 44 STP areas are required to make their next “full” submission to national bodies by 21 October. However, NHS England and NHSI have not set out an STP approval process, including what will happen if any of the October plans are not deemed ‘good enough’.

5.10 The Institute of Directors has continued its work to raised governance standards and
awareness with its publication this month of its second annual *The 2016 Good Governance Report*.

5.11 The report sets out the findings of research into the measurement of corporate governance in the FTSE100 by combining traditional governance indicators with a measure of the quality of corporate governance as perceived by stakeholders. The report highlights the ‘naïve’ approach to giving equal weight to different governance indicators and found that the quality of audit and risk / external accountability are the most important factors in the perception of good corporate governance, whereas board effectiveness had little effect on the perceived quality of corporate governance in an organisation.

5.12 A long awaited report from the National Advisory Group on Health Information Technology in England, *Making IT Work, Harnessing the Power of Health Information Technology to Improve Care in England*, (‘the Watcher Review’) has been published this month.

5.12 This lengthy report, commissioned by the Department of Health, provides an assessment of the digitisation of secondary care in England.

5.13 At present commissioners and providers are working on STPs, including a Local Digital Roadmap (see previous agenda item), which will identify how local health and care systems will deploy and optimise digitally-enabled capabilities to improve and transform practice, workflows and pathways. The publication of the Review, therefore, takes place in a context of high national and local policy interest in leveraging the potential of technology to transform healthcare services.

5.14 Ten recommendations – including £4.2 billion funding - are made in the report to advance healthcare IT via a national strategy, suggesting that most Trusts should be ‘largely digitised’ by 2023.

6. **Other developments to note**

6.1 A recent case High Court case relating to the factual accuracy of *CQC inspection* reports has now said that - in the interests of fairness - the CQC must introduce some process whereby decisions by lead inspectors not to amend draft reports in response to a provider's concerns about factual accuracy, should be reviewed at the request of the provider by someone within the CQC who is not involved in the inspection.

6.2 In response to this case, the CQC has now amended its Factual Accuracy Check Guidance and Forms to reflect the court’s decision.

6.3 Finally, following a review led by NHS England Chair, Sir Malcolm Grant, it is anticipated that from April 2017, every hospital will be required to publish a register of NHS consultants’ income from private work. The review, led by Sir Malcom, cites concerns that some senior doctors may be giving too much time to private work and delegating excessively to junior colleagues at the expense of NHS patients.

Anna Milanec  
*Director of Corporate Affairs/ Company Secretary*  
*September 2016*
The following provides details of some of the work undertaken by the Information Governance department and myself for the period 1 August to 31 August 2016. I will update this on a monthly basis for information.

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<th>1 to 31st August 2016</th>
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<td>Number of colleagues attending corporate induction and receiving IG training</td>
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Report: Seal Register - review

Presented by: Lisa Reid, Head of Governance
Author(s): Anna Milanec, Director of Corporate Affairs/Company Secretary

Strategic Objective: Governance: Trusted, open governance

Regulatory relevance:
Monitor: Licence Condition FT4
CQC Domain: effective well-led

Risk Reference:
BAF: B7
Corporate Risk Register: none specifically

Purpose of this paper:
To present to the Trust Board details of activity related to the use of the Trust Seal.

Summary of Key Points:
The Board is asked to note the use of the Trust Seal for the following items:

1. NHS Standard Contract with Rotherham Clinical Commissioning Group;
2. Underlease relating to part of Medical Centre at 15 Quarry Lane, North Anston, Sheffield;
3. Licence to underlease part of Medical Centre at 15 Quarry Lane, North Anston, Sheffield;
4. Lease for car parking spaces at Claire Court, Rotherham;
5. Lease relating to Kiveton Park Primary Care Centre, Sheffield.

Board action required: for noting

Anna Milanec
Director of Corporate Affairs / Company Secretary
September 2016
## Event/Issue

### TRUST BOARD MEETINGS

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<th>Event/issue</th>
<th>Chair</th>
<th>Lead</th>
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Monthly clinical presentations will be made at the monthly seminar sessions.

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### TRUST BOARD MEETINGS

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### STRATEGY AND STRATEGIC PLANNING (cont)

- **Strategic Review: Estates**  COO  ●
- **Strategic Review: IT & HI**  COO  ●
- **Strategic Review: HR and Workforce**  DoW  ●
- **Strategic Review: Procurement**  DoF  ●
- **Strategic Review: Risk Management**  Ch N  ●
- **Strategic Review: Communications**  Co Sec  ●
- **Strategic Review: Health and Safety**  COO  ●  ●  ●
- **Strategic Review: Clinical Strategy**  MD  ●  ●  ●

### OPERATIONAL

- **Integrated Performance Report:**  COO  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●
- **Quality Report (incl. Nursing and Midwifery Staffing Report, Mortality):**  Ch N  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●
- **Operational Performance Report**  COO  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●
- **Workforce Report**  DoW  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●
- **Finance Report**  DoF  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●
- **Safeguarding Report (part 2)**  Ch N  ●  ●  ●  ●
- **Annual NHS Staff Survey Report**  DoW  ●
- **Business Case Approval (ad hoc)**  DoF  ●
- **Agency Staffing Report (part 2)**  DoW  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●
- **Data Quality Report**  COO  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●
- **Quality Improvement Programme Report**  CN  ●  ●  ●  ●  ●  ●

### RISK FRAMEWORK

- **Governance Report**  Co Sec  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●  ●
- **Board Assurance Framework**  Co Sec  ●  ●  ●  ●
- **Corporate Risk Register (16 and above only scored risks)**  Ch N  ●  ●  ●  ●
- **Monitor: Corporate Governance and §5/6 submission**  Co Sec  ●
- **Monitor: §1 & 2 Compliance with licence conditions submission**  Co Sec  ●
- **Monitor: 1/4ly Compliance (Risk Assessment Framework)**  Co Sec  ●  ●  ●  ●

### REGULATORY AND STATUTORY REPORTING

- **Annual Report and Audited Accounts, including Quality Report**  DoF  ●
- **Annual Quality Account (approval)**  Ch N  ●
- **Annual Quality Report (indicators / audit approval)**  Ch N  ●

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### Event/Issue

#### TRUST BOARD MEETINGS

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#### POLICY APPROVALS (as per Matters Reserved)

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#### BOARD GOVERNANCE

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## Board Planner

### Event/issue

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