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

**Date:** Tuesday 29 May 2018  
**Time:** 0830hrs – 1100hrs  
**Venue:** Boardroom, Executive Corridor, Level D, Rotherham Hospital

<table>
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<tr>
<th>Time</th>
<th>Item no.</th>
<th>Description</th>
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| **0830**  | 191/18   | Chairman’s welcome and apologies for absence                                                  | Verbal | -                | For noting  
**Martin Havenhand, Chairman** |
| **Quality and Safety** | **192/18** | Patient Story                                                                  | Verbal | -                | -                          
**Chris Morley, Chief Nurse** |
| **Procedural Items** | **0845**  | Declaration of Conflicts of Interest                                                          | Verbal | -                | For noting  
**Martin Havenhand, Chairman** |
| **194/18** | Minutes of the previous meeting held on 24 April 2018                                      | Enc.  | 3                | For approval  
**Martin Havenhand, Chairman** |
| **195/18** | Matters arising from the previous minutes (not covered elsewhere on the agenda)             | Verbal | -                | For noting  
**Martin Havenhand, Chairman** |
| **196/18** | Action Log                                       | Enc.  | 15               | For approval  
**Martin Havenhand, Chairman** |
| **Strategy and Strategic Planning** | **0900**  | Report from the Chairman                                                             | Enc.  | 16               | For noting  
**Martin Havenhand, Chairman** |
| **198/18** | Report from the Chief Executive                 | Enc.  | 20               | For noting  
**Louise Barnett, Chief Executive** |
| **Operational Performance** | **0915**  | Integrated Performance Report                                                        | Enc.  | 29               | For noting  
**Louise Barnett, Chief Executive** |
| **199/18(a)** | Quality Report                                  | Enc.  | 34               | For noting  
**Chris Morley, Chief Nurse** |
| **199/18(b)** | Clinical Report                                 | Enc.  | 41               | For noting  
**Conrad Wareham, Medical Director** |
| **199/18(c)** | Operational Performance Report                  | Enc.  | 48               | For noting  
**George Briggs, Chief Operating Officer** |
| **199/18(d)** | Workforce Report                                 | Enc.  | 55               | For noting  
**Cheryl Clements Director of Workforce** |
| **199/18(e)** | Finance Report                                  | Enc.  | 59               | For noting  
**Simon Sheppard, Director of Finance** |
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<tr>
<th>Assurance Framework</th>
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<tr>
<td>1010 200/18 Governance Report</td>
<td>Enc.</td>
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<td>201/18 Board Assurance Framework: Revised risk descriptor for B7</td>
<td>Enc.</td>
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<td>For approval</td>
<td>Anna Milanec, Director of Corporate Affairs/Company Secretary</td>
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<td>202/18 Terms of Reference: Assurance Committees</td>
<td>Enc.</td>
<td>69</td>
<td>For approval</td>
<td>Anna Milanec, Director of Corporate Affairs/Company Secretary</td>
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<tr>
<td><strong>Regulatory and Statutory Reporting</strong></td>
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<td>1030 203/18 Annual Freedom to Speak Up Guardians Report</td>
<td>Enc.</td>
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<td>204/18 Guardian of Safe Working Hours Report</td>
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<td>205/18 Progress against the Clinical Negligence Scheme for Trusts incentive scheme maternity safety actions</td>
<td>Enc.</td>
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<td><strong>Board Governance</strong></td>
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<td>206/18 Any other business</td>
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<td>For approval</td>
<td>Martin Havenhand, Chairman</td>
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<td>1055 207/18 Date of next meeting:</td>
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<td>For noting</td>
<td>Martin Havenhand, Chairman</td>
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<tr>
<td><strong>Tuesday 26 June 2018</strong></td>
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**To ensure smooth transaction of business, the Chairman will invite questions from the public at the end of the meeting only.**

*In accordance with §152(4) of the Health and Social Care Act, 2012, a copy of this agenda has been provided to Governors prior to the Board Meeting*
MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON TUESDAY 24 APRIL 2018 IN THE BOARDROOM, LEVEL D

Present: Mr M Havenhand, Chairman
Mrs G Atmarow, Non-Executive Director
Mrs L Barnett, Chief Executive
Mr J Barnes, Non-Executive Director
Mr G Briggs, Chief Operating Officer
Mrs C Clements, Director of Workforce
Mrs H Craven, Non-Executive Director
Mr M Edgell, Non-Executive Director
Ms L Hagger, Non-Executive Director
Dr D Hannah, Non-Executive Director
Mr C Holt, Director of Strategy and Transformation
Mr B Mellor, Non-Executive Director
Mr C Morley, Chief Nurse
Mr S Sheppard, Director of Finance
Dr C Wareham, Medical Director

Apologies: None

In attendance: Ms A Milanec, Director of Corporate Affairs / Company Secretary
Miss D Stewart, Corporate Governance Manager (minutes)

Observers: Governors x4
Members of the Public x3

136/18 CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE
Mr Havenhand welcomed those present to the meeting and noted that there were no apologies.

QUALITY AND SAFETY
137/18 PATIENT STORY
The Chief Nurse took the opportunity to share with the Board a patient story, provided in their own words, in the form of a video recording.

The patient story highlighted the work of the Community Occupational Therapy department, which had been shortlisted for a Health Service Journal Award, and the collaborative work with the Local Authority’s Single Point of Access Service.

Mr Morley indicated that this patient’s experience highlighted the importance for services to remain patient centred, and provide care which most supported them in their own home, rather than in another setting.
The Chairman thanked the Chief Nurse for the details, with the Board noting the patient story.

PROCEDURAL ITEMS
138/18 DECLARATIONS OF CONFLICTS OF INTERESTS

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

139/18 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 27 March 2018 were agreed as a correct record subject to a minor spelling correction.

140/18 MATTERS ARISING FROM THE PREVIOUS MEETING

There were no matters arising from the previous meeting which were either not covered by the agenda or action log save for the amendment to the minutes from 27 February 2018 (minute 95/18 refers).

The revised minute was approved as follows

58/18(d) WORKFORCE REPORT

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

Mrs Clements took the opportunity to highlight various sections of her report which included the latest position with regard to recruitment and retention. Sickness absence had increased to 5.03% in January (the target being 3.95%). The Board noted that for every a 1% increase in sickness absence, the additional costs incurred were would be approximately £0.5m - £1m. for the organisation………..

141/18 ACTION LOG

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

The Board noted that with regard to log number 13, the Pathology Memorandum of Understanding had been approved by the delegated officers.

STRATEGY AND STRATEGIC PLANNING
142/18 REPORT FROM THE CHAIRMAN

The Board of Directors received the report from the Chairman.

Mr Havenhand reported that, although still subject to validation by the External Auditors, the Trust had achieved the revised 2017/18 financial year end forecast outturn of £22.3m deficit.
With regard to operational performance, there remained challenges regarding achievement of the A&E 4-hour access and 62-day cancer targets. More information on both matters was included in later reports. The Board was informed that focus remained on both matters in order to improve the position.

The Board of Directors noted the report from the Chairman.

143/18 REPORT FROM THE CHIEF EXECUTIVE

The Board of Directors received the Chief Executive’s report.

Mrs Barnett affirmed the statement from the Chairman in that the revised year-end forecast had been achieved, with the learning from 2017/18 to be utilised to strengthen the financial governance arrangements for 2018/19.

With regard to operational performance metrics, Mrs Barnett confirmed that the 62-day cancer target had not been achieved in quarter four 2017/18. Mrs Barnett advised that as a consequence of managing the backlog, quarter one 2018/19 would also not be achieved and actions were in place to support the Trust in achieving this standard in quarter 2.

It was noted that challenges remained in achievement of the A&E 4-hour access target.

Mrs Barnett indicated that although the Acute Care Collaboration Vanguard had formally ceased its work in March 2018, organisational relationships would be maintained, with some elements of the work of the Vanguard to be progressed by the Integrated Care System. The formal evaluation report on the work of the Vanguard would be circulated to Board members.

ACTION – Chief Executive

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

OPERATIONAL PERFORMANCE

114/18 INTEGRATED PERFORMANCE REPORT

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

Mrs Barnett highlighted a number of top achievements and those most improved in month, which also demonstrated strong performance during the whole financial year. These were the number of Clostridium Difficile cases at 15 against a target of 26, the overall reduction in mortality rates, and improved Mandatory and Statutory Training compliance.

Areas of key concern included the cancer 62-day standard the A&E 4-hour access target. Areas of most in-month deterioration had been the percentage increase of patients discharged pre-noon, and the 18 week referral to treatment time target. Whilst in month performance against the latter had not seen a significant deterioration, there had been a downward trend over the last six months, whilst continuing to meet the national standard.
With regard to pre-noon discharge, Mr Briggs confirmed that an action had been included as part of the acute care programme in order to address and improve this area. However, he did not anticipate any significant improvement before the summer.

Dr Wareham commented that whilst pre-noon discharges were not at the preferred level, it should also be acknowledged that the Trust’s overall length of stay was significantly better than other organisations, meaning that more patients were being discharged, rather than staying as in-patients; both metrics should be considered together.

The Board noted that the Finance and Performance Committee, had sought additional assurance on the actions being taken to improve pre-noon discharge.

The Board questioned the reasons for the downward trend in the 18 week referral to treatment time target. The Board was informed that there had been recent bad weather issues which had forced cancellation of elective work for three days, and also the planned slowing down of activity as part of the winter plan, which had been forecast. The Executive Directors indicated that they were focussed on this matter and were confident that performance would continue to achieve the national standard with an increase in performance anticipated. It was noted that this would be monitored by the Finance and Performance Committee.

The Board of Directors revisited the matter of dementia assessments which had seen a further in-month deterioration. Dr Wareham, clarified that the IPR contained data for February 2018 and not the more recent March data, and he took the opportunity to outline the mitigating actions being taken, as detailed within his Clinical Report, including the recruitment of key personnel. These actions, he advised, would ensure the whole process was more robust and embedded within the organisation, rather than being dependent on any one individual as it had been in the past.

It was agreed that an update report relating to Dementia should be considered by the Quality Assurance Committee. **ACTION – Medical Director**

Mr Barnes highlighted that 50% of the key performance indicators on the IPR were not being achieved. He questioned whether the Board should be concerned in terms of operational and financial performance based on the data presented. Mrs Barnett confirmed that the 2018/19 Operational Plan would address the areas as identified by Mr Barnes, with the revised IPR to be introduced from May to provide clarity on the local and national targets. Additionally, Mr Holt indicated that indicators had been selected to provide a balanced picture of performance and to ensure that there was an opportunity to drive improvement over the coming year. Mr Holt confirmed that a balanced scorecard was being established with tolerance levels that were for some indicators, above the national average, which would provide additional assurance for the organisation.
The Board of Directors noted the Integrated Performance Report, with detailed information on a number of matters to be contained within subsequent reports.

144/18(a) QUALITY REPORT

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

Mr Morley commented that for most of the areas reported, the indicators remained either stable or within the required parameters.

There had been improvements in completion of Initial Health Assessments for Looked after Children within 20 days from 30% to 56% in March 2018. However, there remained further collaborative work to be undertaken with Rotherham agencies, to further improve the position.

As reported at the March meeting, the Trust continued its proactive recruitment of newly qualified nurses. Since the last Board meeting, further interviews had been held resulting in twenty-four offers of employment. The total number of offers now stood at eighty-eight.

The Board of Directors noted the Quality Report.

144/18(b) CLINICAL REPORT

The Board of Directors received and noted the Clinical Report from the Medical Director.

Dr Wareham informed the Board that mortality data continued to show an improving position with the Hospital Standardised Mortality Ratio (HSMR) now at 96, the benchmark being 100. The Summary Hospital Mortality Indicator (SHMI) had been recently recalculated and now stood at 106.67.

With regard to hospital acquired infections, at year-end there had been three MRSA bacteraemia cases against the zero trajectory and 15 cases of Clostridium difficile against the trajectory of 26.

It was commented that although the Trust was facing challenges in some areas, it should not be forgotten that in a number of other quality performance metrics, the Trust was in a strong, local and national, position. Mr Edgell suggested that in some areas of quality standards, particularly mortality, significant improvements had been made during 2017/18.

With regard to research and development, it was once again noted that this area could be attractive to potential job applicants. Mrs Barnett indicated that it would be beneficial for the next report to outline for the Board, the scale of ambition, in terms of research and development.

ACTION – Medical Director

Whilst Dementia had been discussed as part of the Integrated Performance Report item, the Board sought clarity as to whether there was line of sight of other services which may be dependent upon either an individual or a small number of colleagues. Dr Wareham confirmed that colleagues were aware of
these and that the clinical service reviews were the mechanism for identifying such areas. Mr Holt added that once identified, it was key for any such service to have in place contingency or mitigating plans.

Dr Wareham reported that he had received a good response from a number of multi-disciplinary areas to support the establishment of an Ethics Group.

The Board of Directors noted the Clinical Report.

**144/18(c) OPERATIONAL PERFORMANCE REPORT**

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

Mr Briggs outlined the position against the four sustainability and transformation standards, as documented within the report.

With regard to cancer, Mr Briggs indicated that as previously discussed it was anticipated that there would be an increase in cancer 62 day breaches in quarter one. Once the backlog had been removed, the position should remain sustainable and return performance to the upper quartile.

It was noted that the Finance and Performance Committee had yet to have the opportunity to receive assurance regarding the recovery plan for cancer; as such, Mrs Craven sought assurance on sufficient resources being in place to manage both the backlog and the new cases. Mr Briggs confirmed that the recovery action plan had been finalised, although this had not precluded interim action being taken, and the patient numbers were known and pathways defined. Additional diagnostic provisions had been approved by the Cancer Network and additional monies had been identified for cancer trackers. Local Trusts and external agencies had also been approached to provide additional support. Mr Briggs remained confident that the position would improve. The Chief Nurse added that patients were being slotted into additional diagnostic clinic times in a well organised and planned manner.

Performance against the A&E 4-hour access target had deteriorated in April, with the Trust now being in the lower quartile nationally. As such the Board sought assurance on delivery of the trajectory for the remainder of quarter 1.

It was acknowledged that there remained challenges in a number of areas such as increased attendances. However, Mr Sheppard advised the Board that the previous day had seen the most attendances since the new Urgent and Emergency Centre had opened, but highlighted that performance had been over 98%. It was noted that there were no plans to significantly change the recovery plan, but that it may be necessary to revisit some areas and address new emerging issues.

Mr Briggs indicated that it was important to change how people worked rather than opening additional beds, which would only add more pressures within the organisation. However, he added that the use of additional beds in the community as part of the winter plan had been beneficial, and consideration
should be given as part of future winter plans to reviewing the timing of the
closure to ensure some flexibility depending on pressures.

Mr Holt added that the effectiveness of the Trust’s winter plans had been
acknowledged by the regulator. However, it was difficult to keep the
momentum going throughout April after a difficult winter, due to ongoing
workforce challenges.

Mr Briggs indicated that the A&E 4 hour access target for April was 80%, which
was deemed achievable. The target remained to achieve the required national
90% by September 2018.

Mrs Barnett confirmed that the Executive Directors were maintaining
significant focus with regard to 4 hour waits, with the next report to provide
additional information on the actions being taken by colleagues to continue to
improve performance.

The Board of Directors noted the report and operational challenges in a
number of areas.

144/18(d) WORKFORCE REPORT

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

Mrs Clements reported that the rolling 12 month sickness absence continued
to improve and currently stood at 3.98%, which was a 0.58% decrease on the
same period in 2017.

In terms of Mandatory and Statutory Training (MAST) the position also
continued to improve, standing at 89% with the target being 85%. The national
target of 95% compliance rates for Information Governance training had been
achieved.

In noting the excellent MAST rates, it was highlighted that three out of the four
Clinical Divisions had not achieved the hand hygiene target. Mrs Clements
indicated that there was likely to be under reporting of compliance in these
areas, rather than training not having taken place, but that this was being
addressed.

It was acknowledged that there were shortfalls in a number of areas such as
MAST and personal development review compliance rates in the Division of
Medicine. Whilst one of the larger Divisions, with many underlying issues,
support was being provided to improve the Division’s position. Mrs Barnett
added that workforce metrics were discussed at the monthly performance
meetings and she was encouraged by the plans already in place and progress
being made.

It was reported that the HR department had been shortlisted for a Healthcare
People Management Association Award in the HR Analytics category.
The Board of Directors continued to discuss monitoring of staff resilience, staff engagement, recruitment and retention and the implications from vacancies.

The Board of Directors noted the Workforce Report.

144/18(e) **FINANCE REPORT**

The Board of Directors received the finance report presented by the Director of Finance.

Mr Sheppard indicated that whilst subject to year-end audit, the 2017/18 outturn was a deficit of £22,328K deficit, which excluded a £3.4m impairment of assets. The cost improvement programme had delivered £8,353K against the target of £8,554K. In overall terms, the revised 2017/18 financial plan had been achieved.

In terms of the cost improvement programme, Mr Barnes commented whilst the Trust had achieved significant efficiencies, considerable cost pressures had been incurred elsewhere, offsetting this benefit. Therefore, it would be important that this was not repeated in 2018/19.

Mr Havenhand commented that it had been important that the revised financial target had been achieved, albeit with a small variance in terms of the cost improvement programme and small overspend on the capital programme. The latter had been offset by the Rotherham Commissioning Group for committed IT expenditure.

Whilst the revised financial plan had been achieved, the Board sought assurance regarding performance in the new financial year. As such, Mr Sheppard confirmed that an evaluation of 2017/18 had been undertaken to strengthen arrangements going forward, and a continuation of performance seen in quarter 4, would support the Trust going into the new financial year.

Additionally, it was considered that in the three key areas of planning, performance and having contingency for unexpected pressures, arrangements in 2018/19 would be more robust. The Executive Directors remained focussed on the requirements, with regular reporting through to the Chief Executive.

The Board of Directors noted the financial report and it was suggested that key to delivery of the 2018/19 financial plan would be accountable budgetary management.

**ASSURANCE FRAMEWORK**

145/18 **GOVERNANCE REPORT**

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

Ms Milanec reminded the Board that at its March 2018 meeting a report which outlined the organisations compliance with 10 Data Security Standards as part of the 2017/18 Data Security Protection requirements had been received.
Following consideration of that report, the Board was now required to formally sign off the 2017/18 Data Security Protection Requirements compliance statement which was appended to the Governance Report.

Whilst accepting that mitigating arrangements were constantly being undertaken with regard to cyber-security, it was agreed that further assurance be provided for the Board with regard to the business continuity plan, and in particular, annual testing, in this area.

**ACTION – Director of Strategy and Transformation**

The Board of Directors approved submission of the 2017/18 Data Security Protection Requirement compliance statement to NHS Improvement by 11 May 2018.

In addition to the report, at the request of the Audit Committee Chair, tabled at the meeting was the Annual Report and Accounts (including Quality Report/Account) 2017/18 production schedule. Ms Milanec indicated that in the main, the timetable was being completed by the required deadlines, with outstanding matters being reliant upon completion of other sections.

Mr Barnes, as Audit Committee Chair, indicated that it had not been possible to undertake the ‘turn page’ exercise as planned at the Audit Committee as the document was not yet complete and the finances had still to be audited. However, he confirmed for the Board that a general review had taken place.

The Audit Committee had been assured that the Quality Report had been considered by the Quality Assurance Committee, as per its own production timetable.

It was essential the 2017/18 Annual Report and Accounts was finalised as planned, as the Audit Committee had requested a copy two weeks prior to its meeting planned for 23 May 2018 in order that it could be given full consideration.

The Board of Directors noted the Governance Report

146/18 **BOARD ASSURANCE FRAMEWORK**

The Board of Directors received the quarter four 2017/18 Board Assurance Framework (BAF) Report presented by the Director of Corporate Affairs/Company Secretary.

Ms Milanec confirmed that the quarter four position had been considered by each of the Board assurance committees, with the recommendations detailed in the report.

The Board of Directors noted the report and approved the proposals from each assurance committee in relation to their 2017/18 Board Assurance Framework risks.
**RISK MANAGEMENT REPORT & REVIEW**

The Board of Directors received the Risk Management Report and Review report presented by the Chief Nurse.

Mr Morley indicated that review of the Trust’s risk management arrangements had been completed and as outlined in the report there were a number of areas which would be strengthened to improve the processes.

Mr Barnes confirmed that the report had also been discussed at the Audit Committee, where both the Internal and External Auditors had been present. All members of the Audit Committee had been satisfied with the proposed arrangements.

The Board noted the review of the risk management arrangements and the proposed timetable for the programme of work.

**TERMS OF REFERENCE: ASSURANCE COMMITTEES**

The Board of Directors received the report presented by the Director of Corporate Affairs/Company Secretary which proposed a standard terms of reference template for three of the board assurance committees.

Ms Milanec indicated that for each committee there would be an additional matrix, developed in conjunction with the Non-Executive Director chair and Executive Director Lead for each committee, outlining the agreed areas for focus in 2018/19.

The Board of Directors agreed the standard terms of reference template, with further consideration to be given to the timeframes for circulation of the meeting papers and turnaround times for the minutes.

**ACTION – Company Secretary**

**TERMS OF REFERENCE: NOMINATIONS COMMITTEE**

The Board of Directors received and approved the Nominations Committee terms of reference which had undergone their annual review with no changes being required at this time.

**POLICY APPROVALS**

**HEALTH AND SAFETY POLICY**

The Board of Directors received the revised Health and Safety Policy which had undergone its annual review.

Mrs Barnett confirmed that the policy had been considered by the Trust Management Committee, who subject to an amendment to the table in section 3.8.1, were supportive of the Board approving the policy.

The Board of Directors approved the revised Health and Safety Policy.
REGULATORY AND STATUTORY REPORTING

151/18 COMPLAINTS ANNUAL REPORT

The Board of Directors received and approved the Complaints Annual Report 2017/18 from the Chief Nurse.

152/18 SENIOR INFORMATION RISK OWNER ANNUAL REPORT

The Board of Directors received and noted the Annual Report from the Senior Information Risk Owner (SIRO), which incorporated the Information Toolkit Report.

With regard to the Information Governance Toolkit, it was pleasing to report that the Trust had improved its performance following the self-assessment, and when benchmarked with other local Trusts, had been the only one to improve its score on the previous year.

153/18 RESPONSIBLE OFFICER REPORT

The Board of Directors received and noted the quarterly report from the Responsible Officer.

Dr Wareham confirmed that he was fully assured that the Trust was meeting its obligations as a designated body and that he had no concerns which he wished to highlight to the Board.

BOARD GOVERNANCE

154/18 ESCALATIONS FROM THE COUNCIL OF GOVERNORS

The Board of Directors noted the one escalation arising from the Council of Governors meeting held on Wednesday 11 April 2018:

The Council of Governors requested that the Board be notified of their continuing concerns regarding the Trust’s financial position.

155/18 REVIEW OF BOARD ANNUAL PLANNER

The Board of Directors received and approved its forward annual planner, which would continue to be updated.

156/18 ANY OTHER BUSINESS

The Board of Directors previewed a short film, which showcased the Trust’s plans for the future and its commitment to work with its partners. This film would be shared at induction and with the general public.

157/18 DATE OF NEXT MEETING

The next meeting of the Board of Directors would be held on Tuesday, 29 May 2018.
At this point the Chairman opened the meeting to any questions from those observing the proceedings.

The Lead Governor commented that it was positive that the 2017/18 financial target had been achieved and as such he believed that it placed the Trust in a better position for 2018/19.

The Deputy Lead Governor raised the matter of the use of acronyms during the discussions which was difficult to follow for those observing the meeting.

A member of the public raised a number of matters relating to availability of papers for the meeting, the plans with regard to stroke services both within the Trust and the wider South Yorkshire network, membership of the Board and the wider committees referred to during the course of the meeting, evaluation of the Vanguard programme, impairment of assets, beds within the community and car parking.

With the exception of the stroke services, for which the Medical Director would provide further detail immediately following the close of the meeting, a response to the other matters would be communicated outside the meeting.

Before formally closing the meeting the Chairman took the opportunity to present to Dennis Wray, Lead Governor, a personal gift from members of the Board. This would be Mr Wray’s final attendance at the Board meeting as his term of office concluded at the end of May 2018, and he would be unable to attend the May Board of Directors meeting.

Mr Wray had been in office for ten years as a Public Governor and also Lead Governor for the last three years. He had dedicated a significant amount of his personal time to the Trust and attended many board committees each month in his role.

In his role he had helped shape the services provided to the people of Rotherham. He was held in high esteem by the Board of Directors and his Governor colleagues and all those he had come into contact with.

The Board thanked Mr Wray for all his contributions and wished him happiness and good health for the future.

Martin Havenhand  
Chairman  
date
<table>
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<tr>
<th>Log No</th>
<th>Meeting Date</th>
<th>Report/Agenda title</th>
<th>Agenda item and Action</th>
<th>Lead Officer</th>
<th>Timescale/ Deadline</th>
<th>Comment/ Feedback from Lead Officer(s)</th>
<th>Open / Close</th>
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<tr>
<td>58</td>
<td>25-Jul-17</td>
<td>Escalations from Governors</td>
<td>To be added to action log: 3 staff governor vacancies out of 5 remain vacant. Execs to consider options available to co-op colleagues to ensure they are engaged and represented through CoG.</td>
<td>Co Sec</td>
<td>31/10/2017</td>
<td>Verbal update will be provided at the May Board Meeting.</td>
<td>Open</td>
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<td>26</td>
<td>27-Mar-18</td>
<td>Report from the Chief Executive</td>
<td>Final version of the Rotherham Place Plan to be shared with the Board for comment, when available.</td>
<td>DS&amp;T</td>
<td>30-Jun-18</td>
<td>This is likely to be end of June 2018 - timeframe for this is out of control of the organisation - but item will be circulated asap.</td>
<td>Open</td>
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<tr>
<td>32</td>
<td>27-Mar-18</td>
<td>Staff Survey Report</td>
<td>Board to be updated on progress against actions to be taken - to be added to board planner</td>
<td>DOW</td>
<td>29-May-18</td>
<td>Matter will be discussed with SWC and then, with timing details, the matter will be added to the Board Planner Engagement Plan (87/18) submitted to SWC on 25 May. Draft Engagement Strategy to be submitted to SWC in June 2018: added to Board Planner for Board approval on 26 June 2018.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>36</td>
<td>24-Apr-18</td>
<td>CEO Report</td>
<td>Report on outturn of the Vanguard to be circulated to Board Members</td>
<td>CEO</td>
<td></td>
<td>Details emailed out to board members on 20 April 2018: reported at April board meeting as part of action log number 25</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>37</td>
<td>24-Apr-18</td>
<td>IPR</td>
<td>Update on the dementia position to be provided to QAC</td>
<td>MD</td>
<td>18-Jul-18</td>
<td>Item added to QAC planner</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>38</td>
<td>24-Apr-18</td>
<td>Clinical Report</td>
<td>Clinical Report to include TRFT’s scale of ambition, in terms of research and development for 2018/19.</td>
<td>MD</td>
<td>29-May-18</td>
<td>Part of Board agenda item 199/18(b) (Clinical Report)</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>39</td>
<td>24-Apr-18</td>
<td>Governance Report</td>
<td>Re Data Security Protection Requirements: Board to be provided with additional information as to what actions have been taken re business resilience / annual testing</td>
<td>DT&amp;S</td>
<td>26-Jun-18</td>
<td>Item added to Board planner</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>40</td>
<td>24-Apr-18</td>
<td>Terms of Reference: Assurance Committees</td>
<td>Consideration to be given to timeframes for circulation of meeting papers, and turnaround times for draft minutes to be circulated to Chairs</td>
<td>Co Sec</td>
<td>29-May-18</td>
<td>Discussion took place at the Board Seminar on 9 May 2018</td>
<td>Recommend to close</td>
</tr>
</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:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring /responsive / well-led

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

Purpose of this paper:
This paper provides an overview of progress on key issues since my last report to the Board on 24 April 2018.

Summary of Key Points:
- South Yorkshire and Bassetlaw Integrated Care System seminar held for its NEDs and Lay Members
- Hospital Services Review report now published
- A busy month for supporting national campaigns
- British Heart Foundation Scanner appeal event
- Dr Ted Appeal to be supported by new Mayor of Rotherham
- Dennis Wray, Lead Governor at the Trust, steps down and the end of May 2018 after 10 years’ of excellent service.
- The Rotherham Together Partnership Showcase Event is taking place on the 12th June 2018

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

1.1 This report provides an update since the last Board Meeting.

2.0 South Yorkshire and Bassetlaw, Integrated Care System (SYB ICS)

2.1 Together with a number of our Non-Executive Directors (NEDs), I attended the South Yorkshire and Bassetlaw Integrated Care System meeting of its NEDS and Lay Members which was held at the New York Stadium.

2.2 Sir Andrew Cash provided an introductory overview of the ICS, whilst Professor Des Breen provided argument for a case for change.

2.3 Professor Chris Welsh provided an update on the most recent developments on the SYB Hospital Services Review – this was the week before the report was due to be published.

3.0 Hospital Services Review

3.1 The Hospital Services Review report was published on 8 May 2018.

3.2 The NHS is currently facing enormous challenges, with shortages of resources including workforce, and increasing demand on services. The independent Review is being undertaken to consider how hospital services across the South Yorkshire and Bassetlaw Integrated Care System, can remain sustainable, so that everyone in South Yorkshire and Bassetlaw has equal access to high quality, safe hospital services, now and into the future.

3.3 A copy of the 180-page Report can be found at:
https://www.healthandcaretogethersyb.co.uk/application/files/2515/2579/1881/1._HSR_Stage_2_Report.pdf

4.0 Trust Based Activities and national campaigns

4.1 The Trust takes part in, and supports a number of health initiatives and national campaigns in which our colleagues and stakeholders participate, and this month was no exception.

4.2 Our Stroke Team have been ‘Making May Purple’ by hosting a number of events across the Trust and wider community. Make May Purple for stroke is national annual stroke awareness month. Friends, families and communities are invited to show their support for people who have been affected by stroke. By fundraising for the Stroke Association, services can be supported which help more people adapt to life after a stroke.

4.3 The Tour de Yorkshire in early May, was a great success for the region, and some of our colleagues took part in our own Tour de Rotherham spin-a-thon, lasting twelve hours in the main hospital entrance, raising funds in aid of The Rotherham Hospital and Community Charity.

4.4 International Day of the Midwife was celebrated on 5 May 2018. This marked the beginning of International Nurses Week, culminating in International Nurses Day on 12 May 2018. A number of colleagues appeared on social media explaining why they felt proud about their role.
4.5 National Sun Awareness week (14 – 20 May) saw our Dermatology Team colleagues providing healthy tips for those who love to spend time in the sunshine.

4.6 Insulin Safety Week (14 – 18 May) saw our Diabetes Specialist Team visiting wards to promote insulin safety, as well as being there to support colleagues in managing patients with diabetes safely.

4.7 International Clinical Trials Day on 20 May 2018 celebrated the anniversary of the first clinical trial by James Lind in 1747 into the causes of scurvy on board the HMS Salisbury. His trial consisted of just 12 men, grouped into pairs and given a variety of dietary supplements from cider to oranges and lemons. The trial only lasted six days but, within that time, there was a noticeable improvement in the group eating the fruit, providing Lind with the evidence required of the link between citrus fruits and scurvy. As part of the celebrations and to help raise the profile of the Rotherham Research and Development Team, an engagement event took place at the Trust on Friday 18 May.

4.8 The Trust has been taking part in the National Audit of Dementia (NAD), as part of national Dementia Action Week (21 – 27 May). The NAD is an improvement programme which aims to increase the quality of care that Acute Hospitals provide to people with Dementia. Once the data from the audit has been analysed, the outcomes will reported nationally.

5.0 British Heart Foundation Echocardiogram Machine Appeal

5.1 A state-of-the-art new heart scanner is helping to save lives thanks to a successful fundraising campaign by the British Heart Foundation, the Rotherham Hospital and Community Charity, supported by Rotherham Metropolitan Borough Council.

5.2 In 2015, the two charities joined forces to launch the Rotherham Scanner Appeal to raise £103,990.59 to buy a new echocardiogram (echo) machine for the Trust.

5.3 Thanks to fundraising in the community and at Rotherham Hospital, together with donations from local businesses including Westfield Health, the echo machine has been helping to play a life-saving role in diagnosing patients with suspected heart conditions.

5.4 The new echocardiogram machine produces 3D images which mean that clinicians can get a better picture of a patients’ heart muscle function. This is important when diagnosing and treating some conditions such as heart failure and determining which patients are suitable for complex cardiac device therapy - a new service offered at the Trust since March 2018.

5.5 Barry Mellor, Chair of the Charitable Funds Committee, attended the official ‘handover’ of the scanner on 16 May 2018.

6.0 Mayor’s Pledge to support Dr Ted

6.1 Cllr Buckley and his wife Sandra were sworn in as the town’s new Mayor and Mayoress during a ceremonial handover at Rotherham Town Hall on Friday 18 May, where they also formally announced their support for the Rotherham Hospital and Community Charity ‘Dr Ted’s children’s appeal’.
6.2 The appeal raises money to fund everything from toys to specialist medical equipment and resources to help ensure the Trust’s youngest and most vulnerable patients, as well as their families, have the best experience of being in hospital as possible.

6.3 The appeal has raised £76,000 since it was set up in April 2012.

7.0 Council of Governors

7.1 The Governors’ Nomination Committee took place on 15 May, which I chair. Joe Barnes also attended the meeting in his capacity as Senior Independent Director, and supported the Lead Governor by providing details of the Chairman’s appraisal. Details of Non-Executive Director appraisals and objective setting for 2018/19 were also discussed.

7.2 I and Conrad Wareham attended the Governors Forum on 23rd May to brief the Governors on the Trust’s Operational Plan for 2018/19, the Non-Executive Director’s Objectives and the recently published Hospital Services Review Report.

7.3 Dennis Wray, The Rotherham NHS Foundation Trust Lead Governor steps down at the end of May having been a public governor for 10 years and Lead Governor for the last 3 years.

7.4 Gavin Rimmer will take over as Interim Lead Governor from the 1st June to 11th July when the results of the formal Lead Governor Elections will be known.

8.0 Rotherham Together Partnership

8.1 The Rotherham Together Partnership are holding their showcase event on the 12th June at the New York Stadium and Lynn Hagger, Vice Chair of the Trust will be attending.

8.2 The Rotherham Together Partnership Spring Bulletin has been circulated to all Board Members.

8.3 Lynn Hagger (Non-Executive Director) our Voluntary Sector Lead, and Chris Morley our Chief Nurse, have recently met with colleagues from Voluntary Action Rotherham to discuss how we can further improve our working together for the benefit of our patients.

8.4 I have recently met with Councillor Read, the leader of Rotherham Metropolitan Borough Council and Chair of the Rotherham Together Partnership for our bi-annual meeting and we discussed how our colleagues and organisations could work more effectively together.

Martin Havenhand
Chairman
May 2018
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:
- NHSI: Licence Condition FT4 / Single Oversight Framework
- CQC Domain: safe / effective / caring /responsive / well-led

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

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

Summary of Key Points:
- Overall, the Trust is on track at Month 1, with the delivery of the Operational Plan.
- A review against the priorities for 2017/18 has been undertaken, which was used to inform the priorities set for 2018/19.
- The Trust has been successful in winning a number of national awards.
- The Trust continues to engage with stakeholders both locally and across the Integrated Care System to improve the quality and sustainability of services for the population we serve.

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

1.1 This paper outlines progress regarding a number of key strategic and operational issues, and stakeholder engagement, since the 24 April 2018 Board of Directors’ meeting.

2.0 Review of 2017/18 Priorities

2.1 A review of the strategic objectives, operational objectives and enablers set out in the 2017/18 Operational Plan has been undertaken. An assessment has been given against each priority, identifying whether delivery of each element has been achieved, partially achieved or not achieved. The outcome of this review is summarised in Appendix A.

2.2 In 2017/18, a considerable amount of work took place with teams across the Trust, with significant close working with key stakeholders, which has moved the Trust forward towards its vision of becoming an outstanding Trust, delivering excellent healthcare, at home, in our community and in hospital. The progress is substantial across most areas. Whilst some elements were not achieved in full, many of these were largely delivered, often with a particular aspect outstanding, which is being taken forward in 2018/19.

2.3 The review was used to inform the determination of the priorities within the 2018/19 Operational Plan to ensure that we build on the positive work that had taken place, and reflect areas for further work where needed.

3.0 2018/19 Operational Plan

3.1 The Operational Plan was submitted to NHSI on 30 April 2018 in accordance with national planning guidance timescales.

3.2 The Plan sets out the ambitions of the Trust, highlighting the strategic milestones, operational objectives and enablers for this year.

3.3 Overall, the Trust is on-track to deliver the Operational Plan at Month 1 (see appendix B).

3.4 The Trust has set a financial year end deficit for 2018/19 of £20.3M and has delivered the Month 1 Income and Expenditure position against plan. Whilst this is a positive start to the new financial year, it is imperative that performance continues to plan. The position continues to be closely monitored by the Executive Team.

3.5 In terms of performance in relation to key national standards, the Trust continues to achieve the 18-week Referral to Treatment standard, but despite some excellent performance on individual days, is not yet sustainably achieving the 4-hour A&E access target of 95% (or 90%, the national threshold to be achieved by September 2018).

3.6 In terms of cancer performance, the Trust is on-track with the detailed recovery plan, which should see the Trust return to performance against the 62 day standard by Quarter 2. An improvement plan will then be progressed to ensure that we sustain this performance for our patients for the future.
3.7 The Executive Team has been working with divisional and corporate colleagues to ensure that plans are in place to deliver the Operational Plan.

3.8 A workshop was held with the senior leadership teams within the Divisions in early May, to reflect on the progress made during 2017/18 and to ensure that we are building upon the positive outcomes and ongoing challenges, whilst also looking ahead into 2018/19.

3.9 In addition, divisional engagement sessions are taking place, led by the Chief Executive and Deputy Chief Executive. These have involved multidisciplinary colleagues throughout the division, who have had an opportunity to ask questions and explore how divisional priorities dovetail with the Trust strategy and plan.

3.10 A booklet has been produced summarising the Plan, which celebrates a selection of the Trust achievements during 2017/18 and priorities for 2018/19, which will be shared with colleagues and key stakeholders over the next few weeks.

3.11 A calendar of events is being established to build such reviews into the work plan of the year to ensure appropriate updates and assessments on progress are being performed throughout the year.

3.10 The short film which has been produced to highlight the vision and values of the Trust for colleagues, was shared with the Board of Directors in April. This was also shared at Team Brief and played at the divisional engagement sessions, and has received excellent feedback. This will be shared across the organisation and externally in May.

4.0 Hospital Services Review Stage 2 Report

4.1 The HSR Stage 2 Report was published in May 2018. This report builds on two key principles outlined in the Chairman’s report.

4.2 Whilst not site-specific, the report includes recommendations relating to the following five services: urgent and emergency care, care of the acutely ill child, maternity, stroke and gastroenterology and endoscopy.

4.3 The Chief Executive, together with members of the Executive Team, held a number of briefing sessions, including a presentation to colleagues working in each of the five areas above, together with open sessions for staff across the Trust. The sessions were attended by a cross-section of colleagues and positively received.

5.0 Stakeholder engagement

5.1 Trust colleagues continue to work with partner organisations across the Trust and South Yorkshire and Bassetlaw (SYB) through the Integrated Care System (ICS), including significant ongoing engagement in the Hospital Service Review (HSR).

5.2 The regular meetings of the Rotherham Integrated Health and Social Care Place Board, Rotherham Together Partnership Chief Executive Officer Group, Health Select Committee and Health and Wellbeing Board have taken place during May 2018 to support the delivery and review of the Rotherham Place Plan. We continue to work closely with partners to achieve our shared plans.
5.3 The Trust will be represented at the national celebrations of the NHS 70th anniversary. The Chairman will be attending York Minster with two colleagues on 5 July 2018, and I will be attending Westminster Abbey with two colleagues on this date. We are also planning a series of activities within the Trust to celebrate the 70th anniversary, and in the build up to this, we have been sharing memories from colleagues about their time, over the years, in the NHS.

5.4 The Trust has recently received a number of awards as follows:

The Trust's Urgent and Emergency Care Centre has won the Project of the Year award from the Health Estates and Facilities Management Association (HEFMA). This is a fantastic achievement for the organisation and for our partners with whom we have worked so closely. Particular recognition goes to John Cartwright, Director of Estates and Facilities, and his team for their role in this significant project.

On the 11 of May, the Trust was formally accredited to Level 2 of the NHS Standards of Procurement. This award is a peer assessment which is managed via the Skills Development Network and supported by the Department of Health and Social Care and NHS improvement.

The Procurement team managed the process of accreditation and began planning for the assessment in June 2017. The standards are broken into 6 categories (Strategy & Organisation, People & Skills, Strategic Procurement, Supply Chain, Data Systems & Performance Management, and Policies & Procedures) and there are set criteria to evidence in each of the categories.

Our Trust became only the 9th Trust in England to receive the Level 2 accreditation. This is a real achievement for the Trust, and a testament to the leadership and hard work of Paul Ralston, Head of Procurement and his team, who continue to do a fantastic job. This is the highest level any Trust has achieved so far and we are the first Trust in Yorkshire to achieve this level of accreditation.

5.5 The Trust has been invited to present at the first day of the NHS Confederation event on the 13 June 2018 on the Focus on Digital stage. We will be discussing the use of digital technology and how technology is helping to break down the barriers between different parts of the care system and taking care closer to home. Building on the presentation the Trust made at the Parliamentary briefing back in December 2017, we will be showcasing the use of the Rotherham Health Record, and presenting with colleagues from community nursing, primary care and social care.

6.0 Conclusion

6.1 Whilst overall the Trust is on track in terms of delivery of the Operational Plan in month, action is being taken to drive improvements, particularly in cancer 62-day performance and 4-hour access standard. The Executive team are working with divisions to ensure effective engagement and delivery of the Operational plan in 2018/19.

Louise Barnett
Chief Executive
May 2018
## Review of 2017/18 Priorities

### Appendix A

<table>
<thead>
<tr>
<th>Reference</th>
<th>Category</th>
<th>Objective</th>
<th>17/18 End Position</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 1</td>
<td>Strategic Objective</td>
<td>Open the new Urgent &amp; Emergency Care Centre (UECC)</td>
<td>Achieved</td>
<td>New UECC opened on time and services transitioned successfully</td>
</tr>
<tr>
<td>Patients 2</td>
<td>Strategic Objective</td>
<td>Evaluate integrated locality pilot &amp; commence implementation</td>
<td>Partially achieved</td>
<td>Evaluation complete and learnings identified and built in to the proposed roll-out plan with partners for 2018/19.</td>
</tr>
<tr>
<td>Colleagues 1</td>
<td>Strategic Objective</td>
<td>Identify and recruit to the Top 30 key vacancies</td>
<td>Partially achieved</td>
<td>Vacancies identified but not all filled, due to dynamic nature of the list. Carried over to year 2 and replace vacancies with posts to include new roles</td>
</tr>
<tr>
<td>Colleagues 2</td>
<td>Strategic Objective</td>
<td>Complete and implement the skill mix review of nursing and allied health professionals</td>
<td>Partially achieved</td>
<td>Band 2 Health Care Assistants being up-skilled against refreshed competences. Next steps included within 18/19 workforce plan</td>
</tr>
<tr>
<td>Governance 1</td>
<td>Strategic Objective</td>
<td>Monthly information agreed and in place, SLM Maturity Assessment complete</td>
<td>Partially achieved</td>
<td>SLM Maturity Assessment complete. Embed consistent use of agreed/refined information in 18/19 to support plan delivery</td>
</tr>
<tr>
<td>Governance 2</td>
<td>Strategic Objective</td>
<td>Quality governance review complete and recommendations agreed</td>
<td>Achieved</td>
<td>Review completed and recommendations agreed and next steps included within plan for 18/19</td>
</tr>
<tr>
<td>Finance 1</td>
<td>Strategic Objective</td>
<td>Senior managers &amp; budget holders trained in financial management</td>
<td>Partially achieved</td>
<td>E-training rolled out to over 90 individuals, plus planned and ad-hoc face to face sessions. Continuing into 18/19</td>
</tr>
<tr>
<td>Finance 2</td>
<td>Strategic Objective</td>
<td>Deliver the financial plan</td>
<td>Not Achieved</td>
<td>A key priority within 2018/19 plan</td>
</tr>
<tr>
<td>Partners 1</td>
<td>Strategic Objective</td>
<td>Enhanced Care Coordination Centre service model in place</td>
<td>Achieved</td>
<td>Mental and physical health integrated into single service model and outline plans for further integration included within Place Plan priorities for 18/19</td>
</tr>
<tr>
<td>Partners 2</td>
<td>Strategic Objective</td>
<td>Partnership arrangements with Sheffield Children’s Hospital</td>
<td>Partially achieved</td>
<td>MoU agreed, but further work required to determine approach. Reflected into 18/19 plan to progress</td>
</tr>
<tr>
<td>OO1</td>
<td>Operational Objectives</td>
<td>Develop and implement the Quality Improvement Plan (QIP)</td>
<td>Partially achieved</td>
<td>A QIP was established and commenced. However, on part-year review, a fresh approach was agreed focussing particularly on the quality priorities.</td>
</tr>
<tr>
<td>OO2</td>
<td>Operational Objectives</td>
<td>Improve quality and access through Emergency Department</td>
<td>Achieved</td>
<td>Opened and consolidated UECC, triage at UECC has been reviewed and improved, GP OOH has been transferred into the Trust. Focus on the SAFER care bundle continues.</td>
</tr>
<tr>
<td>OO3</td>
<td>Operational Objectives</td>
<td>Implement assessment, ambulatory and frailty pathways</td>
<td>Achieved</td>
<td>Reviewed and reconfigured AMU assessment pathway (with support from NHS Elect), with enhanced assessment and ambulatory facilities. Frailty team business case approved and team launched. Gynae assessment unit trialled as a pilot. Enhanced SAU model defined and business case developed.</td>
</tr>
<tr>
<td>OO4</td>
<td>Operational Objectives</td>
<td>Improve operational resilience across urgent and emergency care</td>
<td>Partially achieved</td>
<td>Escalation management system revised with work to be done on redefining triggers and the response. Progress on integration of hospital Social Work team and Transfer of Care Team which are now co-located.</td>
</tr>
<tr>
<td>OO5</td>
<td>Operational Objectives</td>
<td>Increase day case and elective surgery activity</td>
<td>Partially achieved</td>
<td>Re-profiled to 2018/19</td>
</tr>
<tr>
<td>Reference</td>
<td>Category</td>
<td>Objective</td>
<td>17/18 End Position</td>
<td>Narrative</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>OO6</td>
<td>Operational Objectives</td>
<td>Establish and adopt a service improvement approach</td>
<td>Achieved</td>
<td>A service improvement methodology has been agreed and is in place based around PDSA. Over 100 colleagues trained in service improvement across the Trust and a training programme has been agreed for 18/19.</td>
</tr>
<tr>
<td>OO7</td>
<td>Operational Objectives</td>
<td>Recruit medical workforce to reduce reliance on locums</td>
<td>Partially achieved</td>
<td>Success in recruiting to UECC and other consultants, with 13 consultant appointments made across the Trust, covering each Division.</td>
</tr>
<tr>
<td>OO8</td>
<td>Operational Objectives</td>
<td>Implement effective quality governance arrangements</td>
<td>Partially achieved</td>
<td>External review of quality governance arrangements completed. A series of actions and recommendations have been proposed with implementation through 2018/19.</td>
</tr>
<tr>
<td>OO9</td>
<td>Operational Objectives</td>
<td>Implement and undertake regular clinical service reviews</td>
<td>Partially achieved</td>
<td>5 key specialties were completed. Self-assessment of remaining services defined. Agreed process and rolling plan of reviews is a priority for 2018/19.</td>
</tr>
<tr>
<td>OO10</td>
<td>Operational Objectives</td>
<td>Reduce corporate costs</td>
<td>Partially achieved</td>
<td>Some corporate areas have been successful in reducing corporate costs during 2017/18 however this has not been achieved in all areas.</td>
</tr>
<tr>
<td>OO11</td>
<td>Operational Objectives</td>
<td>Implement theatre and outpatient efficiency programmes</td>
<td>Partially achieved</td>
<td>Theatres: efficiency performance had elements of delivery through 17/18. However, challenges in activity levels and specifically case mix did not deliver the savings required. Outpatients: improvements were made across a range of indicators and efficiencies created were used to offset backlogs on waiting lists. Work against both elements will continue into 2018/19.</td>
</tr>
<tr>
<td>OO12</td>
<td>Operational Objectives</td>
<td>Identify and secure external funding to deliver digital solutions</td>
<td>Achieved</td>
<td>£1.3M of income has been secured from external sources to support the digital agenda.</td>
</tr>
<tr>
<td>OO13</td>
<td>Operational Objectives</td>
<td>Implement effective demand and capacity planning</td>
<td>Achieved</td>
<td>Achieved prior to reprioritisation. Full scope of demand and capacity tools in place was undertaken, demonstrating demand and capacity planning at speciality level across all key areas. More standardisation and consistency in tools is required. Further work is re-profiled into 2018/19.</td>
</tr>
<tr>
<td>OO14</td>
<td>Operational Objectives</td>
<td>Complete pilot evaluation and roll out of integrated locality model</td>
<td>Partially achieved</td>
<td>Completed evaluation of integrated locality pilot and developed new service model, and agreed with partners. Roll out is a priority for 2018/19.</td>
</tr>
<tr>
<td>OO15</td>
<td>Operational Objectives</td>
<td>Reconfigure community bed base, intermediate care, CCC and IRR</td>
<td>Partially achieved</td>
<td>Scoping work around community bed base was completed and benchmarked against neighbouring trusts. Approach for 2018/19 which will create an enhanced 'home first' offer.</td>
</tr>
<tr>
<td>OO16</td>
<td>Operational Objectives</td>
<td>Define, agree and test integrated model of care for children</td>
<td>Achieved</td>
<td>New service model for children's community services has been implemented and is successfully diverting children with urgent health needs into the community and supporting more at home.</td>
</tr>
<tr>
<td>A</td>
<td>Enabler</td>
<td>Implement a PALS Service</td>
<td>Partially achieved</td>
<td>A pilot PALS has been up and running since Feb 2018 and will continue to enable a decision about whether to seek substantive funding (6 month pilot).</td>
</tr>
<tr>
<td>B1</td>
<td>Enabler</td>
<td>Develop the Senior and Middle Managers and clinical leaders through a leadership programme</td>
<td>Partially achieved</td>
<td>Developed senior leaders programme (launched first cohort of Shadow Board) and successfully engaged with 50% of Band 7 leaders on middle managers programme.</td>
</tr>
<tr>
<td>Reference</td>
<td>Category</td>
<td>Objective</td>
<td>17/18 End Position</td>
<td>Narrative</td>
</tr>
<tr>
<td>-----------</td>
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<td>-------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>B2</td>
<td>Enabler</td>
<td>Improve colleague engagement</td>
<td>Partially achieved</td>
<td>Whilst improvement in some key areas, there was a reduction in the national staff survey engagement score, with action plans in place to listen to feedback and drive improvement.</td>
</tr>
<tr>
<td>C1</td>
<td>Enabler</td>
<td>Improve forecasting and implement PLICS</td>
<td>Partially achieved</td>
<td>Forecasting: There has been an improvement in financial forecasting in 2017/18 as supported by a recent Internal Audit report. PLICS: has not been implemented in 2017/18 but is an organisational priority for 2018/19.</td>
</tr>
<tr>
<td>C2</td>
<td>Enabler</td>
<td>Provide info. to deliver plan. Complete SLM maturity assessment</td>
<td>Achieved</td>
<td>Completed the SLM Maturity assessment.</td>
</tr>
<tr>
<td>D</td>
<td>Enabler</td>
<td>Modernise the nursing workforce model to release time to care and optimise use of skills</td>
<td>Partially achieved</td>
<td>Nursing associates in place on 5 wards and a request for a further 12 has been submitted.</td>
</tr>
<tr>
<td>E</td>
<td>Enabler</td>
<td>Develop and implement a primary care engagement plan to support service development and delivery</td>
<td>Not achieved</td>
<td>Due to de-prioritisation in 2017/18 this was not pursued. However, with the transfer of the GP Out-of-Hours service, the Trust is now engaging directly with over 30 primary care colleagues.</td>
</tr>
</tbody>
</table>

The objectives and enablers shaded represent those which were agreed to be reprioritised at the Oct'17 Board of Directors meeting.
<table>
<thead>
<tr>
<th>Summarised Objective</th>
<th>Milestones (defined in plan)</th>
<th>By when</th>
<th>Lead Exec</th>
<th>RAG status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and recruit to the top 30 key posts</td>
<td>1.1) Agree the top 30 posts and a strategy to fill, with clear timescales</td>
<td>Apr-18</td>
<td>DoW</td>
<td>COMPLETE</td>
<td>Agreed by Exec team and shared with SWC</td>
</tr>
<tr>
<td></td>
<td>1.2) Produce corporate Trust video to support recruitment</td>
<td>Jun-18</td>
<td>DoW</td>
<td>COMPLETE</td>
<td>On track / completed.</td>
</tr>
<tr>
<td>Service Line Management principles rolled-out to 10 service lines</td>
<td>2.1) Identify and agree the 10 specialties for implementation</td>
<td>Apr-18</td>
<td>DoST</td>
<td>COMPLETE</td>
<td>Agreed by Exec team and shared with teams</td>
</tr>
<tr>
<td></td>
<td>2.2) Agree detailed implementation plans with clinical leads along with detailed success criteria</td>
<td>Jun-18</td>
<td>DoST</td>
<td>Underway and on track</td>
<td></td>
</tr>
<tr>
<td>Implement the 9 quality priorities for 2018/19</td>
<td>1.1) Agree the baseline measures and improvement trajectories</td>
<td>Apr-18</td>
<td>CN</td>
<td>COMPLETE</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>1.2) Produce report on progress since last CQC inspection report and recommend new key actions</td>
<td>Jun-18</td>
<td>CN</td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>Produce a draft outline 5-year sustainability plan</td>
<td>3.3) Produce a draft outline 5-year sustainability plan</td>
<td>May-18</td>
<td>CEO</td>
<td>COMPLETE</td>
<td>Completed and shared with Board</td>
</tr>
<tr>
<td>Train key people across the organisation in service improvement</td>
<td>3.1) Agree wave 2 training cohort and training plan and deployment plan for wave 1 and wave 2</td>
<td>May-18</td>
<td>CN</td>
<td>Plan on track and presented to SWC</td>
<td></td>
</tr>
<tr>
<td>Replace the core IT Infrastructure</td>
<td>5.1) Community laptop replacement programme complete</td>
<td>Jun-18</td>
<td>DoST</td>
<td>Underway and on track</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All Board members &amp; all first line reports to Exec Directors to have had PDR</td>
<td>Apr-18</td>
<td>DoW</td>
<td>COMPLETE</td>
<td>Complete. 27/27 undertaken.</td>
</tr>
<tr>
<td></td>
<td>All budget holders have had PDR</td>
<td>May-18</td>
<td>DoW</td>
<td>Underway and complete. Managers being reminded.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Band 7’s and above to have had PDR</td>
<td>Jun-18</td>
<td>DoW</td>
<td>Underway and on track</td>
<td></td>
</tr>
</tbody>
</table>
### 18/19 Operational Objectives Priorities

<table>
<thead>
<tr>
<th>Summarised Objective</th>
<th>Milestones (defined in plan)</th>
<th>By when</th>
<th>Lead Exec</th>
<th>RAG status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational support for all Band 8 colleagues to have 360-degree feedback</td>
<td>All Band 8 colleagues to have access to the Leadership Academy 360 Feedback Tool by June 2018.</td>
<td>Jun-18</td>
<td>DoW</td>
<td></td>
<td>On track. By the end of March 2019 all Band 8ds to have undertaken feedback.</td>
</tr>
<tr>
<td>To refresh and strengthen the performance framework</td>
<td>To refresh and strengthen the performance framework and associated dashboards and implement changes</td>
<td>Jun-18</td>
<td>DoST</td>
<td></td>
<td>On track. Measures already in place</td>
</tr>
<tr>
<td>Develop a plant &amp; equipment plan with funding options</td>
<td>1.1) Develop a risk assessed plant and equipment replacement plan</td>
<td>Jun’18</td>
<td>DoF</td>
<td></td>
<td>Underway and on track</td>
</tr>
<tr>
<td>Reconfiguration of the emergency &amp; assessment floor</td>
<td>1.1) Proposal on Phase 2 bed base configuration agreed</td>
<td>May’18</td>
<td>COO</td>
<td></td>
<td>Outline Business Case submitted to ICS internal project has commenced but awaiting ICS notification</td>
</tr>
<tr>
<td>Locality model agreed and implementation operational</td>
<td>4.1) Locality service specification and model and implementation timescales signed of by ICP board</td>
<td>May-18</td>
<td>DoST</td>
<td>COMPLETE</td>
<td>Complete. Model and implementation plan agreed with Place Board</td>
</tr>
<tr>
<td>Collaboration arrangements agreed with key partner(s)</td>
<td>Collaboration arrangements agreed with key partner(s)</td>
<td>Jun’18</td>
<td>DoST</td>
<td>COMPLETE</td>
<td>Joint principles agreed with Barnsley.</td>
</tr>
<tr>
<td>Deployment and funding agreed for EPMA</td>
<td>Deployment and funding agreed for EPMA</td>
<td>Jun-18</td>
<td>DoST</td>
<td></td>
<td>Funding in the capital plan and initiation meeting held</td>
</tr>
<tr>
<td>Secure 2nd Graduate Management Training post</td>
<td>Secure 2nd Graduate Management Training post</td>
<td>May-18</td>
<td>DoST</td>
<td>COMPLETE</td>
<td>Confirmed additional 2nd year placement will start in Sept’18</td>
</tr>
<tr>
<td>Senior Nursing Review: systematically review the role and functions of the senior nursing teams to optimise and maximise their input</td>
<td>Systematically review the role and function of the ACP’s</td>
<td>May’18</td>
<td>CN</td>
<td></td>
<td>Plan developed and presented to SWC</td>
</tr>
</tbody>
</table>

Legend:
- Green: On track to complete or COMPLETE
- Yellow: Off track, but plan in place
- Red: Off track, no plan currently in place

Date Printed: 24/05/2018
## Integrated Performance Dashboard (May 2018)

### Top Achievements

- **Inpatient Friends and Family Test**
  - 98.7%
  - Current performance gives clear top quartile performance and once national figures are published we would be looking to be within the top 5 of all CQC registered acute providers

- **C.DIFF Incidence Rate**
  - Over the past 12 months the C.diff incidence rate per 100,000 bed days has improved from 13.3 to 9.9 taking TRFT from a national ranking of 70th to 20th.

### Most Improved

- **Sickness Rates (In Month)**
  - Sickness rates improved from 3.86% to 3.68% in the month of April and ongoing improvement in the rolling 12 month average. These improvements give TRFT better than national average performance.

### Key Concerns

- **Emergency Department**
  - A&E % Left without being seen: the rate of 7.04%, places the Trust in the bottom 5 of providers nationally

### Most Deteriorated

- **Urgent Care 4 Hour Standard**
  - Whilst performance increased by 0.4% to achieve 83.5%, the peer ranking for Rotherham fell from 64th to 96th of 134 Acute Trusts. On Type 1 performance, our peer ranking was average. These improvements give TRFT better than national average performance.

### In Month Activity (M1)

<table>
<thead>
<tr>
<th></th>
<th>17/18</th>
<th>18/19</th>
<th>Diff. No</th>
<th>Diff. %</th>
<th>17/18</th>
<th>18/19</th>
<th>Diff. No</th>
<th>Diff. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>5,941</td>
<td>8,194</td>
<td>2,253</td>
<td>38%</td>
<td>5,941</td>
<td>8,194</td>
<td>2,253</td>
<td>38%</td>
</tr>
<tr>
<td>NON ELECTIVE</td>
<td>2,499</td>
<td>2,231</td>
<td>-268</td>
<td>-11%</td>
<td>2,499</td>
<td>2,231</td>
<td>-268</td>
<td>-11%</td>
</tr>
<tr>
<td>EXCESS BED DAYS</td>
<td>505</td>
<td>496</td>
<td>-9</td>
<td>-2%</td>
<td>505</td>
<td>496</td>
<td>-9</td>
<td>-2%</td>
</tr>
<tr>
<td>DAY CASES</td>
<td>2,415</td>
<td>2,620</td>
<td>205</td>
<td>8%</td>
<td>2,415</td>
<td>2,620</td>
<td>205</td>
<td>8%</td>
</tr>
<tr>
<td>ELECTIVE</td>
<td>422</td>
<td>337</td>
<td>-85</td>
<td>-20%</td>
<td>422</td>
<td>337</td>
<td>-85</td>
<td>-20%</td>
</tr>
</tbody>
</table>

### Outpatient Activity

<table>
<thead>
<tr>
<th></th>
<th>17/18</th>
<th>18/19</th>
<th>Diff. No</th>
<th>Diff. %</th>
<th>17/18</th>
<th>18/19</th>
<th>Diff. No</th>
<th>Diff. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP PROCEDURE FIRST</td>
<td>1,034</td>
<td>1,319</td>
<td>285</td>
<td>28%</td>
<td>1,034</td>
<td>1,319</td>
<td>285</td>
<td>28%</td>
</tr>
<tr>
<td>OP PROCEDURE FU</td>
<td>2,972</td>
<td>3,894</td>
<td>922</td>
<td>31%</td>
<td>2,972</td>
<td>3,894</td>
<td>922</td>
<td>31%</td>
</tr>
</tbody>
</table>

### Data Quality*

*Data Quality kite marks are only currently available for those indicators retained from the 17/18 Integrated Performance Report

---

**Key Performance Indicator**

- **A&E % Left without being seen**
  - Reporting Period: Mar-18
  - Target: 5.00%
  - Performance: 7.04%
  - Trend: NA

- **IP Friends & Family Test (% Positive)**
  - Reporting Period: Apr-18
  - Target: 95.0%
  - Performance: 98.7%
  - Trend: NA

- **% LAC assessments reported <20 days**
  - Reporting Period: Apr-18
  - Target: 95.0%
  - Performance: 52%
  - Trend: NA

- **New Complaints per WTE**
  - Reporting Period: Apr-18
  - Target: 7.6
  - Performance: 6.2

- **Ambulance Turnaround Times % > 60 mins**
  - Reporting Period: Mar-18
  - Target: 0.00%
  - Performance: 3.86%
  - Trend: NA

- **Cancelations Operations Apr-18**
  - Reporting Period: Apr-18
  - Target: 0.56%
  - Performance: 0.88%
  - Trend: 0.56%
<table>
<thead>
<tr>
<th>METRIC</th>
<th>Target</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>YTD 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Stroke patients who spend at least 90% of their time on a stroke unit</td>
<td>&lt;= 80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>64%</td>
</tr>
<tr>
<td>% of non-admitted higher risk TIA cases who are treated within 24 hours of first contact with any healthcare professional</td>
<td>&lt;= 60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>% of People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital</td>
<td>&lt;= 90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>97%</td>
</tr>
<tr>
<td>Proportion of patients presenting with stroke with AF anti-coagulated on discharge</td>
<td>&lt;= 60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of stroke patients scanned within one hour of hospital arrival</td>
<td>&lt;= 50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>44%</td>
</tr>
<tr>
<td>Proportion of stroke patients scanned within 24 hrs of hospital arrival</td>
<td>&lt;= 100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>97%</td>
</tr>
<tr>
<td>Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke</td>
<td>&lt;= 40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of patients and carers with joint care plans on discharge from hospital</td>
<td>&lt;= 85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of stroke patients that are reviewed six months after leaving hospital</td>
<td>&lt;= 95%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>81%</td>
</tr>
<tr>
<td>Proportion of patients supported by a stroke skilled ESD team</td>
<td>&lt;= 40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19%</td>
</tr>
<tr>
<td>% of patients who receive thrombolysis following an acute stroke</td>
<td>&lt;= 11%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.0%</td>
</tr>
</tbody>
</table>
## Appendix 2 - March 2018 Tumour Site Breakdown*

<table>
<thead>
<tr>
<th>Tumour Site</th>
<th>62 Day from 2ww Target 85%</th>
<th>62 day CUG Target TBC</th>
<th>62 Day Screening Target 90%</th>
<th>31 Day 1st Treated Target 96%</th>
<th>31 Day Subsequent Surgery Target 94%</th>
<th>31 Day Subsequent Drug Target 98%</th>
<th>31 Day Subsequent Palliative Target TBC</th>
<th>2WW Target 93%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
</tr>
<tr>
<td>Acute Leukaemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain/Central Nervous System</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>88.2%</td>
<td>88.2%</td>
<td></td>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>78.1%</td>
</tr>
<tr>
<td>Childrens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>Gynaecological</td>
<td>57.1%</td>
<td>66.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>87.1%</td>
</tr>
<tr>
<td>Haematological</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>83.3%</td>
<td>80.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>97.5%</td>
</tr>
<tr>
<td>Lower Gastrointestinal</td>
<td>85.7%</td>
<td>85.7%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>80.0%</td>
<td>80.0%</td>
<td></td>
<td>93.1%</td>
</tr>
<tr>
<td>Lung</td>
<td>66.7%</td>
<td>66.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td>96.6%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarcoma</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>Skin</td>
<td>91.7%</td>
<td>91.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>89.3%</td>
</tr>
<tr>
<td>Testicular</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper Gastrointestinal</td>
<td>80.0%</td>
<td>100.0%</td>
<td>83.3%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>93.2%</td>
</tr>
<tr>
<td>Urological</td>
<td>100.0%</td>
<td>100.0%</td>
<td>75.0%</td>
<td>75.0%</td>
<td>88.2%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>94.6%</td>
</tr>
<tr>
<td>Total</td>
<td>87.5%</td>
<td>88.9%</td>
<td>91.0%</td>
<td>92.2%</td>
<td>87.0%</td>
<td>87.0%</td>
<td>96.5%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Pre-validation - subject to change
## Appendix 3 - April 2018 - 18 Week RTT Return Data

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust Total Admitted</th>
<th>Trust Total Non Admitted</th>
<th>Trust Total Incomplete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;18Wks</td>
<td>18Wks+</td>
<td>% &lt;18Wks</td>
</tr>
<tr>
<td>General Surgery</td>
<td>117</td>
<td>35</td>
<td>75.96%</td>
</tr>
<tr>
<td>Urology</td>
<td>80</td>
<td>9</td>
<td>89.89%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>150</td>
<td>64</td>
<td>70.09%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>46</td>
<td>20</td>
<td>86.96%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>128</td>
<td>1</td>
<td>99.22%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>168</td>
<td>20</td>
<td>84.48%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
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### TARGETS

- **Admitted**: 90%
- **Non Admitted**: 95%
- **Incomplete**: 92%
## Diagnostics (DM01) - Patients Still Waiting at Month End
### April 2018

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<tr>
<th>Category</th>
<th>Investigation</th>
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Report: Quality Report

Presented by: Chris Morley, Chief Nurse

Author(s): Helen Dobson, Deputy Chief Nurse

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

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

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

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

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

- The Classic ‘Harm Free’ Care score has decreased slightly this month, as has the Paediatric score and the Combined Maternity ‘Harm Free’ score although this remains above the national average.
- Complaints responded to within the agreed timescale decreased to 92% in April from 100% the previous month.
- One Never Event has been declared in April. This related to wrong tooth extraction within Community Dentistry, this is currently being investigated as a Serious Incident.
- The improvement in completion of Initial Health Assessments for Looked After Children within 20 days achieved last month has been broadly maintained in April.
- Additional capacity for in patients on Ward A3 has now closed with some intermittent use of beds on B1 when required. The vacancy rate for qualified nurses and Support Workers has decreased in April following the newly qualified nurse recruitment. A further successful recruitment event for newly qualified nurses has taken place.
- New indicators on complaints and incident reporting are included in the report.

Board action required: For noting
1.0 Harm Free Care

1.1 The Classic ‘Harm Free’ Care score for the Trust is 93% for March. The score demonstrates a slight decrease from March when the score was 95%. The breakdown for this month is 94% for the acute areas, a decrease from 97% in March. This appears to be due to an increase in recorded pressure ulcers on the day of the survey. The sustained reduction in the number of falls has continued for a third month.

1.2 In the community there has been a slight decrease this month in the Harm Free Care score to 92% from 93% in March.

1.3 There has been a decrease in the Combined ‘Harm Free’ Care maternity score to 81% in April from 91% in March. The National Score for Combined ‘Harm Free’ Care for April was 75%. The reduction is due to an increase this month in post-partum haemorrhages. All these incidents are investigated within the maternity team and further validation of the data will be undertaken by the Assistant Chief Nurse with the Matron for Maternity Services.

1.4 The paediatric score has reduced to a score of 96% in April from 100% in March with no areas of specific concern identified. This reflects an incomplete Early Warning Score for one patient and one incident of extravasation which is being investigated.

2.0 Complaints

2.1 The Trust received 103 concerns and 23 formal complaints in the month of March. 21 complaints were closed. Of the formal complaints received one (4%) was risk rated as red, 7 (31%) risk rated as amber and 15 (65%) as yellow. It should be noted that the complaint risked as red is being investigated as a Red Internal Serious Incident in line with Trust policy. The Patient Experience Team will monitor this process to ensure all aspects of the original complaint are addressed.

2.2 There was no particular theme emerging from the increase in concerns during April.

2.3 Written complaints responded to within the agreed timescale of 30 working days was 92%.

2.4 One case remains under investigation by the Parliamentary Health Service Ombudsman (PHSO).

2.5 There is a new metric relating to complaints reported on this year’s Integrated Performance Report, number of new complaints per 1000 whole time equivalent (WTE) staff. This is monitored via NHS Improvement (NHSI) as part of the Single Oversight Framework (SOF). The Trust is placed in quartile 2 when compared with all other Trusts with a rate of 18.34, the national median is 22.74. This metric was last updated for December 2017.

3.0 Friends and Family Test (FFT)

3.1 There has been an increase in the number of responses captured in April 3,804 compared to March 3,173. These responses are the combined total from the following areas: Inpatient, Day Cases, Urgent and Emergency Care, Maternity, Outpatients and Community services. The inpatient areas with the highest response rates were
Special Care Baby Unit (77%) and the Children’s ward (88%). Three ward areas did not achieve the 40% target for response rates.

3.2 The Trust FFT positive scores for April are 98% for inpatients (97% in March), and 99% for day case (99% in March). The combined national average for these two areas remains at 96%. As highlighted in the Integrated Performance Report, this level of performance gives top quartile performance when compared to other Trusts and once national figures are published we would be looking to be within the top 5 of all CQC registered acute providers. Maternity services achieved 99.7% in April (98% in March /97% national average), 97% for outpatients (98% in March/national average 94%). The Urgent and Emergency Care Centre achieved 97.5% (national average 84%) although response rates remain low at 2.8%.

3.3 Community response rates were higher in April (858) compared to March (493). The positive score for April is 95% (national average 95%). Children and Family services had the lowest score of 93% which is a decrease from 99% in March. Four community areas achieved a 100% positive score - Community Nursing services, Community Inpatient, Specialist services and the Rehabilitation and Therapy Services.

4.0 Nurse Staffing Report

4.1 There has been a slight increase in Registered Nurse fill rates on days and nights when compared to those for March. There has been a reduction in Healthcare Support Worker shift fill rates on days and an improvement on nights in April. Please see appendix 1.

4.2 The overall vacancy rate has reduced during April, with the largest number of vacancies being in the Division of Medicine.

4.3 93 conditional offers were made to prospective soon-to-qualify nurses at the recruitment open day held on 24 March 2018 and interviews on 19 April 2018.

4.4 Additional capacity for inpatients on Ward A3 closed at the end of April. The Discharge lounge is now open on B10 on Monday, Tuesday and Friday.

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

4.6 The Safer Nursing Care Tool was deployed during January 2018 in all adult in-patient wards, ward establishment reviews took place during April. Further work is underway to ensure alignment between ward roster templates and budgeted establishments, prior to final sign off.

5.0 Looked After Children

5.1 The number of Initial Health Assessments completed within 20 working days (statutory) was maintained between March (56%) and April (52%). The service continues to manage the backlog resulting from the increase in the number of children/young people becoming looked after. Discussions are on-going with both
Rotherham Metropolitan Borough Council and Rotherham Clinical Commissioning Group to streamline the notification process from Social Care to provide further improvements in performance.

6.0 Quality Governance Review

6.1 Quality Governance provides a framework for organisations and individuals to ensure the delivery of safe, effective and high quality healthcare. Its purpose is to help organisations, and their staff, monitor and improve standards of care. In 2017 the Trust commissioned an externally facilitated review of Quality Governance by KPMG. The report was completed in February 2018 and reported to the Quality Assurance Committee in the same month. The findings and action plan from the final report were presented to the March 2018 Board meeting. Progress against the actions is being reported through the Quality Assurance Committee.

7.0 Incident Reporting

7.1 One Never Event has been declared in April. This related to wrong tooth extraction within Community Dentistry, this is currently being investigated as a Serious Incident.

7.2 There are two new metrics relating to incidents reported on this year’s Integrated Performance Report, potential under reporting of incidents and incident reporting culture - % incidents severe.

7.3 The potential under reporting of incidents metric is calculated by dividing the count of reported incidents by the estimated total person bed days for rolling six months shown as a rate per 1000 bed days.

7.4 This is monitored via NHSI as part of the SOF. The Trust is placed in quartile 2 when compared with all other Trusts with a rate of 41.54, the national median is 43.33. This metric was last updated January 2018. The Trust is therefore reported as green/amber as a better performing Trust by NHSI, however it is shown as red on the Trust report as it is felt that a higher score is better on this metric than a lower score. This is currently being discussed with NHSI to determine how this metric should be correctly interpreted.

7.5 The incident reporting culture - % incidents severe metric is a calculation of the proportion of all incidents which are classed as severe. Trusts with a higher percentage of severe incidents as a proportion of all incidents are likely to have a poor reporting culture. The Trust is better than the target set for this metric. This is not monitored as part of the SOF.

8.0 Quality Assurance Committee Update

8.1 The Medical Director explained that he was currently reviewing membership, quoracy, timing and length of the Clinical Governance Committee as recent meetings have not always been quorate.

8.2 The Committee received reports on three of the 2018/19 Quality Improvement Priorities, outlining proposals for how these will be delivered and monitored over the year. The rolling presentation programme enables all nine priorities to be presented each quarter.
8.3 The Deputy Chief Nurse provided an evaluation of the Patient Advice and Liaison Service pilot project after two months of operation. This report included performance against metrics and provided some recommendations of variations to the service that will be trialled to evaluate impact.

8.4 The Deputy Head of Midwifery presented the findings of the national Care Quality Commission Maternity Survey (2017). The committee requested an update on progress against the action plan for next month.

8.5 The Deputy Chief Nurse presented an update on Serious Incidents. Four were declared in February 2018. These are currently all under investigation. It was noted that the Trust is seeing a reduction in the backlog of Serious Incident reports awaiting completion.

8.6 The Committee received the Infection Prevention Control report and a verbal update on the Ward Metric Dashboard progress.

8.7 The Committee received the Quality Report and Quality Account. The Chief Nurse took Committee members through the report with no specific issues arising.

9.0 Conclusion

9.1 The majority of areas are reporting similar performance to last month with some minor variation. In particular, FFT scores have increased although there has been a slight deterioration in complaints response times. There is a further decreased vacancy level reported for Registered Nurses following the newly qualified nurse recruitment in March and April. The ability to close additional capacity beds on Ward A3 has helped to support achieving appropriate staffing levels.

Mr Chris Morley
Chief Nurse
May 2018
Nurse Staffing report

1. Registered Nurse/Midwife (RN/M) shift fill rates (daytime) were 86.1% in April 2018 compared to 84.7% in March 2018 and 95.8% on nights compared with 93.6%. Healthcare Support Worker (HCSW) fill rates were 108.1% on days compared with 110.1% in March and for nights were 101.8% compared with 98.5%.

2. Twelve in-patient areas had Registered Nurse fill rates (days) below 90%. These were A1, A2, A4, A5, A7, AMU, Community Unit, Stroke Unit, and Labour ward, B4, Fitzwilliam and Keppel. Of these, seven had a day time shift fill rate less than 80% and these were; A1 at 64.3% compared with 62.6% in March, A2 at 61.3% compared with 56.5%, A4 at 58.2% compared with 57.1%, A5 at 59.0% compared with 55.0%, AMU at 76.8% compared with 76.2%, Stroke Unit at 59.3% compared with 57.7% and Keppel at 68.3% compared with 68.0% in March. This demonstrates small improvements in all areas.

3. Two areas had a fill rate below 80% on nights, these were AMU at 77.4% and Keppel at 78.6%.

4. There were 0 shifts in the month with over 50% of RNs on duty being within the 12 month preceptorship period compared with 5 shifts in March. There has been a reduction in the percentage of Registered Nurses/Midwives flexible staffing (internal bank) across all Divisions. RN agency usage has marginally increased in the Division of Medicine and reduced in the Division of Surgery, there was no RN/M agency usage in the Division of Family Health during April. The percentage of shifts not staffed to plan has reduced to 25.95% in April as compared with 30.06% in March.

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

6. In the Community there was a deficit of 0.06% against plan, which represents an improved position compared with March at 1.06% and can be accounted for by only one shift being one nurse below plan. Sickness absence has increased to 5.76% as compared to 3.72% in March.

7. Care Hours per Patient Day (CHpPD) is a metric introduced following Lord Carter’s review of efficiency in the NHS[1] to record a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. During April the overall actual CHpPD is 8.3 compared with 8.2 in March.

8. The current overall nursing and HCSW vacancy position when recruitment plans are included is in a negative position at -85.40 wte as at 30 April 2018 compared with -99.78 at 31 March 2018. This continues to pose a challenge across the divisions to ensure safe, effective and sustainable staffing. The substantive workforce is supported by bank and agency staff to ensure safe and effective staffing. There is a correlation between safe staffing and patient outcomes and this is monitored on a daily basis by the Matrons and all incidents are reported in the Trust’s Datix system.

9. 17 Newly Qualified nurses commenced employment in the Trust during April.

10. 92 conditional offers were made to soon-to-qualify nurses at the Trust recruitment open
day on 24 March and subsequent interviews on 19 April. Colleagues are maintaining regular
contact with those offered posts in an attempt maintain their interest in TRFT as their
preferred place to work and to covert the conditional offers to actual starters.
Report: Clinical Report

Presented by: Dr C Wareham, Medical Director
Author(s): Dr C Wareham, Medical Director

Strategic Objective: Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance

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

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

Purpose of this paper:
This report provides an update on the Trust’s position on mortality, dementia, provides details as to the current position on infection control matters and outlines research and development activity.

Summary of Key Points:
Mortality performance shows continuous signs of progressive improvement. Hospital Acquired infections performance is also strong overall with small areas of concern highlighted. Dementia performance remains a concern despite significant actions being taken in this area.

Board action required:
For noting
1.0 **Mortality**

1.1 Hospital Standardised Mortality Ratio (HSMR) is currently 94 (data from March 2017 to February 2018) which continues to show an onward decrease. Ranking nationally however remains in the upper (highest HSMR) quartile. As such the absolute number for HSMR should be interpreted with caution. The Trust has approached CHKS to try to gain assurance that the rebasing of HSMR is being handled in the same way as other national data providers.

1.2 Standardised Hospital Mortality Indicator (SHMI) is 106.67 (this was rebased in April and will next change in July). This shows an improvement of the previous quarter as was predicted based on the reduction seen in HSMR (SHMI uses older data). The current SHMI result remains raised but is no long statistically outlying. It is expected that SHMI will show a further reduction in the next quarter.

1.3 Crude mortality has increased slightly in February to 2.02% which is not unexpected in the winter however the rolling three month result was somewhat lower at 1.84% which a reasonable figure. Weekend mortality (that is mortality rate for patients admitted at the weekend over the last year) was 2.77%. This is expected to be higher as almost all weekend admissions are non-elective cases where a higher mortality is expected.

1.4 The HSMR by day of the week shows no significant changes ranging from a low of 83.4% on Friday to a high of 107.3% on Sunday. A rate of up to 15% higher at weekend is not unusual.

1.5 Mortality for various lengths of stay is showing a generalised improvement with no particular pattern.

1.6 There are no specific diagnosis where the mortality rates are outlying that constitute a large enough cohort to warrant detailed review yet in the HSMR or SHMI data. However deaths in low mortality diagnosis is flagging with 23 cases. This may be a coding issue but will be reviewed in the coming months.

2.0 **Hospital Acquired Infections**

2.1 **Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia:** The 2018/19 trajectory is for zero cases. One case was reported in April and is under investigation with initial indication that this is a contaminated sample, however, the Multi-Disciplinary Team review of the case with the Clinical Commissioning Group (CCG) has taken place 23rd April and further questions have arisen as to whether this is likely to be a contaminant or an infection (The patient was well and discharged). The opinion of a senior Consultant colleague from Barnsley has been sought and a response was awaited.

2.2 National investigation and reporting of MRSA bacteraemia has changed for 2018/19 with only Trusts with a high rate being required to complete the national Public Health England (PHE) investigation, all other Trusts (TRFT included) are to investigate using local systems. All samples will continue to be reported nationally to PHE. The required Trusts will be reviewed on a rolling basis dependent upon figures submitted. There is no longer any review of cases using an arbitration process previously used when a provider and a commissioner are not in agreement of the provenance of a case.
2.3 **Blood culture contamination:** reduction is being monitored via the Infection Prevention and Control Committee and is operationally included within the Sepsis group. All contaminated samples are reported via the Datix system, where the sample taker can be identified via Meditech the details are shared with the relevant governance lead to investigate further. Additional training in blood culture technique is provided by the Clinical Skills Educator or by the Vascular Access Team. Named personnel in Emergency Department (ED) as determined by the Sepsis Lead Consultant are the only people who are deemed appropriate to take samples to reduce risk of contamination. This method is under consideration for wider roll out with the back up support of the Phlebotomy team during the day and the Hospital at Night team for out of hours. The National benchmark for blood culture contamination is a maximum of 3%; TRFT has been above this benchmark for 2017/18 reporting a figure of 3.65% for April but with ED continuing to have a consecutive monthly reduction since December 2017 at 4.8% for April.

2.4 Consideration is being made to change the current blood culture sampling for possible sepsis from one set of cultures to two. The implications of changing are under review by the Microbiology laboratory manager. The recommendation for this change is based on National Institute for Clinical Excellence (NICE) accredited Public Health England (PHE) UK standards for Microbiology investigations (2014) UK SMI B 37.

2.5 **Clostridium difficile infection:** The 2018/19 hospital trajectory has been decreased by 1 case to 25 cases with the same reporting rationale and there has been 1 hospital acquired case to date which is currently under review. There has been 4 community acquired cases of C diff to date.

2.6 **Gram negative bacteraemia:** National reporting of Gram negative bacteraemia commenced in April 2017 and included the specific organisms of E.coli, Klebsiella species and Pseudomonas aeruginosa. No trajectory for providers was set but CCGs were challenged to reduce cases within each CCG by 10%.

2.7 A list of the rate by all provider Trusts for calendar year 2016 and 2017 showed TRFT as 96 out of 150 Trusts, the Trust classed as number 1 had reduced their rate by 100% which in actual figures was two cases in 2016 and one case in 2017. In actual case figures TRFT were joint 31st in 2016 and joint 35th in 2017. The number of cases reported in April via the Microbiology Lab is 23, of which one is hospital acquired.

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

2.9 The Infection Prevention and Control (IPC) team are working with the Clinical Commissioning Group IPC Nurse and the Local authority looking at other possible risk factors and prevention ideas with work with care homes in terms of education around hydration and continence hygiene already in progress.
2.10 **Influenza:** The 2017/18 flu season has been a challenging one with an increase in symptoms, possible cases and confirmed cases which mirrored the National incidence. The flu season reporting continues until 23rd May 2018.

2.11 **Diphtheria:** Is a rare bacterial infection of the throat which has been controlled due to immunisation programs. Rotherham and Barnsley Microbiology laboratory routinely check for Diphtheria on all bacterial throat swabs submitted and there has been no history of cases in the past 20 years. A recent swab submitted by a GP from a child identified Diphtheria, the child was assessed at the hospital, treated and recovered at home. PHE led the investigation due to the nature of this infection and the potential impact to the wider community. Extensive multi-disciplinary working has taken place between the Yorkshire and Humber PHE, National PHE, Rotherham Metropolitan Borough Council local authority, CCG, and TRFT IPC team, 0-19 team and Microbiology laboratory in terms of contact tracing, mass screening, prophylaxis and communications. As has been reported in the local media screening included a school within the Rotherham area and 2 of the children screened were found to be asymptomatic carriers of the bacteria, this widened the screening to include the relevant family contacts and the full school, no further cases were identified from the wide school screening.

2.12 A probable case of diphtheria was clinically diagnosed in an adult in ED at a similar time, the patient was admitted and successfully treated with antibiotics, screening and prophylaxis was given to staff who had had potential exposure. The case remains as a probable as the samples taken did not microbiologically confirm the diagnosis. PHE also led on the investigation of this case and no links between the cases were identified.

2.13 A further possible case was ruled out by PHE following in depth review, screening and sample results. Vaccinations have taken place within the school with the 0-19 team working with PHE.

2.13 **Measles:** PHE have reported outbreaks in various areas including West and North Yorkshire. Trust colleagues have been made aware to have heightened awareness and to check they are fully vaccinated. 1 out of area case had attended the UECC and potential contacts have been written to by the Director of Infection Prevention & Control (DIPC).

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

3.1 This report outlines the current status and ambition for 2018/19 research within the Trust. The number of recruits into clinical research studies on the National Institute for Health Research Clinical Research Network (NIHR) portfolio at The Rotherham NHS Foundation Trust (TRFT) is 232, including 222 for Yorkshire Health Study, against a target of 550 for the financial year 2018/19 [data cut 09 May 2018, taken from NIHR]

3.2 There are 80 studies that are currently active (recruiting or in follow up), listed in attachment.

3.3 There are 15 new studies in set up including four commercially sponsored studies.
3.4 Current funding for R&D includes the Clinical Research Network (CRN) 17/18 allocation of £218,780 and commercial and non-commercial research income of £14,554 in the financial year 18/19 to date.

3.5 The increase in clinical research recruitment and general awareness of TRFT as a research active trust over the last 2 years reflects the successful implementation of R&D Department infrastructure to support the set up and delivery of clinical research by effective and efficient use of resource. The longer term ambition of the R&D team is to enable both staff and patients to have access to locally relevant clinical research in all settings. Potential barriers to increasing capacity include: financing an increase in R&D Department resource due to flat income from CRN; attracting commercial research due to a lack of experienced Principal Investigators with dedicated clinical time and the ability to win research grants due to limited academic links. To address these issues R&D has: submitted a business case to the Clinical Research Network to cover a period of maternity leave with aim of increasing income and sustaining this additional post; is working on building on its reputation with commercial sponsors of the ability to support research with the experienced R&D team and look forward to working with the new Research Lead in General Surgery to lay the foundations for relationships with academic partners. R&D would welcome the Board’s input into their vision for the future direction of clinical research at TRFT.

4.0 **Dementia, Delirium and Person-Centred Care**

4.1 Dr Kersh has received an update from the Chief Nurse relating to specialist/lead nurse support for dementia/person-centred care in the Trust.

4.2 The Trust has launched and are participating in the national #EndPJParalysis campaign, aimed at empowering our patients, encouraging independence and autonomy and reducing the harms of deconditioning. This has been advertised locally by wards and we have created a press-release.

4.3 The Trust is piloting a new clinical assessment document on Acute Medical Unit (AMU) which provides a more accurate assessment of delirium and dementia than before. This has been used since 8th May 2018.

4.4 Dr Kersh has created an updated database of nursing, medical and therapy staff from across the organisation interested in supporting dementia, delirium and person-centred care; and will be scheduling a meeting within the next month.

4.5 The Trust’s new ‘This is Me’ document is held-up with printing.

4.6 Dr Kersh and colleagues are working to shift towards opening visiting times. There has been some anxiety relating to this and on AMU it is planned to trial open visiting between 11am and 8pm.

4.7 In April a delirium training session for junior doctors was run by Dr Kersh.

4.8 Dr Kersh is in discussion with the Speech and Language Team (SALT) to run a delirium session.

4.9 Posters highlighting the risks/hazards of delirium have been used on AMU
5.0  **In Summary**

5.1  Significant ongoing work within the Trust to ensure the quality of clinical care is continuing and outlined in detail in this paper.

Dr Conrad Wareham  
Medical Director  
May 2018
### Appendix 1

#### NIHR* Portfolio studies

**Open to Recruitment**

<table>
<thead>
<tr>
<th>RFT REF</th>
<th>TITLE</th>
<th>SPECIALTY</th>
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</thead>
<tbody>
<tr>
<td>17-06-02</td>
<td>Transfer of Health Study</td>
<td>Public Health</td>
</tr>
<tr>
<td>17-01</td>
<td>Urinary MSCS</td>
<td>Haematology</td>
</tr>
<tr>
<td>16-07-04</td>
<td>Faster: a randomised controlled trial of a calf-sec intervention</td>
<td>HIV/AIDS, Infectious diseases and Immunology</td>
</tr>
<tr>
<td>16-08-05</td>
<td>Impact of air and surface disinfection on the risk of nosocomial infections in hospital</td>
<td>Infection</td>
</tr>
<tr>
<td>15-11-04</td>
<td>Cancer Diagnosis via Emergency Presentation Study (Empires) c.0</td>
<td>Cancer</td>
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<tr>
<td>15-08-06</td>
<td>MIBAIL</td>
<td>Dermatology</td>
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<tr>
<td>16-08-07</td>
<td>Head &amp; Neck 500 Follow up Study</td>
<td>Cancer</td>
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<tr>
<td>15-02-05</td>
<td>ORAMAD 50</td>
<td>Ophthalmology</td>
</tr>
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<td>15-11-25</td>
<td>NPSA</td>
<td>Surgery</td>
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<td>17-05-05</td>
<td>INSALLS</td>
<td>Cancer</td>
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<tr>
<td>16-06-05</td>
<td>CRISP set (testing and high risk type 2 diabetes cohort) - ADDRESS-2</td>
<td>Diabetes</td>
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<td>16-06-05</td>
<td>Cabapetan for Peptic Ulcer (CAP 2)</td>
<td>Reproductive Health and Childbirth</td>
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<td>15-09-04</td>
<td>MAID - IT (bOost)</td>
<td>Cardiology</td>
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<td>15-09-03</td>
<td>Tumour from Blood therapy (THABR)</td>
<td>Musculoskeletal disorders</td>
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<td>15-05-04</td>
<td>AMI 10</td>
<td>Haematology</td>
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<td>15-02-04</td>
<td>Anti-Kinin</td>
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<td>16-07-02</td>
<td>OUTPASS</td>
<td>Musculoskeletal disorders</td>
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<td>The Adult Autism Spectrum Clinics - LK</td>
<td>Mental Health</td>
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<td>Bridging the Age Gap in Breast Cancer</td>
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<td>12-03-04</td>
<td>PREDIVIS 2</td>
<td>Childrens</td>
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<td>12-03-01</td>
<td>FORUS</td>
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<td>16-01-03</td>
<td>BOSCO</td>
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<tr>
<td>13-08-01</td>
<td>PEEP Impact</td>
<td>Sexual Health</td>
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<td>16-11-05</td>
<td>SYMPAS</td>
<td>ENT</td>
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<td>16-11-06</td>
<td>High Intensity Specialist Led Acute Care (HISLAC) Project</td>
<td>Consultant Trust Wide</td>
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<td>17-02-01</td>
<td>TRAMANET</td>
<td>Diabetes/Children</td>
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<td>15-09-04</td>
<td>SIESTOP</td>
<td>Dermatology</td>
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<tr>
<td>16-11-07</td>
<td>Implementation, impact &amp; costs of policies for safe staffing (No C&amp;C but counts towards accrual)</td>
<td>Health Services and Delivery Research</td>
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<tr>
<td>17-04-04</td>
<td>SuM: Audiology and Hearing Audit survey</td>
<td>Audiology</td>
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<tr>
<td>17-02-05</td>
<td>PIAHAR</td>
<td>Orthopaedics</td>
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<tr>
<td>17-09-01</td>
<td>AHI - Ankle Injury Rehabilitation</td>
<td>Orthopaedics</td>
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<tr>
<td>18-05-05</td>
<td>Investigation of wellbeing interventions in NHS staff - delayed implementation</td>
<td>Trust Wide</td>
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<tr>
<td>17-05-04</td>
<td>National cohort study of late effects of Hodgkin's lymphoma treatments</td>
<td>Haematology</td>
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<tr>
<td>16-10-01</td>
<td>NCRI Study</td>
<td>Neurology</td>
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<tr>
<td>17-07-04</td>
<td>Yorkshire Cancer Research Board Cancer Improvement Program</td>
<td>Cancer</td>
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<tr>
<td>18-04-02</td>
<td>Ix SB0 TRAC Study (No C&amp;C but counts towards accrual)</td>
<td>Pharmacy</td>
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<tr>
<td>18-02-05</td>
<td>E4 Fast Track Paediatric Careprotein</td>
<td>Cancer</td>
</tr>
</tbody>
</table>

**In Follow Up**

| 06-08-05 | REACT | Cancer |
| 09-11-04 | ROSS | Gastroenterology |
| 16-09-03 | GIN/HIV | Diabetes |
| 11-09-04 | REVEAL | Cardiovascular |
| 15-08-06 | SYMPAS | Cardiovascular |
| 14-01-05 | THEMIS | Cardiovascular |
| 15-06-04 | uRAMONY | Diabetes |
| 15-08-06 | ARMSAT 2 | Haematology and Emergency |
| 17-07-02 | SYST | Neurology |

**Total:** 5

**Participant Identification Centre (PIC)**

| 06-06-03 | CAP | Cancer |
| 16-02-04 | Interpreting Clinical Practice for Babies with Hearing loss study | ENT |
| 15-04-13 | CODS | Neurology |
| 16-04-04 | The EroFEC TIP | Cardiology |
| 17-04-02 | Narratives of Health and Illness | Trust Wide |
| 08-04-03 | BICGDGS | Cancer |
| 14-11-05 | Impact of vascular conditions on quality of life | Cardiovascular |

**Non-Portfolio Studies**

**Open to Recruitment**

| 10-07-02 | Evaluating the age extension to the NHS breast screening programme | Cancer |
| 15-10-03 | Life after prostate cancer | Cancer |
| 15-10-09 | Grant COTE | Respiratory |
| 17-05-06 | Data linkage for urgent care data | Injuries and Emergencies |
| 17-05-09 | Together to learn. Pharmacy | Health Services and Delivery Research |
| 17-05-03 | Methods in knee Arthroplasty | Orthopaedics |
| 17-08-04 | Vitamin D and immune responses in haematopoietic stem cell transplant | Haematology |

**In Follow Up**

| 13-11-04 | Critical Care Follow-up of ASH patients post-recovery | Orthopaedics |

**Participant Identification Centre (PIC)**

| 17-02-02 | Interventional Processing in Patients | Neurology |
| 17-10-01 | Patients decision making for primary prevention cardiac device | Cardiovascular |

**Supporting Post Graduate Qualifications**

**Open to recruitment**

| 17-04-04 | Women with Gestational Diabetes | Health Services and Delivery Research |
| 17-09-04 | Measurement of Hypocapnia by Noninvasive Capnography | Endocrinology |
| 18-03-03 | Cardiac Rehabilitation Study | Cardiovascular |

**Sponsored by TRFT**

| 16-04-03 | Photographers | Haematology |
| 15-09-03 | Clear Environmental Pilot Study | Orthopaedics |
| 17-08-02 | Improving quality of life for patients and carers living with Intermittent Lung Disease | Respiratory |

**No C&C Studies**

| 16-04-13 | Clinical leaders’ views on the usefulness of patient surveys questions | Trust Wide |
| 17-02-04 | Hemoglobin monitoring in frail elderly patients | Geriatrics and Gerontology |
| 16-07-08 | Evaluating the ten year impact of the Productive World | Trust Wide |
| 17-05-02 | Viral Inflammation for Life and Emergencies Study | Inflammation and Emergency |
| 17-09-06 | ODF-FLR: Optimising restricted service provision for persistent babies (27-33 weeks) | Neonatology |
| 18-02-06 | Adolescent Control Screen Survey | HIV/AIDS, Infectious diseases and Immunology |
| 18-02-01 | Pharmacy professionally perceived of patient medication online | Pharmacy |
| 11-11-07 | National survey of patient experience leads | Trust Wide |

**Total:** 2

We also support 3c Cancer studies from Weston Park Hospital by providing tissue samples

---

*GRAND TOTAL 8*
Purpose of this paper:
This paper provides, for each key operational indicator, an overview of performance in April 2018, summarising headline progress and actions being taken to address ongoing issues.

Summary of Key Points:

Sustainability and Transformation Standards

- Emergency 4-hour access target – April 2018 position: 83.52% up from 83.1%. The submitted trajectory was 80%. The year to date position is 85.1%.

- The Rotherham Cancer 62 Day position for April 2018 is 82.8% against the 85% compliance target.

- Diagnostics (DMO1) – the un-validated position for DMO1 for April 2018 is 0.1% this reflects 3 breaches.

- 18 week RTT incomplete pathway – un-validated position for March 2018 is showing an improvement to 94.3%.
### Additional Operational Information

**Target**

<table>
<thead>
<tr>
<th>(click on a target to see a breakdown by Tumour Group)</th>
<th>APR 2018 Validation ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Operational standard (%)</td>
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<tr>
<td></td>
<td>Before reallocations</td>
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<tr>
<td></td>
<td>After reallocations</td>
</tr>
<tr>
<td>2ww</td>
<td>93</td>
</tr>
<tr>
<td>2ww Breast Symptoms</td>
<td>93</td>
</tr>
<tr>
<td>62 Day from GP</td>
<td>85</td>
</tr>
</tbody>
</table>

- Cancer referrals have increased over the previous 6 months, with key services under significant pressure.
  - Action plan has been shared with the cancer alliance
  - Deputy Chief Executive is leading on cancer recovery
  - Set-up of ‘war room’ approach to support recovery – escalations with services
  - Daily dashboard reports (longer term plan - live data including further metrics in Power BI software) see Appendix A. Targets and trajectories set for overall PTL size, >62 days, >38 days
  - Additional support to tracking team (bank staff, funding secured to support)
  - Clinical teams engaged within need for recovery
  - Additional breast and Gynae lists, typing, CT and MRI reporting
- The actions agreed with the cancer alliance and led by the Deputy CEO will deliver a return to the national performance by the end of June 2018

- Family Health has submitted an outline business case for £8 million to the Integrated Care System for reconfiguring Women’s Services and the development of an Alongside Midwifery Led Unit (AMLU).

- Referral to Treatment Time (RTT) Performance at the Rotherham Hospital NHS Foundation Trust (TRFT) has consistently been above the 92% standard but has seen a decrease in the last few months. This has now improved as per local plan.

- TRFT is positioned the 13th lowest risk of failing the standard in the country.

- The Trust has commenced a pilot to ring-fence 2 beds on the Stroke Unit allowing admission to the Unit within 4 hours. Present performance is at 33.3%.

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

1.1. This paper provides, for key operational indicators, an overview of performance in April 2018, summarising headline progress and actions being taken to address areas of concern and deliver continuous improvements.

2.0 Four-Hour Emergency Access Target

2.1. Performance for April 2018 against the 4-hour access target was 83.52%. This shows an improvement in month from the March 2018 position of 83.05%. The Quarter 1 position is at 85.5% (as at 16 May 2018).

2.2. The position has improved in April from the March position. The Trust has experienced very challenging operational delivery periods over the Bank Holidays and weekends. This has largely been due to the lack of doctors in the Emergency Department (ED) at “out of hours” periods.

2.3. The Trust has experienced normal levels of infection control issues over the past month.

2.4. The Trust has closed all the additional winter capacity in the last week of April but is planning to flex up for short periods of time community beds, if required, over the Bank Holidays rather than create additional beds within the acute facility.

2.5. The national programme regarding 111 has continued with on line booking, this has shown to have minimal effects on the Urgent and Emergency Care Centre (UECC).

2.6. The ED team is commencing an analysis of the “left without being seen” performance within the UECC.

3.0 Cancer

3.1. The Rotherham only 62-day cancer position for March-April 2018 is 82.8% yet to be finalised. This is slightly up from last month and above trajectory against the 85% compliance target and, as more breaches are apportioned, we expect this to come down nearer to the trajectory.
3.2. The current forecast position against the 62-day cancer pathway is that Quarter 1 will not achieve the 85% compliance target due to the recent deterioration in performance. Initial reviews are showing 75-80%.

3.3. Recovery is ongoing and will be delivered in quarter 2 July 2018. The over 38 days and 62 day numbers are on plan and reducing.

3.4. A request for funding was submitted on 12 April 2018 and confirmation of funding has been received. The following agreed support has been implemented.

- Increased support for cancer trackers (commenced)
- Additional MRI facility (starts week commencing 14 May 2018)
- Histopathology trackers (recruitment commenced)

4. **18 week RTT Incomplete**

4.1. The un-validated position for April 2018 is 94.3% against the 92% 18 week RTT incomplete target. This represents a continued strong operational performance against this performance metric.

4.2. Performance at TRFT has consistently been above the 92% standard but the Trust has seen a decrease in the last few months. This is in line with the national trend.

4.3. This puts TRFT as the 13th lowest risk of failing the standard in the country. Although performance at TRFT and the CCG has declined, national performance has also declined, meaning TRFT remains relatively low risk nationally.

4.4. Over 60% of Trusts are failing the standard nationally.
5. **6 Week Wait Diagnostic Tests**

5.1. The un-validated position for DMO1 for April 2018 is 0.1%, which shows 3 people waited 6 weeks or longer for diagnostic tests.

6. **Operational Improvement Planning**

6.1. The Trust has formally, with the AE Delivery Board, joined this year's “Action on AE” programme with an agreed focus on Home First “Why not today, why not now”.

6.2. On analysis of the ED performance and reviewing the breach analysis for all performances below 90%, it is clear that medical cover at key times is causing long waits within ED and the UECC.

6.3. The junior doctor rotas and the Emergency Nurse Practitioner and Advanced Nurse Practitioner cover are reliant upon training posts and agency posts. On average we are at least 1 post down or are reliant upon untried agency staff to cover these essential posts.

6.4. The de-escalation of additional capacity is delivering a reduction in demand for bank and agency staff as expected, with a reduction in demand for circa 70-80 additional shifts per week.

6.5. The key focus this month had been the planning for de-escalation of the additional capacity:

- The Trust has engaged The Remedium Agency to assist in a focused international recruitment plan.
  - We have had initial positive responses via this route.
  - Recruited a Histopathologist Consultant commencing September 2018.
  - We have undertaken 36 plus skype interviews for trained middle grade Doctors.
  - Shortlisted 20 candidates.
  - The Trust is sending a team of senior clinicians, 2 Consultants a Senior Manager and Medical Staffing HR Lead to India.
  - Initial plans are to fill all vacant middle grade rota gaps with up to 12 recruited staff

- A number of concerns about the ability of these staff to get visas have been raised and, although this is a known risk, we believe with the support from The Remedium Agency we are targeting staff who meet the exemption criteria.
  - Senior doctors above the financial threshold
  - Working across ED an exempted role

6.6. A further piece of work will be undertaken to review the number and use of acute beds to further free up nursing resources.
6.7. The Trust has commenced the improvement work around patient flow and improving discharge.

- Working with Pharmacy to put in place Technicians to support ward rounds and recruiting Pharmacists to support ward rounds transcribe medications.
- Physician Assistant roles on agreed wards to support ward rounds TTOs. and discharge letters, agreed ward round SOP.
- Golden patient pre-planning for discharge.
- Reinstate Red Green Amber Programme.

7. Conclusion

7.1. Performance against the 4-hour access standard in April 2018 remains lower than the 90% plan for September, but above trajectory. We have seen some improvement in performance over the last month, with key operational points of failure around capacity within the ED and doctor rota being non-compliant.

7.2. Performance against the DMO1 diagnostic target in month has remained good.

7.3. Performance against the cancer 62-day target has remained under the standard as a result of both activity demand and access across a number of pathways’ delays. Whilst remedial action is underway, the 85% compliance target for Quarter 1 will not be achieved.

7.4. Trust performance against the 18-week RTT incomplete target for the month continues to perform well with the March position being up from last month’s position of 93.4% to 94.3% against the 92% target.

7.5. Specific recruitment and ward capacity de-escalation plans are being implemented. The process for managing and utilising/closing additional beds has been well managed, resulting in all additional beds being emptied by 30 April 2018 with a plan to open additional Ackroyd beds, if required, for the Bank Holiday periods. Ward A3 was closed by the beginning of May 2018 which has had a positive effect on morale and ability to staff medical wards.

George Briggs
Chief Operating Officer
May 2018
Appendix A

Cancer Recovery Data
BOARD MEETING: 29 May 2018

Report: Workforce Report

Presented by: Cheryl Clements, Director of Workforce
Author(s): Debbie Holmshaw, Workforce Information Analyst
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:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring / responsive / well-led

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

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

Summary of Key Points:

- Staff in post in April 2018 is 3718.24 whole time equivalent (WTE), a reduction of 19.36 WTE compared to March 2018.
- Rolling 12 month sickness absence is 3.99%. Compared with April 2017 rolling 12 month sickness absence has decreased by 0.55%.
- In month sickness absence has decreased from 3.86% to 3.68% for April 2018, 0.27% below the 3.95% target. Compared with April 2017 in month sickness absence has decreased by 0.07%.
- Performance Development Reviews (PDR) tracking resets every April. Trust target for April 18 was for all Executive Directors and their Direct Reports to have had a PDR carried out. This target has been met.

Board action required: For Noting
1.0 Recruitment and Retention

1.1. Turnover in April 2018 is 0.56% (99.44% retention), a 0.14% increase compared to April 2017.

1.2. Corporate and Clinical Support Services Divisions have the highest turnover for April 2018.

2.0 Sickness Absence

2.1. The Trust’s sickness absence for April 2018 is 3.68%, which is below the 3.95% target and represents a decrease of 0.18% from the previous month (3.86%). Compared with April 2017 in month sickness absence has decreased by 0.07%

2.2. Short term absence has increased to 1.22% from previous month (1.18%) and long term sickness absence has decreased to 2.46% from previous month (2.68%).

2.3. Rolling 12 month sickness absence is 3.99%, an increase of 0.01% compared to March 2018. Compared with April 2017 rolling 12 month sickness absence has decreased by 0.55%.

3.0 Mandatory and Statutory Training (MaST)

3.1. The Trust core Mandatory and Statutory Training (MaST) compliance is 87%, 2% above the Trust target of 85%.

3.2. Information Governance MaST compliance has decreased to 94%, 1% below the national target of 95%.

3.3. Two new subject areas; Health, Safety and Welfare and Freedom to Speak Up – Raising a Concern have been introduced as of the 1st April 2018 for all staff, however these subjects will not be included in the main compliance table figures until next year. Compliance against these subjects will be monitored monthly by the Operational Workforce Group and relevant Subject Matter Expert (SME) to ensure compliance is reached by March 2019.

4.0 Personal Development Review (PDR)

4.1. The Trust target for PDR compliance was all Board members and their first line reports to Executive Directors to have had their review. This has been achieved so the compliance against target is 100% for April.

4.2. PDR reviewer and reviewee workshops are currently rolling out across the Trust and are available for bookings and bespoke sessions on request. These workshops support colleagues to prepare and contribute towards a quality PDR.

5.0 Leadership, Culture and Engagement

5.1. The dates for Leadership, Exploration and Discovery (LEAD) 2018/2019 have been scheduled, with 7 more cohorts commencing in June 2018 until February 2019.
5.2. The Trust submitted applications for funding for new Advanced Clinical Practitioner roles during 2018/2019. These posts are planned to be in general surgery, the care homes team, hospital at night, women’s health, acute medicine and the UECC. Feedback on the success of these applications is expected imminently.

5.3. The clinical apprenticeship recruitment is increasing significantly and we are hoping to appoint to a new cohort of Trainee Nursing Associate Apprentices (planned commencement June 18). We are also interviewing existing staff members to start an Assistant Practitioner Foundation Degree Apprenticeship (planned commencement September 2018). The training roles have clearly been identified to meet the Trust workforce development needs.

5.4. It has been confirmed that the Trust has secured 2 places for the Apprenticeship World Skills competition which will be held in Birmingham in June 2018.

6.0 **General Update**

6.1 Skills are at the centre of the government’s devolution agenda. Local leaders are seeking to develop their own economy by aligning the needs of high value local employers with the focus of their schools and further and higher education providers. To support this, the government is increasingly handing responsibility for prioritising, financing and directing many aspects of local skills provision to metro mayors, combined authorities and local enterprise partnerships (LEPs). The new University College build which is on plan to open in August is an exciting opportunity for Rotherham.

6.2 The Department of Education has launched a new careers strategy to better equip young people with the skills they need, and employers want, post-Brexit. Aims of the strategy include building a careers system that encourages earlier engagement between employers and the potential future workforce, and increasing the knowledge of education providers, and young people, about the different routes into employment. From January 2018, schools will also be required to give apprenticeship providers and other technical education providers more opportunities to talk to pupils about the courses and jobs they offer. This is an opportunity for employers to be active in these conversations to promote apprenticeships in the NHS and grow their workforce supply for the future.

6.3 NHSi have produced a framework tool which enables boards to carry out an organisational diagnostic against a key set of indicators, of which there are six areas: leadership, technology, information, method and governance, engagement and integration, and strategy. It also includes guidance on supporting evidence, policies and resources. It will be useful for boards, divisional teams, commissioners and stakeholders, workforce planning leads and also for staff who work in the five areas looking to improve workforce planning. The self-assessment will be discussed at Strategic Workforce Committee in September.

6.4 NHSi have developed a Freedom to Speak Up self-review tool. They want all trust boards in England to use the self-review tool to identify areas for development and improve the effectiveness of their leadership and governance arrangements in relation to Freedom to Speak Up. The self-review is being completed by the Trusts Freedom to Speak Up Guardian.
BOARD MEETING: 29 May 2018

Report: Finance Report

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

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

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

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

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

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

Summary of Key Points:

- The Trust is delivering ahead of plan for April. The Trust reported an overall deficit of £2,367k in April 2018 which is £70k favourable to the planned deficit
- The Trust is underspent against the capital programme in April. Capital expenditure for the first month of the new financial year amounts to £108K representing an under-spend of £7K against the in-month budget
- The Trust is ahead of its Cost Improvement Programme at the end of April.
- The Trust ended April 2018 with a cash balance of £1.43m compared to a planned level of £1.35m which is an £0.08m favourable variance
- At the end of April 2018 the Trust incurred agency costs of £935k inclusive of supporting the additional capacity. This monthly spend was £60k favourable to the internal budget yet £140k adverse to the NHSI ceiling.

Board action required:
For noting
1. **Key Financial Headlines**

1.1. The key financial metrics for the Trust are shown in the table below. These are;

- Performance against the monthly income and expenditure plan
- Performance against the internal agency spend and against the NHSI ceiling
- Cost Improvement Programme
- Capital
- Cash

<table>
<thead>
<tr>
<th></th>
<th>In Month Plan £ms</th>
<th>In Month Actual £ms</th>
<th>In Month Variance £ms</th>
</tr>
</thead>
<tbody>
<tr>
<td>I&amp;E Performance</td>
<td>(2.44)</td>
<td>(2.37)</td>
<td>0.07</td>
</tr>
<tr>
<td>TRFT Agency Spend</td>
<td>1.00</td>
<td>0.94</td>
<td>0.06</td>
</tr>
<tr>
<td>NHSI Agency Ceiling</td>
<td>0.80</td>
<td>0.94</td>
<td>(0.14)</td>
</tr>
<tr>
<td>CIP</td>
<td>0.35</td>
<td>0.40</td>
<td>0.05</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>0.12</td>
<td>0.11</td>
<td>0.01</td>
</tr>
<tr>
<td>Cash Balance</td>
<td>1.35</td>
<td>1.43</td>
<td>0.08</td>
</tr>
</tbody>
</table>

1.2. As at the end of 30 April 2018 (month1) the Trust is reporting favourable variances against all of the key metrics with the exception of the NHSI agency ceiling. The following sections provide further information against these financial metrics.

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

2.1. As the Board of Directors is aware, the Trust submitted its final operational and financial plan on the 30 April 2018. The financial plan/budget was also formally signed off by each Clinical Division and Corporate Directorate.

2.2. The financial plan for 2018/19 is to deliver a £20.3m deficit or better.

2.3. Month 1 performance is shown in the table below
2.4. The key points to highlight to the Board at the end of April are;

- An overall deficit of £2,367k which is £70k favourable to the planned deficit
- Clinical income in line with the budget, although there is a favourable position against day cases, offset with underperformance on elective activity.
- The overall pay bill is £44k better than plan, being driven by substantive vacancies off set by bank and agency.
- Non pay costs are showing an adverse position against budget predominately due to gas and electricity costs.

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

2.6. The first set of meetings with Divisional teams have focused on;

- Month 1 financial performance at a Divisional level both in terms of income and expenditure, but also clinical activity and income
- Clear actions required to improve performance and/or mitigate any potential future risks
- Escalation of any issues to the Executive Management Committee

3. Agency Expenditure

3.1. As was the case in 2016/17 and 2017/18 providers have received an agency target from NHSI for the new financial year. The target for 2018/19 is an annual spend of £8.8m which is a reduction of £1.4m from the £10.2m target in 2017/18.
3.2. Whilst the Trust will strive to meet the target, this ambition needs to be set in the context of 2017/18 costs being in excess of £11m. These costs were predominately driven by medical vacancies and the requirement to use agency staff. In light of the spend in 2017/18 the Trust has therefore set an internal budget for agency expenditure profiled across the financial year to reflect forecast costs.

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

3.4. At the end of April 2018 the Trust incurred costs of £935k inclusive of supporting the additional capacity. This monthly spend was £60k favourable to the internal budget yet £140k adverse to the NHSI ceiling.

3.5. Further actions implemented to support delivery against these targets include:
   - Agreement and monitoring of the key vacant posts – individual recruitment strategies
   - Working with external partners to secure permanent recruitment including from overseas
   - Expansion of the direct engagement model

Progress against these actions and the impact on the agency spend will be reported through the operational committees and assurance committees.

4. Cost Improvement Programme

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

4.2. The month end position is shown below and includes both cash releasing and efficiency schemes.

<table>
<thead>
<tr>
<th>Division</th>
<th>Plan £000s</th>
<th>Actual £000s</th>
<th>Var £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSS</td>
<td>12</td>
<td>9</td>
<td>(3)</td>
</tr>
<tr>
<td>Surgery</td>
<td>66</td>
<td>83</td>
<td>17</td>
</tr>
<tr>
<td>Family Health</td>
<td>26</td>
<td>31</td>
<td>5</td>
</tr>
<tr>
<td>Medicine</td>
<td>87</td>
<td>88</td>
<td>1</td>
</tr>
<tr>
<td>Corporate</td>
<td>157</td>
<td>184</td>
<td>27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>350</strong></td>
<td><strong>395</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>

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

4.4. At the time of writing the Trust has identified total opportunities in year of £12.8m, with a risk adjusted value of £8.5m. Internal resources have been prioritised to support the Divisions and Corporate Directorates to ensure by the June reporting cycle;
   - In year risk adjustment value in excess of £9.7m
   - Full year effect of schemes in excess of £13.1m
   - The schemes have been quality impact assessed in line with the new policy
4.5. The Director of Finance, Chief Operating Office and the Lead Non-Executive Director for the Model Hospital have also met with the regional lead for the NHSI Operational Productivity workstream (Model Hospital). Following this meeting the Trust has written to the Operational Productivity team to ask for further engagement across 3 categories;

- Estates Rationalisation
- Nursing & Midwifery workforce
- Speciality review

5. **Capital**

- Total capital expenditure plans have been produced in accordance with the maximum internally generated funds available to the Trust and in conjunction with appropriate colleagues throughout the Trust
- The Trust has a planned capital expenditure programme for 2018/19 of £5,800K
- Expenditure for the first month of the new financial year amounts to £108K representing an under-spend of £7K against the in-month budget
- Improved financial controls have been introduced during 2018/19 to support improved management of the capital programme, implications for the fixed asset register and subsequent impact upon revenue depreciation charges
- Work is presently underway to produce a longer-term view of capital requirements together with subsequent funding options that will be used to inform the Trust’s five-year financial planning outlook. This will be reported to the Board in line with the agreed timetable.

6. **Cash**

- The trust ended April 2018 with a bank balance of £1.43m compared to a planned level of £1.35m which is an £0.08m favourable variance
- All non NHS and NHS suppliers are paid within the payment terms approved by the Board of Directors (45 days)

Simon Sheppard  
Director of Finance  
May 2018
Report: Governance Report

Presented by: Anna Milanec, Director of Corporate Affairs/ Company Secretary
Author(s): As above

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

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

Risk Reference:
- BAF: B6 and B8
- Corporate Risk Register: none

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

Summary of Key Points:
- The Trust’s annual report and accounts 2017/18 have been submitted to NHS Improvement by the required deadlines (2.0);
- New self-review tools developed by NHSI (3.0);
- The Incident Decision Tree has been replaced by a new guide (4.0);
- Healthcare Safety Investigations Branch now to investigate all maternal, and specific natal deaths, from 1 April 2018 (5.0);
- Sharing of patient data between NHS Digital and the Home Office, now ceased (6.0);
- Five Year Forward View for Mental Health – and additional funding for South Yorkshire and Bassetlaw (7.0); and
- Judicial Review outcome (8.0)

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

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

2.0 Annual Report and Accounts 2017/18

2.1 The Trust’s annual report and accounts 2017/18 were due for submission to NHSI by noon on Tuesday 29 May 2018.

2.2 All documentation was submitted online by Friday 25 May 2018.

2.3 Once the process for laying the accounts at Parliament has been finalised, the Trust’s Annual Report and Accounts 2017/18 will be available to collect from the Annual Members’ Meeting to be held on 18 July 2018.

3.0 Self-Assessment and supportive tools issued by NHSI

3.1 NHSI has published further guidance, and a self-review tool, which supports Boards’ role with regard to their duties relating to Freedom to Speak Up. In supporting a more open culture that encourages staff to speak up about issues of patient care, quality or safety, the new guidance and tool also supports Trusts’ review around the eight key lines of enquiry set out in the well-led framework.

3.2 NHSI has also published a new operational workforce planning self-assessment resource tool for organisations to carry out assessments against six key indicators – leadership, technology, information, method and governance, engagement and integration, and strategy. The tool has been developed in conjunction with a number of Trusts in order to support robust workforce planning.

3.3 To support NHS providers implementing their pathology networks, NHSI have produced a suite of guides and templates which aim to support delivery of high quality, collaborative pathology services. The documents include:
   • Business Care Template
   • Due Diligence Guide
   • Operational Governance Guide
   • Consolidation Framework (project plan template)
   • Essential services laboratory design: blood services
   • Legal watchpoints guide
   • Clinical governance toolkit

3.4 Clearly, NHSI is seeking some consistency across the new pathology services structures, but the suite of documents provides helpful compliance guidance across the range of initiatives to be considered when setting up a new operational structure.

3.5 NHSI have also now published a statistical process control tool (SPC), which is an analytical technique that plots data over time. It allows the reader to understand whether changes that are being implemented, are resulting in improvement. Whilst the technique has been used in the NHS for some time, the new tool allows data to be automatically plotted onto an SPC chart, and indicates when a process may have changed by automatically applying SPC rules to the data.
4.0 Replacement of the Incident Decision Tree

4.1 The Incident Decision Tree (IDT), developed by the National Patient Safety Agency, has been replaced by ‘A just culture guide’. In any organisations where a blame culture is still prevalent, the guidance supports a conversation between managers about whether a staff member, involved in a patient safety incident, requires specific individual support or intervention to work safely.

4.2 The guidance can be used at any stage of a patient safety investigation, but should not be used routinely; the guidance is specifically for use when there are doubts as to whether a member of staff requires some management to enable them to continue to work safely.

4.3 The guide will be reviewed in light of any recommendations arising from the Professor Sir Norman Williams Review (into how healthcare professionals are adequately informed about where the line is drawn between gross negligent manslaughter and negligence, and what processes must be progressed before initiating a prosecution) which is due to report back at any time.

4.0 NHS Trust Development Authority (HSIB Additional Investigatory Functions in respect of Maternity Cases) Directions 2018.

4.1 It had been announced in November 2017 that the Healthcare Safety Investigations Branch (HSIB) would investigate all cases of early neonatal deaths, term intrapartum stillbirths and severe brain injury in babies in England, and all cases of maternal death in England. These directions came into effect on 30 April 2018 and cover HSIB’s additional functions and duties in carrying out maternity investigations.

5.0 Sharing of confidential information between the NHS Digital and the Home Office

5.1 In April 2018, the Commons’ Health and Social Care Committee raised serious concerns about NHS Digital’s ability to protect patient data, in its report into a Memorandum of Understanding on data-sharing between NHS Digital and the Home Office for the purpose of tracing immigration offenders.

5.2 Concerns expressed about the practices enshrined in the MoU included:

- incompatibility between the disclosure of information about people in contact with health services and the obligations of confidentiality assumed to apply to that information;
- the risk that sharing of patients’ addresses with other Government departments would become accepted as normal practice;
- the wider effect on public perception of the confidentiality of data supplied to the NHS; and
- the knowledge that information may be passed to immigration authorities could deter people from seeking treatment, resulting in detriment to the individuals concerned, hazard to public health, and greater cost to the NHS due to more expensive emergency treatment needing to be administered later.

5.3 This follows earlier direction to NHS Digital in January 2018 requesting that it suspends its involvement in the MOU, which was rejected. This led to the Chair and Chief Executive of NHS Digital being summoned to give further evidence to the Committee, leading to the Committee’s continued concerns and decision that NHS Digital should suspend its participation in the MOU.
5.4 On 9 May, it was reported that ministers had suspended, with immediate effect, the arrangements to share patient data with the Home Office in order that it could trace people breaking immigration rules.

6.0 Judicial Reviews

6.1 At the time of writing, one of the two judicial reviews against NHS England’s accountable care organisation (ACO) contract, had concluded, with a second, still taking place.

6.2 Campaign group ‘999 Call for the NHS’, brought a judicial review against NHS England, claiming that plans to introduce annual whole population annual budgets (WPAP) through the ACO contract, was unlawful. They claimed WPAPs impose budgetary control at the expense of not being demand led, e.g. the ACO does not know how many hip replacements it would have to fund from the fixed budget.

6.3 Judge Mr Justice Kerr, presiding at Leeds Crown Court, ruled that the court did not find anything unlawful, the payment mechanism proposed by the ACO contract.

Anna Milanec
Director of Corporate Affairs/ Company Secretary
May 2018
**Purpose of this paper**

The proposed risk descriptions of the BAF risks for 2018/19 were approved by the Board at its April 2018 meeting, save for one item:

*Powers of the Board are threatened by external partnership pressures to conform to majority decision making*

The purpose of the risk was to recognise that the regulatory / statutory framework is not yet fully in place to support integrated partnership decision making. This also aligns with the findings of the NHSP report into regulation, published in April 2018. This risk is intended to recognise the governance implications of this situation.

The risk descriptor has been reconsidered, and a revised wording has been proposed:

*Misaligned governance and decision-making may arise from divergent Trust, Place and ICS interests and objectives.*

**Key Points**

- The revised wording for risk descriptor B7 has been proposed;
- The revised wording has been presented to the Audit Committee, which took place on 23 May 2018;
- Audit Committee have recommended that the Board approve the revised wording with a minor addition, as highlighted in red text above.

**Action required:** For approval
Report: Terms of Reference: assurance committees

Presented by: Anna Milanec, Director of Corporate Affairs / Co Secretary
Author(s): As above

Strategic Objective: Governance: Trusted, open governance

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

Risk Reference:
BAF: B6
Corporate Risk Register: none

**Purpose of this paper:**
A standard template for three out of four board assurance committees (Quality Assurance Committee (QAC), Strategic Workforce Committee (SWC) and Finance and Performance Committee (FPC)) has been developed.

**Summary of Key Points:**
At the last meeting of the Board, it was agreed that the format of the Terms of Reference be approved, save for dates when papers should be sent out, and dates by which draft minutes would be available.

At the last Board Seminar, these matters were discussed, and details agreed in principle, which are now included in the document.

**Board action required:**
For approval

Anna Milanec
Director of Corporate Affairs/Company Secretary
May 2018
# Terms of Reference

## Committee Status

The xxxxxxxxxxxx ("the Committee") is a standing committee of the Board of Directors.

It is authorised to consider any matter within its terms of reference and to be provided with the Trust resources to do so.

It also has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion.

The Committee is empowered to obtain external professional advice and to invite external consultants with relevant experience to attend if necessary.

The Committee has no executive powers other than those set out in these Terms of Reference.

## Reporting to

The Committee is accountable to the Board of Directors.

In order for the Governors to fulfil their duty of holding the NEDs to account, the Committee Chair (or in their absence, the Vice Chair) will provide a quarterly report on the Committee’s activities to the Council of Governors.

The minutes of the Committee meetings shall be formally recorded and made available to all members of the Board of Directors once approved and signed by the Committee Chair.

Any issues relating to the Trust’s Provider Licence or CQC Registration will be reported to the Trust Chairman immediately.

## Purpose

The Board of Directors has approved the establishment of the Committee for the purpose of supporting the timely delivery of the Trust’s strategic objectives / Annual Operational Plan.

## Committee Membership

The Committee shall be appointed by the Board of Directors and shall consist of at least x members made, up as follows:

A Non-Executive Director who will chair the meeting. Two further Non-Executive Directors, one of whom will be Vice Chair and shall act in the absence of the Chair.

- **[Lead Executive Director]**
- **[Executive Director]**

## Quorum

A quorum shall be made up of three members comprising at least two
Non-Executive Directors and one Executive Director.

No decisions will be made by the Committee unless a quorum is present.

**Attendees**

The following colleagues are expected to attend for the duration of each meeting. If any of these named individuals are unavailable for a meeting, the [Lead Executive Director] will determine whether an alternative post holder should attend instead:

- [Post Holder (as may be required)]
- [Post Holder (as may be required)]
- [Post Holder (as may be required)]

Trust Executive Directors and/or other colleagues will attend as required by the Committee to provide an account of the performance of their area, or for the performance against specific areas of the strategy or plan, for which they have a responsibility.

The Company Secretary, or nominee, to ensure coordination of Board committees.

The Chairman may attend at the invitation of the Committee Chair.

The Chief Executive (or in their absence, the acting Chief Executive) holds an ex officio position on the Committee, but does not count towards the quorum.

Meetings are not open to members of the public.

Once confidentiality agreements have been signed (on an annual basis), two Governors from the Council of Governors (ordinarily, this will be the Lead Governor or their Deputy, and one other) may attend Committee meetings as observers.

The Governors’ role at the Committee is to observe the Non-Executive Directors seeking assurance against delivery of the Plan. In order to maintain the integrity of board governance, Governors may not participate unless specifically invited to do so, by the Chair, at their discretion.

However, the Chair reserves the right to hold all, or part of the meeting in private without Governors and / or other attendees (except the minute taker) if deemed appropriate.

**Those in attendance do not count towards the quorum.**

**Frequency of Meetings**

Meetings shall usually be held monthly, but may be held more or less frequently should circumstances require (which will be determined by the Committee Chair).

**Meeting administration**

Notice of meetings will be given at least 7 working days in advance unless members agree otherwise.
The agenda of each meeting shall be determined by the agreed Committee Annual Work Plan. Any agenda omission from the Committee’s Annual Work Plan, must be agreed between the Committee Chair and the Company Secretary. Any agenda addition – which has not arisen by a board action or similar - must be agreed between the Committee Chair and Executive Lead.

Items for inclusion on the agenda shall be submitted to the Committee Secretary at least 5 working days prior to the meeting.

The agenda and papers will normally be circulated 3 working days prior to the meeting to Committee members. (Papers which do not require up-to-date data, will be sent out 5 working days prior to the meeting.)

A copy of the agenda and papers will be provided to attending Governors on the day of the meeting, and will be returned to the Committee Secretary at the end of the meeting.

The Company Secretary, or their nominee, shall record the minutes of meetings.

The Company Secretary, or their nominee, shall record all points of action arising from the meeting.

Draft minutes and action logs will be sent to the [Executive Lead] for review by the 5th working day after the meeting. It is the responsibility of the [Executive Lead] to then send the draft minutes to the Committee Chair for review and comment. The minutes will be returned to the Committee Secretary in a timely manner to ensure that they are available prior to meeting papers being collated for the subsequent meeting.

Should the [Executive Lead] not be available to review the minutes within the designated deadline above, the [Executive Director] will carry out the review of the minutes and send them to the Committee Chair for review.

Once approved and signed off, Committee minutes will be available for all Trust Board Members.

A break of five minutes will be required for all meetings which exceed two hours in length.

**Committee’s Duties**

The duties of the Committee are set out as follows:

The principle purpose of the Committee is to support the timely delivery of the Trust’s strategic objectives / Annual Operational Plan.

The table below provides specifics of the matters that the Committee will consider.

The agreed Committee Annual Work Plan, will provide further guidance as to the issues to be overseen by the Committee.
In addition, the Committee will

- receive the +16 scored risks from the Risk Register relating specifically to the remit of the Committee, as determined by the [Executive Lead] in conjunction with the Trust’s Quality Governance Compliance and Risk Manager.

- receive the Board Assurance Framework risks delegated to the Committee for review, and to make recommendations to the Board for any required change of risk score or content.

- receive for information only (as these groups do not report to the Committee) the minutes from each of the following committees / groups:
  1. [as required and agreed between Chair and Lead Exec]
  2. [as required and agreed between Chair and Lead Exec]

Escalations may be raised to the Board. This will be done by inclusion of the item on the Escalations Tracker that is presented to Board on a monthly basis. Escalations will relate only to the business of the Committee and to risk to delivery of objectives and / or similar. Issues relating to committee administrative matters will be raised with the Company Secretary in the first instance.

| Monitoring and review | The Committee's Terms of Reference, including membership, will be subject to annual review. Proposed variations will require approval of the Board of Directors. The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board of Directors. |

(Grid with agreed objectives to appear here.)
BOARD MEETING: 29 May 2018

Agenda item: 203/18

Report: Annual Freedom to Speak up Guardian Report

Presented by: Cheryl Clements, Director of Workforce
Author(s): Sarah Cooper Freedom to Speak up Guardian Lead

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

Regulatory relevance: NHSI: Licence Condition FT4
CQC Domain: well-led

Risk Reference: BAF: B4
Corporate Risk Register: No risks on risk register

Purpose of this paper:

To provide the Board with an update of concerns which would be deemed whistleblowing, raised both to the Freedom to speak up Guardian and through other official routes and offer a comparison for TRFT against other local and similar sized organisations and to provide an update from the National Guardians office in terms of priorities for the organisation in 2018/19

Summary of Key Points:

The key points arising from the report are:

- The Trust Freedom to Speak Up: raising concerns (whistle blowing) policy has been reviewed and updated based on national templates with ratification through Trust Board in March 2018
- At the current time there are 12 Freedom to Speak up Guardians with representation from all divisions and now has representation for the Medical workforce through one of the Consultant Orthopaedic Surgeons
- Data for 2017/18 benchmarked against national data
- Themes from Freedom to Speak Up (FTSU) concerns raised to date and learning from those themes
- Highlights from case review process and actions for TRFT

Board action required:

For noting
1.0 Introduction

1.1 The Freedom to Speak Up Guardians (FTSU) implemented following the Francis Report (2015). The aim of Freedom to Speak Up Guardians is to help create a culture of openness within the NHS, where staff are encouraged to speak up, lessons are learnt and care improves as a result.

1.2 This paper provides a review of FTSU concerns raised within TRFT in 2017/18 and an update following the last report in October 2017. The report also details extracts of the data collated by the National Guardians office (NGO), including national and regional comparative data in order to contextualise the FTSU agenda within TRFT.

1.3 In the final section of the paper information is provided in regards to future intended audit actions in regards to FTSU information at TRFT related to the change in the CQC inspection assessment structure.

1.4 During 2017/18 there have been 2 case review reports published by the National Guardians Office, this report will also highlight the actions identified for TRFT.

2.0 Reporting and Governance

2.1 Following the audit report in October 2017 it was proposed that that FTSU escalation reports would be received by the Operational workforce committee as required and reports to the Quality Assurance Committee quarterly, this will be enacted within 2018/19.

2.2 A challenge for the FTSU within 2017/18 has been gaining assurance of an appropriate response to patient safety concerns in order for this to be met FTSU issues raised that give rise to a patient safety concern will be escalated to the patient safety group as. The FTSU lead is also attending the Joint partnership forum on a quarterly basis to provide updates on the role.

2.3 Details of the concerns raised themes and trends within 2017/18 are detailed within appendix 1.

2.4 The NGO are keen to ensure workers from all demographic groups are encouraged to speak up, in 2017/18 the majority of those raising concerns would be deemed White British, with 1 concern raised by a white non British colleague and one raised by an individual from another ethnic group. Of all concerns 88% were raised by women.

2.3 Individuals who have raised a concern are sent a questionnaire to gain feedback of their experience the results of which are detailed within Appendix 3. Responses from detailed 72% of individuals felt that they would raise a concern again, however this does lead to concern regarding the 28% of respondents who have reservations.

2.4 The NHS staff survey results related to Speaking up evidence a slight deterioration in all measures associated with raising a concern as detailed within appendix 3. The response to Q12a and Q13b relating to fairness and security in raising concerns, triangulates with the data from those raising a concern with FTSU and individuals expressing that they have suffered detriment.
3.0 National Guardians Office

3.1 The Trust has submitted data on a quarterly basis to the National Guardian’s Office (NGO). The key performance indicator for the organisation is that the NGO receive a data return each quarter which contains some data. The full year’s data will be available later in quarter 1 2018/19.

3.2 During 2017/18 the NGO have completed 2 case reviews these have highlighted a number of actions required for the 2 organisations reviewed. These reports have been reviewed and potential actions TRFT identified. The key action for consideration by the board is for it to articulate a vision of how it intends to support workers to speak up including strategy with deliverable objectives. Other actions include, visibility at Induction, training for managers regarding management of concerns and for colleagues in relation to raising a concern. visibility of FTSU across the Trust and promotion of the revised Trust Policy.

3.3 In May 2018 NHS improvement issued ‘Guidance for Boards on Speaking up In NHS Trusts and NHS Foundation Trusts’ which provides guidance for the responsibilities for executive colleagues in relation to Speaking up. This guidance also includes a self-assessment tool, it proposed that this will be completed by 31st May 2018, for submission to the Strategic Workforce Committee.

Sarah Cooper
Freedom to Speak up Guardian Lead

Cheryl Clements
Executive Director of Workforce
18 May 2018
### Appendix 1: Summary of FTSU Concerns for TRFT

#### Table 1: FTSU Concerns 2017/18

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of concerns</th>
<th>Nature of concern</th>
<th>Investigations completed</th>
<th>Detriment</th>
<th>Learning</th>
</tr>
</thead>
</table>
| 1       | 6                  | 2 Attitudes and Behaviours  
3 Policies and procedures  
1 Quality and safety  
1 Undisclosed | 0                         | 1                      | • Review of NIV policy NIV remains an issue being addressed through patient’s safety  
• Review of Trust Whistle Blowing policy  
• Escalation process for management of surges in capacity awaited |
| 2       | 4                  | 3 Quality and safety  
1 Policies and procedures | 1                         | 1                      | • Appropriate Investigation of patient safety issue instigated revision of Trust policy to include mitigation for detriment |
| 3       | 5                  | 4 Attitudes and Behaviours  
1 Quality and Safety | 1                         | 1                      | • Review of winter ward and processes  
• Door access enabled for all nursing colleagues |
| 4       | 2                  | 1 Quality and Safety  
1 Attitudes and behaviours | 0                         | 1                      | • • Review of winter ward and processes  
• Door access enabled for all nursing colleagues |
| Total   | 17                 |                                     | 2                         | 4                      |                                                                           |
Table 2: FTSU Concerns per Division

<table>
<thead>
<tr>
<th>Divisional Split</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>Integrated Medicine</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Family Health</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>Surgery</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Corporate</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>Undisclosed</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

Table 2 details the divisions that staff raising concerns and the division the concern related to. General medicine had the highest number of FTSU concerns raised, due to 2 of the concerns being related to more than one division N=19, with 17 concerns raised over the year.

Of the concerns raised to date, 1 has required some further action by the FTSU which has led to resolution and 1 has required further investigation. A significant proportion (52%) of cases have related to attitudes and behaviours, in the majority of cases this has involved discussion of options in terms of potential HR processes and support available with the FTSU, with no further action required.

Table 3: Nature of concerns Raised

<table>
<thead>
<tr>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude and Behaviours</td>
<td>6</td>
</tr>
<tr>
<td>Equipment and maintenance</td>
<td></td>
</tr>
<tr>
<td>Staffing levels</td>
<td></td>
</tr>
<tr>
<td>Policies, procedures and processes</td>
<td>4</td>
</tr>
<tr>
<td>Quality and safety</td>
<td>6</td>
</tr>
<tr>
<td>Patient experience</td>
<td></td>
</tr>
<tr>
<td>Performance capability</td>
<td></td>
</tr>
<tr>
<td>Service changes</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Undisclosed</td>
<td>1</td>
</tr>
<tr>
<td>Detriment</td>
<td>4</td>
</tr>
</tbody>
</table>

78
Appendix 2: Feedback following Raising a FTSU concern

A total of 20 questionnaires were sent in 2017/18 as largely questionnaires are sent 1 quarter behind. It has not been appropriate to send questionnaires to all those individuals who have raised a concern, in addition some individuals had left the organisation prior to a questionnaire being sent. The response rate for questionnaires has been variable as can be seen in table 4.

Table 4: Questionnaire Responses

<table>
<thead>
<tr>
<th></th>
<th>Concerns received</th>
<th>Questionnaires Sent</th>
<th>Questionnaires returned</th>
<th>% response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td>Q2</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>Q3</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>80</td>
</tr>
<tr>
<td>Q4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
</tbody>
</table>

The feedback received has been collated and can be seen in within figure 1, the key highlights from which are that only 43% felt that their issues had been resolved, 29% or respondents felt that they had suffered detriment, however as detailed previously in the majority of cases this was the reason for contacting FTSU.
**Fig 1: Feedback from Colleagues who have raised a concern through FTSU**

<table>
<thead>
<tr>
<th>Reporting Quarter</th>
<th>2017-18 Q1</th>
<th>2017-18 Q2</th>
<th>2017-18 Q3</th>
<th>2017-18 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 - How did you find out about the Freedom to Speak Up Guardians?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Word of mouth 22%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff interaction 14%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other 4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Column D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2 - How easy was it to make contact with the Guardian?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Very easy 86%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reasonably helpful 14%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3 - How did you find the response from the Guardian?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Very helpful 86%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reasonably helpful 14%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4 - Did you feel your concerns were taken seriously?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 68%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No 26%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q5 - Did you receive regular feedback from the Guardian?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 77%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No 12%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q6 - How do you feel your concerns were addressed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In part 42%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not sure 36%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 22%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q7 - Did you feel you were treated confidentially?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 88%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No 7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8 - Do you feel you have suffered any detriment as a result of our concern?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 72%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not sure 22%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No 7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q9 - Based on your experience of raising a concern, would you do it again?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 77%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No 12%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not sure 22%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 3: NHS staff survey results

<table>
<thead>
<tr>
<th>Question</th>
<th>Your Trust in 2017</th>
<th>Average (median) for combined acute and community trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q11a-% witnessing errors, near misses or incidents in the last month that could have hurt staff</td>
<td>13</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Q11b-% witnessing errors, near misses or incidents in the last month that could have hurt patients / service users</td>
<td>20</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>Q11c-If they witnessed an error, near miss or incident that could have hurt staff or patients / service users (YES to Q11a or YES to Q11b), % saying the last time this happened, either they or a colleague had reported it</td>
<td>92</td>
<td>95</td>
<td>94</td>
</tr>
<tr>
<td>Q12a-&quot;My organisation treats staff who are involved in an error, near miss or incident fairly&quot;</td>
<td>44</td>
<td>55</td>
<td>49</td>
</tr>
<tr>
<td>Q12b-&quot;My organisation encourages us to report errors, near misses or incidents</td>
<td>84</td>
<td>88</td>
<td>85</td>
</tr>
<tr>
<td>Q12c-&quot;When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again&quot;</td>
<td>65</td>
<td>69</td>
<td>68</td>
</tr>
<tr>
<td>Q12d-&quot;We are given feedback about changes made in response to reported errors, near misses and incidents&quot;</td>
<td>54</td>
<td>57</td>
<td>57</td>
</tr>
<tr>
<td>Q13a-% saying if they were concerned about unsafe clinical practice they would know how to report it</td>
<td>95</td>
<td>95</td>
<td>97</td>
</tr>
<tr>
<td>Q13b-&quot;I would feel secure raising concerns about unsafe clinical practice&quot;</td>
<td>66</td>
<td>70</td>
<td>68</td>
</tr>
<tr>
<td>Q13c-&quot;I am confident that the organisation would address my concern&quot;</td>
<td>52</td>
<td>58</td>
<td>56</td>
</tr>
</tbody>
</table>
Report: Guardian of Safe Working Hours Report

Presented by: Dr Conrad Wareham, Medical Director
Author(s): Dr Gerry Lynch, Guardian of Safe Working Hours

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance

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

Risk Reference:
BAF: B1, B2
Corporate Risk Register: No risks on Risk Register

Purpose of this paper:
The Guardian of Safe Working is required to report to the Board on a quarterly basis that working in the trust is safe for Junior Doctors and patients; or, where this is not the case, that measures are taken to address this, with the Board’s help if necessary.

Summary of Key Points:
- This paper represents the winter quarter and is therefore, particularly busy in terms of activity and workload for junior doctors.
- The number of Exception Reports is similar in this quarter to the previous one.
- The actual number of reports and additional hours represented is quite small in comparison to the number of junior doctors working.
- The narrative comments about how the doctors who have submitted reports feel at the end of their shifts is a concern and is the focus of efforts for improvement going forward.

Board action required:
For noting.
1. Introduction

1.1 The Junior Doctor Contract 2016 has been in force in TRFT since 7 Dec 2016 and all junior doctors not on run-through training at the time of introduction are now on the contract. Excess hours and educational issues which breach the trainees’ personalised work schedule are dealt with by exception reporting. Breaches to 48 hour average, missed breaks > 25%, and 72 hour total working week attract Guardian fines.

2. Exception report update

2.1 The number of exception reports is similar at 64 compared to 63 in the last quarter (as of 12 April 18).

3. Exception Report details (with regard to working hours)

3.1 Twenty-two doctors including 12 Foundation Year 1 doctors (F1), eight Core Trainees (CT) and one Specialist Registrar (SpR) have submitted 57 exception reports related to hours and rest in the last quarter. There were also six exceptions related to training and education and seven related to both. 50 hours of additional payment were approved and no time off in lieu.

<table>
<thead>
<tr>
<th>Specialty by Supervisor</th>
<th>No. exceptions raised (Hours/Hours plus education)</th>
<th>Number of Hours/quarter</th>
<th>No. exceptions closed</th>
<th>No. exceptions outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine (total)</td>
<td>50</td>
<td>66.05</td>
<td>31</td>
<td>19</td>
</tr>
<tr>
<td>Diabetes</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Respiratory</td>
<td>6</td>
<td>4.8</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Care of Elderly</td>
<td>34</td>
<td>46.75</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>Stroke medicine</td>
<td>4</td>
<td>8.5</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Surgery</td>
<td>8</td>
<td>9.75</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Urology</td>
<td>3</td>
<td>3.5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3</td>
<td>6.75</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>64</td>
<td>86.05</td>
<td>39</td>
<td>25</td>
</tr>
</tbody>
</table>

4. Work Schedule Reviews

4.1 Work schedule reviews are mandated by Terms and Conditions of Service when exceptions within a post are persistent.

4.2 No work schedule reviews have been carried out this quarter.
5. **Fines**

5.1 No fines have been imposed this quarter for exceeding 48 hours average or 72 hours total weekly hours.

6. **Qualitative Information**

6.1 Rota gaps and unfilled shifts combined with the extended winter pressures continue to pose concerns as evidenced by the qualitative information contained in the exception reports. A Datix form has been completed in addition to the Exception Report by one doctor who was concerned about the safety of the workload they had.

6.2 Examples of commentary provided by junior doctors, redacted for anonymity, are presented below. It should be noted that exception reports of their nature reflect the perception of the doctor at the time and may not present a balanced view of actions taken to ameliorate the situation.

- understaffed Medical On-call team
- vacant SHO slot
- no apparent attempts to get a locum or transfer other staff were evident on the rota and nothing was arranged during the day
- despite take team having only one SHO and SpR, we were asked by management to spare the only on-call SHO to go to cover xx (As they only had 1 SHO and 1 consultant for their normal ward cover)
- significant number of jobs handed over by xx team to the only take SHO which meant effectively only the SpR was clerking (as well as reviewing sick ward patients) from 1600 – 2000
- resulted in 16 patients handed over to night team and significant delays in new patients been seen - delayed antibiotics, fluids and other treatments as a direct consequence
- no consultant for the whole week as Dr x was off sick and also handed in his notice that he will resign on Friday
- SpR left earlier than us for an important meeting and we still had few patients not yet seen for the day at 6 pm that us SHOs needed to see
- lots of jobs left to do
- it’s been a tough week
- again only doctor rostered for xx on the ward
- checked rota less than a week earlier and their was someone on with me but then came to work to find out that I was yet again alone on one of the busiest wards on the hospitals
- again I wasn’t able to have a break
- had a quick 5 min eat of my lunch as I was concerned jobs wouldn’t get done
- the workload meant that I was just doing job after job not learning anything
- feeling stressed and unable to take time away from the ward as I was concerned for patient safety
- also had outliers which meant these had jobs to be done too

7. **Actions taken to resolve issues**

7.1 Junior doctors’ forum has met regularly.
7.2 Regular informal junior doctors’ feedback sessions with Medical Workforce feed into the above and are a useful way to raise issues. They are appreciated by the trainees and issues raised are fed back to relevant groups. The challenges caused by vacant rota slots are considerable.

7.3 Most Exception Reports are dealt with in a timely manner by the educational supervisors, although they have been somewhat slower of late.

7.4 The Guardian of Safe Working has been meeting regularly with the Medical Director to feedback on performance between the quarterly Board reports.

7.5 It is intended that future reports will include the outcome of investigation of the issues raised by junior doctors in the Exception reports.

7.6 The Trust has invested in a very comprehensive recruitment effort abroad which will hopefully succeed in employing additional medical staff to fill gaps in A/E and AMU.

8. Conclusion

8.1 Contractually working hours are within safe limits but intensity and workload due to vacancies in medical specialties are unresolved and remain concerning.

Dr Gerry Lynch
GSW TRFT.
Report: Progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Presented by: Chris Morley, Chief Nurse
Author(s): Daksha Patel, Divisional Director, Family Health

Strategic Objective:
- Patients: Excellence in healthcare
- Colleagues: Engaged, accountable colleagues
- Governance: Trusted, open governance

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

Risk Reference:
- BAF: B1
- Corporate Risk Register: No risks on risk register

Purpose of this paper:
This paper is to provide the Board of Directors with the final self-assessment against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions. The CNST scheme require the Board of Directors to approve the self-certification process.

Summary of Key Points:
- The report is designed to assist the DoH's ambition to halve the number of still births, deaths and brain injuries that occur during or soon after birth, by 2025.
- This report introduced a scheme to incentivise implementation of good practice across all maternity units.
- Those Trusts who can demonstrate compliance with the 10 criteria, will be entitled to at least a 10% (£210k) reduction in their CNST maternity contribution
- This report lists the evidence that is to be provided, there is a separate set of appendices which details this evidence to be submitted to NHS Resolution (NHSR).
- Information about the Trust’s progress with the Saving Babies’ Lives Care Bundle is included for information and to provide additional evidence (Appendix 1)
- The detailed evidence has been reviewed against the criteria provided by NHSR by the Chief Nurse and the Divisional Director for Family Health

Board action required:
For approval.
Saving Babies’ Lives: A care bundle for reducing stillbirth

Introduction

What is the Saving Babies’ Lives Care Bundle?

Saving Babies’ Lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

It is part of an initiative to achieve the national ambition to halve the rates of stillbirths by 2030, with a 20% reduction by 2020, bringing the UK in line with other well performing nations (Iceland/Finland).

The evidence from the confidential enquiry into term antepartum stillbirths and the Royal College of Obstetricians and Gynaecologists (RCOG) ‘each baby Counts’ initiative indicate that focused intervention in the detection of a compromised fetus would be the most effective method to achieve this aim.

Compliance to the four elements of this bundle also forms one of the ten criteria for the discretionary rebate of the CNST maternity contribution (up to 10%).

The Compliance of the Rotherham Maternity Service against the Saving Babies’ Lives Care Bundle:

The service can demonstrate the full adoption and ongoing compliance with the following:

Element 1: Reducing smoking in pregnancy
Compliant

Element 2: Risk assessment and surveillance for fetal growth restriction

Currently unable to achieve full provision of systematic ultrasound scanning for all at ‘risk pregnancies’ from 36 weeks gestation until the time of birth. Only those fetuses identified as compromised have full screening till delivery. Those fetuses growing normally cannot be screened beyond 36 weeks and therefore we are unable to detect failing growth beyond this point. The current capacity for scanning is insufficient for the local demand due to insufficient accredited obstetric ultra-sonographers.

Mitigations in place:

1. A business case has been prepared for submission to the Trust’s Business Investment Committee to recruit an additional ultra-sonographer.
2. The service has undertaken extensive national Growth Assessment Protocol (GAP) training
3. The service utilises the national GROW software to plot a customized growth chart for all pregnant women showing the expected trajectory of their babies’ growth
4. Continued vigilance through symphysis fundal height measurement and fetal movement monitoring until delivery

Element 3: *Raising awareness of reduced fetal movement*

Element 4: *Effective fetal monitoring during labour.*

**Partial compliance**

**Compliant**
Board report on The Rotherham NHS Foundation Trust’s progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

The Department of Health’s report, 'Safer Maternity Care: The National Maternity Safety Strategy - Progress and Next Steps', was published on 28 November 2017. The report is designed to further implement and accelerate change that will assist the DoH’s ambition to halve the number of still births, deaths and brain injuries that occur during or soon after birth, by the earlier date of 2025.

This report introduced a scheme to incentivise implementation of good practice across all maternity units. Those Trusts who can demonstrate compliance with the 10 criteria, agreed by National Maternity Champions, will be entitled to at least a 10% reduction in their CNST maternity contribution. Compliance will be assessed through a verification system in June 2018 and NHSR will confirm any discounts.

The 10 criteria are as follows:

1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths? (Y/N)
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? (Y/N)
3. Can you demonstrate that you have transitional care facilities in place and operational to support the implementation of the ATAIN Programme? (Y/N)
4. Can you demonstrate an effective system of medical workforce planning? (Y/N)
5. Can you demonstrate an effective system of midwifery workforce planning? (Y/N)
6. Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives care bundle? (Y/N)
7. Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback? (Y/N)
8. Can you evidence that 90% of each maternity unit staff group have attended an ‘in-house’ multi-professional maternity emergencies training session within the last training year? (Y/N)
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues? (Y/N)
10. Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution’s Early Notification scheme?
SECTION A: Evidence of Trust’s progress against 10 safety actions:

Please note that trusts with multiple sites will need to provide evidence of each individual site’s performance against the required standard.

<table>
<thead>
<tr>
<th>Safety action – please see the guidance for the detail required for each action</th>
<th>Evidence of Trust's progress</th>
<th>Action met? (Y/N)</th>
</tr>
</thead>
</table>
| 1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths? | 1.1 Email Chain Evidence of Authorisation of Perinatal Tool.  
1.2 MBBRACE-UK Screenshot  
1.3 Four example discussions following use of Perinatal tool.  
1.4 Minutes of Perinatal Audit Meeting  
1.5 Rapid Review Flowchart  
*NHS Resolution will also use data from MBRRACE to verify the Trust’s progress against this action.* | Yes |
| 2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | 2.1 MSDS Submission  
2.2 Email Confirmation that latest submission contained at least 80% of HES births expectation  
*NHS Resolution will also use data from NHS Digital to verify the Trust’s progress against this action.* | Yes |
| 3). Can you demonstrate that you have transitional care facilities that are in place | 3.1 Guideline for Transitional Care | Yes |
and operational to support the implementation of the ATAIN Programme?

3.2 Risk Assessment - Interim Arrangements Transitional Care Patients

*NHS Resolution will cross-check trusts’ self-reporting with Neonatal Operational Delivery Networks to verify the Trust’s progress against this action.*

<table>
<thead>
<tr>
<th>4). Can you demonstrate an effective system of medical workforce planning?</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 CNST Workforce Data Collection Tool Reporting</td>
</tr>
<tr>
<td>4.2 Royal College Workforce Maternity Tool Usage</td>
</tr>
<tr>
<td>4.3 Guideline for Obstetrics Staffing Levels</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5). Can you demonstrate an effective system of midwifery workforce planning?</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Rotherham Final BR+ Report_31 07 17</td>
</tr>
<tr>
<td>5.2 Birthrate + Staffing Paper Nov 17</td>
</tr>
<tr>
<td>5.3 &amp; 5.4.1 Family Health Establishment Review</td>
</tr>
<tr>
<td>5.4 Staffing report for February</td>
</tr>
<tr>
<td>5.5.1 March 2018 Directorate of Family Health</td>
</tr>
<tr>
<td>5.6 Safe Staffing Escalation Policy</td>
</tr>
<tr>
<td>5.7 Paediatric Staffing Report</td>
</tr>
<tr>
<td>5.7.1 CRG 13 Rotherham March 18</td>
</tr>
<tr>
<td>5.8 Safe Staffing Records – TRFT (Link)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6). Can you demonstrate compliance with all 4 elements of the Saving Babies’ Lives (SBL) care bundle?</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Action Plan + Evidence Case (Stillbirth Care Bundle)</td>
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<tr>
<td>6.2: Briefing paper and presentation to the Trust Board.</td>
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| 7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback? | 7.1 The 15 Steps Challenge for Maternity DRAFT  
7.1.1 RFM poster developed with MVP  
7.2 (and 7.2.1) Rotherham MVP Minutes and Terms of Reference  
7.3 Rotherham Maternity Led Unit Survey Result  
7.4 Maternity Survey Action log  
7.4.1 SOP Partners on Ward | Yes |
|---|---|---|
| 8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year? | 8.0 CNST Training Records April 17 – March 18  
8.1 CNST Training Agendas April 17 – March 18  
8.2 Signatures of Training Attendees  
8.3 Teaching Plans  
8.4 Staff MaST Compliance Records  
8.5 New Starter Forum Minutes, and Feedback on New Starter Forums. | Yes |
| 9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues? | 9.1 Terms of Reference for Safety Champion Meetings  
9.2 Action Log for Safety Champion Meetings  
9.3 Maternity Safety Meetings Action Log (16/04/18) | Yes |
| 10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme? | 10.1 Email Chain Confirming qualifying 2017/18  
10.2 Confirmation by NHSR to TRFT of EN Incident (Nov, 17)  
10.3 Confirmation by NHSR to TRFT of EN Incident (Jan, 18) | Yes  
*NHS Resolution will also use data from the National Neonatal Research Database to verify the Trust's progress against this action.* |
SECTION B: Further action required:

If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.
SECTION C: Sign-off

For and on behalf of the Board of The Rotherham Foundation Trust confirming that:

- The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.
- The content of this report has been shared with the commissioner(s) of the Trust’s maternity services.
- If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B.

Position: ............................
Date: ...............................  

We expect trust Boards to self-certify the Trust’s declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm’s length body/NHS System leader.

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