# Board of Directors

**Public AGENDA (held in public)**

**Date:** Tuesday 25 September 2018  
**Time:** 0830hrs – 1100hrs  
**Venue:** Boardroom, Level D, Rotherham Hospital

<table>
<thead>
<tr>
<th>Time</th>
<th>Item no.</th>
<th>Required Actions</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>0830</td>
<td>344/18</td>
<td>Verbal -</td>
<td>Martin Havenhand, Chairman</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For noting</td>
<td></td>
</tr>
<tr>
<td>0835</td>
<td>346/18</td>
<td>Verbal -</td>
<td>Chris Holt, Deputy Chief Executive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For noting</td>
<td></td>
</tr>
<tr>
<td>0850</td>
<td>347/18</td>
<td>Verbal -</td>
<td>Chris Morley, Chief Nurse</td>
</tr>
<tr>
<td>0855</td>
<td>348/18</td>
<td>Enc. 3</td>
<td>Martin Havenhand, Chairman</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For approval</td>
<td></td>
</tr>
<tr>
<td>0855</td>
<td>349/18</td>
<td>Verbal -</td>
<td>Martin Havenhand, Chairman</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For noting</td>
<td></td>
</tr>
<tr>
<td>0855</td>
<td>350/18</td>
<td>Enc. 13</td>
<td>Martin Havenhand, Chairman</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For approval</td>
<td></td>
</tr>
<tr>
<td>0910</td>
<td>351/18</td>
<td>Enc. 16</td>
<td>Martin Havenhand, Chairman</td>
</tr>
<tr>
<td>0925</td>
<td>353/18</td>
<td>Enc. 24</td>
<td>Louise Barnett, Chief Executive</td>
</tr>
<tr>
<td>0925</td>
<td>353/18 (a)</td>
<td>Enc. 29</td>
<td>Chris Morley, Chief Nurse</td>
</tr>
<tr>
<td>0925</td>
<td>353/18 (b)</td>
<td>Enc. 36</td>
<td>Callum Gardner, Interim Medical Director</td>
</tr>
<tr>
<td>0925</td>
<td>353/18 (c)</td>
<td>Enc. 42</td>
<td>George Briggs, Chief Operating Officer</td>
</tr>
<tr>
<td>0925</td>
<td>353/18 (d)</td>
<td>Enc. 48</td>
<td>Paul Ferrie, Interim Director of Workforce</td>
</tr>
<tr>
<td>Meeting No.</td>
<td>Document No.</td>
<td>Title</td>
<td>Enclosure</td>
</tr>
<tr>
<td>------------</td>
<td>--------------</td>
<td>-------</td>
<td>-----------</td>
</tr>
<tr>
<td>353/18 (e)</td>
<td>Finance Report</td>
<td>Enc.</td>
<td>53</td>
</tr>
<tr>
<td>354/18</td>
<td>Data Quality Report</td>
<td>Enc.</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td><strong>Assurance Framework</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1025</td>
<td>355/18</td>
<td>Governance Report</td>
<td>Enc.</td>
</tr>
<tr>
<td>356/18</td>
<td>Board Assurance Framework: B4 Risk Identity</td>
<td>Enc.</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td><strong>Regulatory and Statutory Reporting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1035</td>
<td>357/18</td>
<td>“How we learn from deaths” Report</td>
<td>Enc.</td>
</tr>
<tr>
<td></td>
<td><strong>Board Governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1040</td>
<td>358/18</td>
<td>Trust Constitution – reviewed and revised</td>
<td>Enc.</td>
</tr>
<tr>
<td>359/18</td>
<td>Any other business</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1100</td>
<td>360/18</td>
<td>Date of next meeting: <strong>Tuesday 30 October 2018</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

*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 28 AUGUST 2018 IN THE BOARDROOM, LEVEL D

Present:  
Mr M Havenhand, Chairman  
Mrs G Atmarow, Non-Executive Director  
Mr J Barnes, Non-Executive Director  
Mr G Briggs, Chief Operating Officer  
Mr P Ferrie, Interim Director of Workforce  
Ms L Hagger, Non-Executive Director  
Dr D Hannah, Non-Executive Director  
Mr C Holt, Acting Chief Executive/Director of Strategy and Transformation  
Dr C Kelly, Acting Medical Director  
Mr B Mellor, Non-Executive Director  
Mr C Morley, Chief Nurse  
Mr S Sheppard, Director of Finance

Apologies:  
Mrs L Barnett, Chief Executive  
Mrs C Clements, Director of Workforce  
Dr C Wareham, Medical Director  
Mrs H Craven, Non-Executive Director  
Mr M Edgell, Non-Executive Director

In attendance:  
Dr A Cooper, Interim Responsible Officer (minute 317/18 only)  
Ms A Milanec, Director of Corporate Affairs / Company Secretary  
Miss V Johns, Committees Secretary & Office Manager (minutes)

Observers:  
Governors x 1  
Members of the Public x 1  
Colleagues x 0

305/18 CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE

The Chairman welcomed those present to the meeting with apologies having been received and noted.

Mr Ferrie as Interim Director of Workforce, and Dr Kelly as Acting Medical Director, were particularly welcomed to the meeting.

QUALITY AND SAFETY

306/18 PATIENT STORY

The Board of Directors received the patient story presented by the Chief Nurse relating to a patient with an Implantable Cardioverter Defibrillator (ICD) which constantly monitors heart rhythm. When it detects a very fast, abnormal heart rhythm, it delivers energy to the heart muscle. The patient contacted the hospital from home feeling unwell, and as the download from their home
monitor showed Ventricular Tachycardia (VT), the patient was brought to the UECC by ambulance and treated by the Cardiac Device Team.

Once their heart was back in normal rhythm, they would normally have been discharged without further treatment, but based on the home monitoring data that was transferred to the Northern General Hospital, the patient is now awaiting VT ablation.

PROCEDURAL ITEMS

307/18 DECLARATIONS OF CONFLICTS OF INTERESTS

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

308/18 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 31 July 2018 were agreed as a correct record and were approved.

309/18 MATTERS ARISING FROM THE PREVIOUS MEETING

Ms Milanec raised an issue from the previous meeting held on 31 July 2018 regarding minute 280/18 and section 11.3 of the Health and Safety Report (Grenfell Tower). Ms Milanec clarified that NHSI guidance had initially been for local fire services to visit Trusts where a particular type of cladding on buildings had been identified. However, this guidance was then withdrawn and it had been a Senior NHSI Fire Inspector that had visited the Trust and had carried out the required checks at the Trust.

Mr Barnes raised an issue from the previous meeting held on 31 July 2018 regarding minute 275/18(a) and learning from complaints. He advised that through the Audit Committee, a report would be presented at a later time as to whether the Auditors and Executives were assured by the processes in place.

Ms Hagger raised an issue from the previous meeting held on 31 July 2018 regarding minute 275/18(a) and the establishment of a Clinical Ethics Committee. A report to be provided to a future Board meeting on the current position.

ACTION: Medical Director

310/18 ACTION LOG

The Board of Directors considered and discussed the Board Action Log, with a number of actions agreed to be formally closed and some which would continue to be monitored.
311/18 REPORT FROM THE CHAIRMAN

There was no written report, but the Chairman raised his concern about the issue of A&E and cancer performance, which were to be covered later on the agenda.

312/18 REPORT FROM THE CHIEF EXECUTIVE

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

With regard to A&E, the Acting Chief Executive added that The Trust’s performance against the A&E four-hour access standard had faced significant challenges recently. The Trust was, until recently, performing well against peers but this had declined due to two main issues; staffing challenges in UECC with lower than usual availability of locums and bank/agency staffing over the summer period, and also the high number of long-stay patients in the Trust.

The Trust continues to work with partners across the South Yorkshire and Bassetlaw (SY&B) Integrated Care System (ICS), and the Rotherham Place. Mr Holt advised that the Hospital Services Review Strategic Oversight Case would be brought to the next meeting, with that being a focus over the coming month.

It was noted that the Trust had been accredited as an Allocate Academy Organisation – the first in England. This had been due to the work and training undertaken by the HR Systems and Compliance Team with regard to e-rostering. The Interim Director of Workforce advised that the new system had definitely had a positive impact on workforce allocations, although he acknowledged that a human element was also involved.

Mr Barnes queried which of the sections of the workforce were not covered by e-rostering, with Mr Ferrie confirming that MedicOnline was due to be functional - with job plans currently being uploaded - by the end of September 2018. However, it was noted that it would take until the end of this financial year for the system to be fully functional.

It was agreed that a report be presented to Board (through Strategic Workforce Committee first) highlighting the outcomes and impact of implementation of e-rostering, and any lessons learned. ACTION: Interim Director of Workforce

With regard to sections 4.4 and 4.5 on the NHS 10 Year Plan in this report, Mr Sheppard highlighted that formal guidance should be issued in early October 2018 relating to sustainability funding rules and control totals. He mentioned that this would be discussed in the Finance and Performance Committee, with a report coming to Board later. 

ACTION: Director of Finance

The report from the Chief Executive was noted.
313/18 BUSINESS PLANNING CYCLE

The Board of Directors received and noted the report from the Acting Chief Executive regarding the annual business planning cycle, along with key timeframes to complete each stage and to clarify the terminology used.

It was agreed that there would be a presentation on the refreshed five-year strategy at the Board of Directors meeting in September.

**ACTION: Deputy Chief Executive**

Mr Holt confirmed that he was confident of complying with timeframes, with robust frameworks in place for divisions and stakeholders to provide input.

Mr Mellor enquired whether the five-year strategy had only four more years to run, and whether the Trust was simply rolling forward a year? Mr Holt advised that there was no end point to the strategy; the only ‘deadlines’ that had been put in place to date had been the two, one-year operational plans.

The Chairman emphasised that the Trust was carrying out a refresh of the strategy, and not reviewing the strategy in detail at this time.

Mr Barnes advised that this has been discussed at the Finance & Performance Committee (FPC) and that it would be helpful for the divisions to attend the February 2019 FPC meeting with their plans. **ACTION: Director of Finance**

Dr Hannah asked for clarity on the number of clinical services which had been previously reviewed, with Mr Holt confirming the ‘long list’ had been circa 43 services in total. Mr Holt advised that the Trust was reviewing the services with a three tier approach being made up of those services which were system-wide, about 8-10 services which appeared in other forums (such as those linked to ‘Right Care’, or our own Service Line Management systems), and about 25-30 services being reviewed at only a high level.

The Board noted the Chief Executive’s report.

OPERATIONAL PERFORMANCE

314/18 INTEGRATED PERFORMANCE REPORT

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

The Board of Directors noted the Integrated Performance Report, with detailed information on a number of matters contained within the subsequent reports. Mr Holt concluded that the Trust is well on track with most areas and we are working particularly hard on achieving the 62-day performance cancer standard.
314/18(a) QUALITY REPORT

The Board of Directors received the Quality Report, presented by the Chief Nurse. The report aimed to summarise the quality indicators and provide assurance as well as complementing the information presented in the Integrated Performance Report (IPR).

Mr Morley advised that the number (49) of new nurses expected to join the Trust in September was very positive, with a few more due to qualify and start in March 2019. The Trust was known as an attractive place to work, and has a good reputation as being very supportive of new nurses.

It was noted that there had been a further increase in the completion of Initial Health Assessments (IHA) for Looked After Children (LAC) within 20 days. However, 13 of these appointments had not gone ahead for a number of reasons, personal to those due to attend. It was acknowledged that this would have a detrimental effect on future performance against the 20-day target. RMBC colleagues were aware of the issue and were supporting the children and adolescents who had missed their appointments.

The Chairman enquired of the Chief Nurse whether there was anything that the Trust could be doing to be more pro-active to address the issue and support those affected.

Dr Hannah suggested that it was an issue which may require looking at differently by all partners by considering what is best for those using the service, rather than trying to fit them into the existing system and structure. He suggested that those who missed their appointments might become lost in the ‘system’.

Mr Morley confirmed that the Trust was not cancelling the appointments, and confirmed that the Trust team was being as flexible as they could be, in responding to need. He underlined that this was not a problem only in Rotherham though.

It was noted that work was progressing, particularly for persistent non-attenders, where specialist nursing staff could work with them to clarify the importance of attending these appointments. Mr Morley advised that it was very difficult from the social workers’ point of view with some of these children moving house or schools at the same time as being required to attend these appointments.

The Quality Report was noted.

314/18(b) CLINICAL REPORT

The Board of Directors received and noted the Clinical Report presented by the Acting Medical Director, Dr Carrie Kelly. This provided the Board with an update on the Trust-wide mortality position.

It was noted that Hospital Standardised Mortality Ratio (HSMR) had been rebased and that the Trust’s current position, following the national rebasing, for the period up to May 2018 showed an improved position from the previous
month and stood at 105.4. The national peer average figure was 99.1. It was noted that weekend and day admissions’ mortality rates had decreased, which meant that the Trust was now performing better than in previous months.

The improvement in crude mortality for 21 days had shown the most marked improvement, with the reported performance standing at 3.03%, as opposed to 9.62% in the previous period.

However, Dr Kelly advised that there were some highlighted alerts in the national data which the Trust was considering in more detail, one of these areas being deaths caused by septicaemia. It was noted that a number of initiatives were in place for more work to be undertaken in this area.

Dr Kelly advised that the Quality Assurance Committee (QAC) was considering sepsis as it is one of the Quality Priorities for 2018/19. Mrs Atmarow suggested that management of sepsis was critical and asked about the activities of the ‘Task and Finish Group’ that had been established. Further to a comment from Dr Hanna about what the ‘Task and Finish Group’ was currently looking at, Mr Morley stated that controls for sepsis were obviously highly necessary but had to be balanced with the appropriate use of antibiotics, to reduce the incidence of antimicrobial resistant bacteria.

An update on the sepsis situation to be provided in the next Clinical Report.

**ACTION: Medical Director**

Dr Kelly advised that the Mortality Group was about to be re-invigorated with the next meeting taking place in September.

**ACTION: Medical Director**

It was noted that there were 12 new Research and Development studies in progress, including three commercially sponsored studies which allow additional funds to be received by the Research Department. It was further noted that the R&D team had been shortlisted in the Clinical Research Nursing category of the Nursing Times award for Advancing Patient Care Through Research, with the finalists to be decided in October.

The Board noted the Clinical Report.

**314/18(c) OPERATIONAL PERFORMANCE REPORT**

The Board of Directors received the Operational Performance Report, which was presented by the Chief Operating Officer who provided an overview of performance for each key operational indicator, for July 2018.

Mr Briggs highlighted that there were a number of medically fit patients in the hospital due to delayed transfer of care. Numbers had been as high as 47 medically fit patients. This had been raised with the local authority, who had confirmed that there had been difficulties in staffing intermediate care beds for the previous 5 to 6 weeks. It was noted that multi-disciplinary teams were meeting regularly to try to mitigate the issues. The new tranche of junior doctors during August had also had an effect with new colleagues getting up to speed with Trust systems.
Mr Briggs acknowledged the difficulty in staffing medical wards. He advised that even though eRoster keeps annual leave up to date, the availability of agency/bank staff had also had an effect on patient flow, especially in Integrated Medicine which relies on agency staff by circa 30%.

He described all these issues as having created a ‘Perfect Storm’ for patient flow through the hospital during August. Mr Briggs advised that he had learned a lesson regarding the management of annual leave in the Trust.

Mr Barnes expressed shock at the figures that had been highlighted and asked for clarification as to whether delays in transfer of care were related to social workers’ annual leave and/or establishment at RMBC. Mr Briggs advised that the issue had arisen only within the last six weeks, during the summer school holidays, so the issue of social workers’ annual leave had to be considered as a factor.

Mrs Atmarow advised that the staffing issue and application of the annual leave policy during August had been discussed at length at the FPC. She acknowledged that the local authority had also had difficulty in providing adequate social worker cover during the summer break, but questioned whether they had sufficient capacity during the normal course of business. Mr Briggs advised that it was his understanding that the current issue was related to annual leave, rather than business as usual capacity.

Mrs Atmarow sought assurance that computer programmes in isolation were not relied upon to oversee annual leave, and that there was also some human oversight involved. Mr Briggs advised that plans were in place to ensure that nurse staffing and medical staffing complement each other during implementation of the latter, over the next few months. He also advised that managing leave over Christmas was absolutely crucial and that he was expecting to have sight of Christmas leave rotas within the next six weeks.

The Chairman highlighted that issues surrounding management of annual leave had been brought to the Board previously, and that he felt that it was time for a review of policy/procedural changes to take place in order to mitigate the risk. He asked that a piece of work be done regarding the management of annual leave, and what actions would be taken to manage annual leave throughout the Christmas period. This should be reported through the SWC first, with assurance being presented to a future Board meeting.

**ACTION:** Chief Operating Officer

Mr Morley added that e-rostering does not control the system, only provides the divisions with information, and that they should ensure that appropriate controls were in place.

The Chairman requested more information around delayed discharge for medically fit patients and how long some of these cases had been taking. Mr Briggs highlighted the processes in place. However, Mr Holt advised that it should be acknowledged that there was a difference between discharge of patients who were medically fit, and those experiencing delayed transfer of care. Mr Briggs added that the situation was better than the same time as
last year, although there was a risk that performance targets of 90% would not be achieved by the end of September. The Chairman stated that actions be taken for this to be avoided. ACTION: Chief Operating Officer

Regarding the cancer position, we are still on track, but, this remained fragile. The Chairman sought assurance that the Trust was doing everything it could to meet the required performance. Mr Briggs advised that that Sheffield Teaching Hospitals support oncology services to the Trust, and those services were currently struggling, but that the Trust was closely working with Sheffield to mitigate poor performance.

It was noted that gynaecology was an area of concern for the Chief Operating Officer with 200 patients (normally circa 110) currently waiting for treatment. He added that additional theatre sessions had been scheduled to support waiting lists going down, but it was noted that the longest wait was currently 40 weeks.

Ms Hagger raised an issue concerning a lack of consultant-led ward rounds on some wards, and linked this with potential new job plan processes where a refocus of culture might be required. Mr Briggs stated that the key is refocusing and transformation in these areas, but also highlighted that ward rounds did not necessarily need to be undertaken by consultants.

The Board noted the Operational Performance Report.

314/18(d) WORKFORCE REPORT

The Board of Directors received the Workforce Report, presented by the Interim Director of Workforce who cited performance against agreed workforce metrics.

The MedicOnline system was highlighted and it was noted that it should be up and running by the end of September. Mr Barnes stated that a lot of work remains to be done if we are to hit the deadlines we have set for September.

It was noted that the Trust had recently outsourced Occupational Health Services, with the Trust expecting the new service to commence in September 2018.

Mr Ferrie mentioned Abiola Lugboso, Assistant Practitioner in Therapy Services, who will represent the Trust at the World Skills national finals at the NEC in Birmingham in November.

The Board noted the Workforce Report.

314/18(3) FINANCE REPORT

The Board of Directors received the Finance Report presented by the Director of Finance, which reported that the Trust remained on plan for 2018/19.

Congratulations from Mr Sheppard were offered to the Family Health Team on the Clinical Negligence Scheme Trust (CNST) Scheme, part of the CIP
scheme where all 10 criteria were successfully met (Sheffield met just five criteria, Doncaster none at all) and savings from this were £200k. This amazing achievement was echoed by the Board of Directors.

The Board noted the Finance Report.

ASSURANCE FRAMEWORK

315/18 GOVERNANCE REPORT

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


In view of the Board’s impending decision regarding the creation of a wholly owned subsidiary, Ms Milanec also highlighted a consultation which would be shortly launched by NHSI, regarding the creation of Wholly Owned Subsidiaries in the NHS.

The Board noted the Governance Report.

316/18 QUARTER ONE BOARD ASSURANCE FRAMEWORK

The Board of Directors received the Board Assurance Framework, presented by the Director of Corporate Affairs/Company Secretary.

Mr Barnes stated the need in future for improved narrative and explanations in the report so that those Board members who were not on particular committees understood the rationale as to why scores might increase or decrease.

ACTION: Company Secretary

Mrs Atmarow stated her wish for thanks to be expressed to Mrs Reid (Head of Governance) for guiding SWC through the document in some detail, which she had found very beneficial.

The Board approved the revised risk scores appearing on the BAF.

REGULATORY AND STATUTORY REPORTING

317/18 RESPONSIBLE OFFICER, ANNUAL REPORT

The Board of Directors received the Responsible Officer (RO) Annual Report presented by Dr Cooper, Interim Responsible Officer.

The purpose of the paper was to present details of activity related to Medical Appraisals and Revalidation as per NHS England and GMC Regulations in order that the statement of compliance could be signed off by the Board and submitted.
It was noted that performance was slightly higher than that of last year, and had included short term contract holders who were now asking for appraisals to take place in-house, rather than going out to agency.

Dr Cooper highlighted that one of these that had arisen during appraisals had related to the outcome of the Dr Hadiza Bawa-Garba legal case [also mentioned at item 315/18].

It was noted that following the report last year, the Trust’s internal auditors had made some recommendations regarding the appraisal process which had been completed, and NHS England had made some recommendations of which, only one was now outstanding with additional Appraisers being recruited.

Dr Cooper agreed to provide to the Board details of anonymised data which would provide more detailed information for easier reading.

**Action – Dr Alison Cooper**

It was agreed that the Responsible Officer Report be approved and that the Statement of Compliance be signed off on behalf of the Board and submitted to NHS England accordingly.

**BOARD GOVERNANCE**

**318/18 REVIEW OF BOARD MEMBERS’ INTERESTS**

The Board of Directors received the Board of Directors Register of Interests, which was approved.

**319/18 ANY OTHER BUSINESS**

There were no items of any other business.

**320/18 DATE OF NEXT MEETING**

It was noted that the next meeting of the Board of Directors would be held on Tuesday, 25 September 2018.

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

Martin Havenhand  
Chairman  
Date
<table>
<thead>
<tr>
<th>Log No</th>
<th>Meeting</th>
<th>Report/Agenda title</th>
<th>Minute Ref</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>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>25-Jul-17</td>
<td>Escalations from Governors</td>
<td>269/17</td>
<td>To be added to action log: 3 staff governor vacancies out of 5 remain vacant. Exco to consider options available to co-op colleagues to ensure they are engaged and represented through CoG.</td>
<td>Co Sec</td>
<td>30/09/2018 (re constitution)</td>
<td>Update to July Board Meeting: Co Sec has met with two individuals who have shown an interest in becoming a governor. Three additional individuals have also enquired. 31 Jul BoD action: to remain open until at least draft Constitution brought to Board. 28 Aug BoD action : to remain open</td>
<td>Open</td>
</tr>
<tr>
<td>51</td>
<td>26-Jun-18</td>
<td>Quality and Clinical Report</td>
<td>238a/18</td>
<td>Review of the contracting requirements relating to 'Looked After Children' to be carried out and reported to the Board.</td>
<td>DoF</td>
<td>31/07/2018</td>
<td>A review of the current service and position has been undertaken by RCGG/TRFT representatives and completed. A joint review of the service delivery model to investigate alternative options has commenced. A deadline for these proposals has been set as 31 August 2018. Verbal update to be provided to 25 September Board meeting</td>
<td>Open</td>
</tr>
<tr>
<td>53</td>
<td>26-Jun-18</td>
<td>Workforce Report</td>
<td>238c/18</td>
<td>Consideration to be given to establish a trophy cabinet or similar in the main, public entrance</td>
<td>CEO</td>
<td>31/07/2018</td>
<td>Details agreed with Chief Executive.</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>31-Jul-18</td>
<td>Report from the Chief Executive</td>
<td>273/18</td>
<td>CEO to consider the format of the quarterly table of objectives to reflect consistency across committees and Board</td>
<td>CEO</td>
<td>30-Oct-18</td>
<td>Progress underway.</td>
<td>Open</td>
</tr>
<tr>
<td>59</td>
<td>31-Jul-18</td>
<td>Quality and Clinical Report</td>
<td>275a</td>
<td>The establishment of a Clinical Ethics Committee to be progressed. August update: Any matters arising from the meeting to be reported to Board. Progress should be made before next meeting.</td>
<td>MD</td>
<td>31/07/2018</td>
<td>A meeting has been arranged for 4 October 2018 to resurrect the Trust's Clinical Ethics Committee. Terms of Reference for this type of committee have been sourced from 3 other Trusts.</td>
<td>Open</td>
</tr>
<tr>
<td>61</td>
<td>31-Jul-18</td>
<td>Operational Performance Report</td>
<td>275b</td>
<td>'Fragile' services to be included as part of the forthcoming review of clinical services by the Trust</td>
<td>COO</td>
<td>30-Oct-18</td>
<td>All services have been scheduled for service reviews. Initial reviews have taken place including surgical services deemed to be fragile (Urology and Breast).</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>Log No</td>
<td>Meeting</td>
<td>Report/Agenda title</td>
<td>Minute Ref</td>
<td>Agenda item and Action</td>
<td>Lead Officer</td>
<td>Timescale/ Deadline</td>
<td>Comment/ Feedback from Lead Officer(s)</td>
<td>Open /Close</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>---------------------</td>
<td>------------</td>
<td>------------------------</td>
<td>--------------</td>
<td>---------------------</td>
<td>----------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>68</td>
<td>31-Jul-18</td>
<td>Guardian of Safe Working Hours report</td>
<td>282/18</td>
<td>Arrangements to be made to facilitate the Guardian meeting with Medical Director before next quarterly report is presented.</td>
<td>Co Sec</td>
<td>30-Oct-18</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>69</td>
<td>28-Aug-18</td>
<td>Action Log</td>
<td>310/18</td>
<td>Arising from action log 62: CEO to confirm to Board who will take over the lead for risk management arrangements once the Chief Nurse leaves the Trust in October 2018 Location as to where Corporate Risk Register will go to be approved, to be determined</td>
<td>CEO</td>
<td>25-Sep-18</td>
<td>Risk management will remain within the Chief Nurse’s portfolio. Corporate Risk Register will be approved at TMC</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>70</td>
<td>28-Aug-18</td>
<td>Action Log</td>
<td>310/18</td>
<td>Arising from action log 63 (Brexit risk): Circulate copy of new BREXIT ‘umbrella’ risk to board members</td>
<td>ChN</td>
<td>25-Sep-18</td>
<td>Document has been circulated.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>71</td>
<td>28-Aug-18</td>
<td>Action Log</td>
<td>310/18</td>
<td>Arising from action log 65/66 (EDS): Provide copy of what was actually submitted, to SWC Chair and CEO</td>
<td>DoW</td>
<td>25-Sep-18</td>
<td>Complete</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>72</td>
<td>28-Aug-18</td>
<td>CEO Report</td>
<td>312/18</td>
<td>Report to Board the outcome of implementation of e-rostering (non-clinical) at the Trust. (to go through SWC first)</td>
<td>DoW</td>
<td>30-Oct-18</td>
<td>To be considered at the 22 October Strategic Workforce Committee and 30 October Board (added to agenda).</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>73</td>
<td>28-Aug-18</td>
<td>CEO Report</td>
<td>312/18</td>
<td>Sec 4.5: Report to Board (to go through FPC first) details of proposed changes to payment system / control totals.</td>
<td>DoF</td>
<td>18-Dec-18</td>
<td>Action will be completed through FPC and then the Board as part of the 2019/20 operational and financial plan. Added to FPC work plan.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>74</td>
<td>28-Aug-18</td>
<td>CEO Report</td>
<td>312/18</td>
<td>Presentation re five year strategy to be taken to next board meeting</td>
<td>DS&amp;T</td>
<td>25-Sep-18</td>
<td>Agenda item 368/18</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>75</td>
<td>28-Aug-18</td>
<td>Business Planning Timescales</td>
<td>313/18</td>
<td>Add to the FPC planner, that divisions, including corporate, attend the February FPC meeting</td>
<td>DoF</td>
<td>Feb-19</td>
<td>Added to FPC workplan for February 2019</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>76</td>
<td>28-Aug-18</td>
<td>Clinical Report</td>
<td>314/18(b)</td>
<td>Update on sepsis / mortality to be provided in the next clinical report.</td>
<td>MD</td>
<td>25-Sep-18</td>
<td>Agenda items 353(b)/18 and 357/18</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>Log No</td>
<td>Meeting Date</td>
<td>Report/Agora title</td>
<td>Minute Ref</td>
<td>Agenda item and Action</td>
<td>Lead Officer</td>
<td>Timescale/ Deadline</td>
<td>Comment/ Feedback from Lead Officer(s)</td>
<td>Open /Close</td>
</tr>
<tr>
<td>--------</td>
<td>--------------</td>
<td>--------------------</td>
<td>------------</td>
<td>------------------------</td>
<td>--------------</td>
<td>---------------------</td>
<td>---------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>77</td>
<td>28-Aug-18</td>
<td>Clinical Report</td>
<td>314/18(b)</td>
<td>Any issues from the September Mortality Group to be provided at Board</td>
<td>MD</td>
<td>25-Sep-18</td>
<td>Agenda item 353(b)/18</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>78</td>
<td>28-Aug-18</td>
<td>Operational</td>
<td>314/18(c)</td>
<td>Board to be assured by ongoing actions relating to annual leave management policy/procedures (to go through SWC first)</td>
<td>COO</td>
<td>30-Oct-18</td>
<td>COO established fortnightly operational meetings which will oversee weekend, holiday and leave planning. A set agenda item will be to review all Christmas, holidays and school non term times, for all key services. Membership is General Managers, Directors of Clinical Service and senior nursing staff.</td>
<td>Open</td>
</tr>
<tr>
<td>79</td>
<td>28-Aug-18</td>
<td>Operational</td>
<td>314/18(c)</td>
<td>Actions to be taken to avoid non-compliance with 90% performance targets relating to discharge</td>
<td>COO</td>
<td>25-Sep-18</td>
<td>Agenda item 353(c)/18</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>80</td>
<td>28-Aug-18</td>
<td>BAF</td>
<td>316/18</td>
<td>Future reports to Board to include improved narrative as to why committees recommend regarding BAF risk scores.</td>
<td>CoSec</td>
<td>30-Oct-18</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>81</td>
<td>28-Aug-18</td>
<td>Responsible Officer (RO) report</td>
<td>317/18</td>
<td>Feedback on arising themes / particular departments etc. from anonymised data contained within the RO report to be provided to Board</td>
<td>RO</td>
<td>30-Oct-18</td>
<td>To be included in next quarterly RO report in October 2018.</td>
<td>Open</td>
</tr>
<tr>
<td>82</td>
<td>28-Aug-18</td>
<td>Responsible Officer (RO) report</td>
<td>317/18</td>
<td>RO annual report to be signed off</td>
<td>Chair</td>
<td>End September 2018</td>
<td>Complete.</td>
<td>Recommend to close</td>
</tr>
</tbody>
</table>
Report: Report from the Chairman

Presented by: Martin Havenhand, Chairman
Author(s): Lisa Reid, Head of Governance

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 28 August 2018.

Summary of Key Points:

- Rotherham Together Partnership meeting was on 19 September 2018 and Lynn Hagger attended on my behalf;
- The Board is continuing with their formal board development schedule;
- I have met with five of the Trust’s apprentices during the month;
- Colleagues at the Trust continue to raise the Trust’s profile through their clinical publications;
- The Trust's Innovation Week has taken place and the Quarterly Shining Star was announced;
- End of Life Care Conference;
- I attended the Barnsley Hospital NHS Foundation Trust Annual General Meeting on 13 September 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 Rotherham Together Partnership

2.1 On the 19 September 2019 Lynn Hagger attended the quarterly Rotherham Together Partnership meeting at Voluntary Acton Rotherham.

2.2 The Rotherham Plan Performance Report measures broad progress against the Plan’s Game Changers (Building Stronger Communities; Skills and Employment; Integrated Health and Social Care; A Place to be Proud Of and the Town Centre). The Game Changer Boards address the more detailed targets.

2.3 Progress is generally in the right direction though there is some concern about the deteriorating target of the ‘feeling safe’ indicator. It is hoped that planned town centre developments will help to address this together with other initiatives.

2.4 Lynn took the opportunity to point out that the apparent improvement in the health assessments for Looked After Children was somewhat misleading as this only reflected those undertaken for new referrals and did little to address the backlog however constructive discussions about this were being undertaken by partners. She also gave an update on the impact of Brexit on our staffing.

2.5 Rather more detailed reports were provided on the joint Council / police team approach to dealing with anti-social behaviour; family friendly initiatives to re-generate the town centre; the town’s broad cultural strategy and the courses offered by the new University campus which opens on 24 September 2018.

3.0 Board Development

3.1 The next Board Development session will be held on 5 October 2018.

3.2 The Trust has commissioned The Governance Forum and RSM Risk Assurance Services LLP to undertake an external Well-led review.

4.0 Apprentices

4.1 I took the opportunity to meet with five of the Trust’s Apprentices this month, all of whom have recently successfully competed against apprentices from across the region and across Rotherham to win awards.

4.2 Abiola Lugboso and Elyse Hubbard represented the Trust at the regional heats for World Skills held in Birmingham and both did extremely well with Abiola progressing to the national World Skills Final. World Skills is a competition which aims to find the best health and social care students in the country by assessing their knowledge, practical skills and employability attributes against a set of strict criteria.

4.3 Abiola is an Assistant Practitioner within Therapy Services and is studying for the Assistant Practitioner Apprenticeship Foundation Degree. Elyse is a Therapy Support Worker from Wheelchair Services who is moving to work with Stroke Unit therapists. She is just completing her Level 3 Senior Healthcare Support qualification with the aim of progressing onto the Assistant Practitioner Apprenticeship Foundation Degree.
4.4 Gwenan Durn, Celia Troop and Samantha Hort on recently received awards at the Rotherham Advertiser Apprenticeship Awards where they competed against apprentices from across Rotherham. Gwen went on to win the Degree level Apprentice of the Year award.

4.5 Gwenan and Samantha are studying the Health Care Science Degree Apprenticeship and work in Respiratory Physiology and Sleep Services. Celia is an Assistant Practitioner within Physiotherapy working in Orthopaedics while studying the Assistant Practitioner Apprenticeship Foundation Degree.

4.6 It was a pleasure to meet with each of these Apprentices who are a credit to the Trust.

5.0 Trust based activities, national recognition and Innovation Week

5.1 Once again, the Trust has been actively taking part in a number of initiatives in which our colleagues and stakeholders participate.

5.2 The Quality Improvement Priority Showcase took place on 6 September with around 40 colleagues, volunteers and members of the public attending. The leads for the priorities were available to listen to comments and answer questions. All those present also had the opportunity to vote for what they considered the final nine quality priorities for 2019/20 should be.

5.3 Innovation Week took place at the Trust between 10 and 14 September when a number of events were organised, including interactive innovation workshops at which colleagues were encouraged to share their ‘bright ideas’. An information stand in the main entrance to the hospital detailed how the key innovations had impacted the lives of the people of Rotherham and colleagues from the Research and Development team were on hand to highlight some of the great work they were involved in to help shape healthcare in the future.

5.4 Lindsey Parkinson, Chief Cardiac Physiologist, raised the profile of the Trust recently when she had a case study published in the British Heart Rhythm Society editorials programme.

5.5 The winner of the Trust’s Quarterly Shining Star award was Lisa Hardy and the team on ward B5. Lisa and her team were nominated by Consultant Dr Richard Went for their care of a patient with an extremely rare blood condition which was lifesaving.

6.0 End of Life Care Conference

6.1 Gabby Atmarow attended this conference which was held at Rotherham United Football Club on 14 September 2018. It was chaired by June Lovett, Assistant Chief Nurse, funded by Rotherham Clinical Commissioning Group (RCCG) and had around 100 delegates. This is an excellent example of partnership working / collaboration in Rotherham.

6.2 The delegates came from Rotherham Metropolitan Borough Council (Social Care), RCCG, Rotherham Hospice, Care Homes and, of course, many of our community staff including District Nurses, Occupational Therapists and Speech & Language Therapists as well as some hospital staff, medical students and junior doctors.

6.3 The day focussed on ‘One Chance to Get It Right’ and reflected the national strategy for End of Life Care. Delegates heard about the RCCG-led strategic group
led by a Lead GP which includes representatives from the Trust, Pharmacy, Social Care and Rotherham Hospice who are all working on a local strategy.

6.4 Additional partnership working includes the development of personalised care planning and membership of the NHS Improvement collaborative (with six other Trusts) on embedding End of Life Care planning. Rapid discharge to the patient’s preferred place of death is another focus (as we know many patients at the end of their lives do not want to die in hospital, but at a place they prefer).

6.5 Data and information sharing is also a priority with the strategic group aiming for single documentation across the agencies, together with community drug cards.

7.0 Barnsley Hospital NHS Foundation Trust Annual General & Public Members Meeting (AGPMM) 2018

7.0 I attended Barnsley Hospital's AGPMM Meeting on 13 September 2018 which was a great opportunity to hear about our partner organisation’s achievements as well as its challenges over the past year.

7.1 The Trust’s plans for the future were discussed, including the partnership working with our Trust, and front-line staff described the high quality care they provide to the population they serve.

7.3 Barnsley Hospital NHS FT have established a ‘New Consultant Programme’ which meets monthly and involves attendance by the Chief Executive, Medical Director and others such as the Coroner. This has been particularly beneficial as it is identifying emerging clinical leaders.

7.4 As part of the Trust’s award programme they have a ‘Governor’s Award’ and as part of their new Trust strategy from 1 April they are developing a ‘People Strategy’ and a ‘Clinical Strategy’ and their focus is on performing well and sustaining the 4 hours access target.

Martin Havenhand
Chairman
September 2018
BOARD MEETING: 25 September 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 with the delivery of the 2018/19 Operational Plan, with good progress in a number of key areas.

- The Trust’s performance against the A&E four-hour access standard continues to be challenging in August and through September, with actions being taken to drive improvement. Actions to achieve Cancer 62 day performance in quarter 2 are on track.

- The Rotherham Place Plan has been refreshed and agreed and positive progress continues to be made with stakeholders to improve the quality and sustainability of services for our population

- The Trust is continuing to actively engage with partners in the South Yorkshire and Bassetlaw Integrated Care System.

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 August 2018 Board of Directors’ meeting.

2.0 **Strategic Issues**

2.1 The Trust continues to make good progress to achieve our vision “to be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital”. A key aspect of this is working with partners in Rotherham, South Yorkshire and Bassetlaw Integrated Care System (ICS) and further afield to improve the resilience and sustainability of services for the population we serve, whilst also ensuring day to day delivery of the one year operational plan.

2.2 There has been significant progress this month, with the agreement of the Rotherham Integrated Care Partnership Place Plan and the Rotherham Integrated Care Partnership Agreement, at the Rotherham Integrated Health and Social Care Place Board in September. Further details about partnership working and progress across the Place and ICS are outlined in section 4.0.

2.3 In terms of the Operational Plan, the Executive Team continues to lead delivery, which is on mainly on track. Where progress is not in line within original timelines, the Trust has mitigating actions in place to address this position to ensure achievement of the overall objectives set out in the plan or to appropriately re-profile timeframes accordingly. The key area of challenge remains performance against the four-hour access target, where performance is below the trajectory set. Specific actions are being taken to improve this for patients.

2.2 Last month, the Board Assurance Committees undertook a review of progress against the objectives and the outcome of this was shared at the Strategy and Transformation Committee. A review of half year performance is taking place with Operational and Clinical Leadership teams in early October. This will celebrate the excellent progress to date, focus on outstanding challenges and risks to delivery and will inform and shape how we focus during the remaining six months of 2018/19 to ensure delivery of quality, operational, workforce and financial priorities.

2.3 Providing high quality care is at the heart of our vision and approach. Our unannounced CQC core services inspection is due imminently, with the use of resources inspection this month, followed shortly by the Well-led Review during October. We welcome the inspection and the feedback which this will provide to support us on our quality improvement journey. The Trust is preparing for this visit to ensure that we share the fantastic work that colleagues are doing across the Trust to provide excellent care and services to patients, alongside the challenges we face, the actions we strive to take to mitigate risks and the way that we ensure learning and continuous improvement in the way we work, to ensure consistent delivery of high quality care for patients. Colleagues will be informed as soon as the unannounced inspection commences.

3.0 **Performance Issues**

3.1 The Integrated Performance Report highlights the key performance within the Trust along with the top achievements and key concerns.
3.2 Performance against the 4-hour access standard has seen particular challenges through August and into September, particularly in relation to the increase in long stay patients. Performance was reviewed at the Rotherham A&E Delivery Board in September, with commitment from all partners to take forward key actions to drive the necessary improvement.

3.3 Actions to achieve Cancer 62 day performance in quarter 2 are on track to achieve quarter 2, albeit there is some risk as performance is tight with clear measures in place to support achievement.

3.4 Winter Planning is well underway within the Trust and with partners. The development and agreement of plans is being overseen through the A&E Delivery Board, building on the success and learning from last year, to ensure effectiveness and resilience across the Rotherham system.

3.5 Teams across our community services continue to work hard to provide high quality care for our patients, and the recent changes to move to a planned and unplanned approach across community nursing teams is already demonstrating significant benefits, improving both patient and colleague experience. Embedding these changes should further contribute to improved resilience during winter.

4.0 Stakeholder Engagement

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

4.2 The Trust is actively engaged in discussions and workstreams, taking a lead role in a number of areas. I am a member of the Executive Steering Group and Collaborative Partnership Board, supported by the Executive Team and clinical and managerial colleagues who participate and engage in various aspects of work to shape and support delivery of the ICS vision and plans.

4.3 Currently discussions are underway with stakeholders to determine next steps following publication of the Hospital Services Review Stage 2 Report, and I have also been involved in a number of meetings and workshops alongside other ICS colleagues to explore how, as an ICS, we can further enhance engagement and governance arrangements across the ICS.

4.4 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 September 2018 to support the delivery of the Rotherham Place Plan. We continue to work closely with partners to achieve our shared plans.

4.5 The Trust Quarterly Review Meeting with NHSI took place on 11 September at which members of the Executive Team and I provided an overview of our performance against plan, risks and mitigations and discussed key strategic and operational issues.
5.0 Conclusion

5.1 Overall the Trust remains on track regarding the delivery of the Operational Plan, with good performance across a number of key standards and targets, and actions to improve delivery where this is currently not on plan, particularly performance against the four hour access target.

5.2 The Trust continues to make progress with partners across Rotherham and the ICS to improve the resilience and sustainability of services for the population we serve.

Louise Barnett
Chief Executive
September 2018
### Integrated Performance Dashboard (September 2018)

#### Key Performance Indicator

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Target</th>
<th>Performance</th>
<th>Trend</th>
<th>Benchmark</th>
<th>Data Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1 A&amp;E % Left without being seen</td>
<td>Jul-18</td>
<td>5.00%</td>
<td>6.48%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2 IP Friends &amp; Family Test (% Positive)</td>
<td>Aug-18</td>
<td>95.0%</td>
<td>97.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C3 % LAC assessments reported &lt;20 days</td>
<td>Aug-18</td>
<td>95%</td>
<td>62%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4 New Complaints per WTE</td>
<td>Aug-18</td>
<td>7.6</td>
<td>8.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E1 Ambulance Turnaround Times % &gt; 60 mins</td>
<td>Jul-18</td>
<td>0.00%</td>
<td>1.70%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E2 Cancelled Operations</td>
<td>Aug-18</td>
<td>0.8%</td>
<td>0.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E3 Delayed Transfer of care</td>
<td>Aug-18</td>
<td>3.5%</td>
<td>4.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E4 Dementia Assessment</td>
<td>Jul-18</td>
<td>90.0%</td>
<td>88.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E5 Hip Fracture Best Practice Compliance</td>
<td>Jul-18</td>
<td>65.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E6 Mortality (HSMR Rolling 12 Month)</td>
<td>Jun-18</td>
<td>100</td>
<td>103.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E7 Stroke: admitted to ward within 4 hours</td>
<td>Aug-18</td>
<td>60.0%</td>
<td>63.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R1 Urgent Care (4 Hour)</td>
<td>Aug-18</td>
<td>95.0%</td>
<td>87.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R2 Cancer Standards 62 Day</td>
<td>Jul-18</td>
<td>85.0%</td>
<td>85.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R3 Cancer Standards 62 Day Screening</td>
<td>Jul-18</td>
<td>90.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R4 Diagnostics (DM01)</td>
<td>Aug-18</td>
<td>1.0%</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R5 18 weeks (RTT Incomplete)</td>
<td>Aug-18</td>
<td>92.0%</td>
<td>95.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R6 e-Referral Slot Issues Rate</td>
<td>Jul-18</td>
<td>4.0%</td>
<td>4.16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S1 Access to Antenatal Services within 90 days</td>
<td>Aug-18</td>
<td>90.0%</td>
<td>92.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S2 C.Diff incidence rate per 100,000 bed days</td>
<td>Aug-18</td>
<td>12.9</td>
<td>12.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S3 Emergency Caesarean Section Rate</td>
<td>Aug-18</td>
<td>16.5%</td>
<td>11.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S4 Harm Free Care</td>
<td>Aug-18</td>
<td>95.0%</td>
<td>94.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5 MRSA bacteraemia rate per 100,000 bed days</td>
<td>Aug-18</td>
<td>0.65</td>
<td>2.57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S6 Potential under reporting of incidents</td>
<td>Aug-18</td>
<td>43.3%</td>
<td>35.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S7 Readmissions (Non Elective 28 day)</td>
<td>Jul-18</td>
<td>13.3%</td>
<td>11.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S8 VTE Assessment Completion %</td>
<td>Jul-18</td>
<td>95.0%</td>
<td>95.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9 VTE Assessment Completion</td>
<td>Jul-18</td>
<td>95.0%</td>
<td>95.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W1 Incident Reporting Culture - % Incidents Severe</td>
<td>Aug-18</td>
<td>0.35%</td>
<td>0.31%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W2 Variance from Plan</td>
<td>Aug-18</td>
<td>0.0%</td>
<td>0.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W3 Proportion of Temporary Staff</td>
<td>Aug-18</td>
<td>4.99%</td>
<td>6.42%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W4 Sickness Rates (12 Month Rolling)</td>
<td>Aug-18</td>
<td>3.95%</td>
<td>4.12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W5 Staff Turnover</td>
<td>Aug-18</td>
<td>0.88%</td>
<td>0.41%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Top Achievements

- **Elective Care and Routine Diagnostics**
  - 18 week incomplete performance has continued to improve and currently stands at 95.1%, equivalent to national top 3 acute providers.
  - Diagnostics DM01 continues to deliver 100% within 6 weeks, an achievement matched by only 3 other providers.

- **Hip Fracture Best Practice Compliance**
  - Benefiting from changes to the trauma coordinator role, TRFT has continued to improve it’s already high performing hip fracture pathway. In July 100% of patients received care that met the best practice standards. National average is 65% an no other provider has delivered 100%.

#### Most Improved

- **Mortality Rates (HSMR)**
  - Following a detailed data quality assurance process with our benchmarking supplier the HSMR has been reintroduced to the trust IPR and has demonstrated significant improvement over the past 3 months.

- **Dementia Assessments**
  - Following a review of processes throughout the organisation the completion of dementia assessments has recovered back to previous TRFT norms. Whilst still falling short of the national 90% target, this has been an area of significant improvement.

- **Urgent Care (4 Hour Standard)**
  - In August 87.5% of patients were treated within the national 4 hour standard. This is below our NHSI recovery trajectory of 88.2%.
  - See operations report for more details

- **e-Referral Slot Issues Rate**
  - Appointment slot issues - national data July was 41.6%. A task and finish group has been set up to reduce the ASI trust rate. Very recently achievement matched by only 3 other providers.

- **Mortality Rates (HSMR)**
  - Following a detailed data quality assurance process with our benchmarking supplier the HSMR has been reintroduced to the trust IPR and has demonstrated significant improvement over the past 3 months.

#### Key Concerns

- **Ambulance Turnaround Times > 60 minutes - 4.4%**
  - The percentage of bed days being occupied by patients with a delayed transfer of care has increased from 2.4% last month to 4.4%. Whilst an improvement on the same month last year (6.1%), the deterioration has impacted bed flow. See operations report for more details.

- **Delayed Transfers of Care - 4.4%**
  - In July 34 patients waited more than 60 minutes in an ambulance from arrival at hospital to entering UECC. This is almost double the rate in June and a key concern as we prepare to go into winter.
  - See operations report for more details

#### Most Deteriorated

- **Ambulance Turnaround Times > 60 minutes - 3.7%**
  - Most Deteriorated - Reduce bed days occupied by patients with a delayed transfer of care. See operations report for more details

<table>
<thead>
<tr>
<th>In Month Activity (MS)</th>
<th>YTD Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td>Elective Inpatient</td>
<td>459</td>
</tr>
<tr>
<td>Elective Day case</td>
<td>2,288</td>
</tr>
<tr>
<td>Non Elective</td>
<td>2,207</td>
</tr>
<tr>
<td>ED Attendance</td>
<td>8,469</td>
</tr>
<tr>
<td>Outpatient New</td>
<td>4,957</td>
</tr>
<tr>
<td>Outpatient FU (CL)</td>
<td>8,890</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>4,579</td>
</tr>
<tr>
<td>Adult Critical Care</td>
<td>336</td>
</tr>
<tr>
<td>Paediatric Critical Care</td>
<td>418</td>
</tr>
<tr>
<td>Assessments</td>
<td>976</td>
</tr>
</tbody>
</table>
### Appendix 1       Stroke Metrics 2018/19

<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>&gt;= 80%</td>
<td>64%</td>
<td>92%</td>
<td>89%</td>
<td>85%</td>
<td>92%</td>
<td>84%</td>
<td>145/173</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>23/36</td>
<td>23/25</td>
<td>33/37</td>
<td>33/39</td>
<td>33/36</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of non-admitted higher risk TIA cases who are treated within 24 hours of first contact with any healthcare professional</td>
<td>&gt;= 60%</td>
<td>80%</td>
<td>70%</td>
<td>68%</td>
<td>75%</td>
<td>62%</td>
<td>63%</td>
<td>32/51</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9/15</td>
<td>7/10</td>
<td>2/3</td>
<td>6/8</td>
<td>8/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital</td>
<td>&gt;= 90%</td>
<td>33%</td>
<td>69%</td>
<td>61%</td>
<td>54%</td>
<td>63%</td>
<td>54%</td>
<td>94/174</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12/38</td>
<td>15/25</td>
<td>22/26</td>
<td>21/39</td>
<td>24/38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of patients presenting with stroke with AF anti-coagulated on discharge</td>
<td>&gt;= 60%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99/174</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3/3</td>
<td>5/5</td>
<td>8/8</td>
<td>3/3</td>
<td>6/6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of stroke patients scanned within one hour of hospital arrival</td>
<td>&gt;= 50%</td>
<td>44%</td>
<td>45%</td>
<td>59%</td>
<td>59%</td>
<td>60%</td>
<td>59%</td>
<td>92/170</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15/34</td>
<td>10/22</td>
<td>22/28</td>
<td>23/39</td>
<td>22/37</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of stroke patients scanned within 24 hrs of hospital arrival</td>
<td>&gt;= 100%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>99%</td>
<td>168/170</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>33/34</td>
<td>22/22</td>
<td>38/38</td>
<td>38/39</td>
<td>37/37</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke</td>
<td>&gt;= 40%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>82/82</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>99</td>
<td>26/26</td>
<td>19/19</td>
<td>15/15</td>
<td>13/13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of patients and carers with joint care plans on discharge from hospital</td>
<td>&gt;= 85%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>88</td>
<td>7/7</td>
<td>3/3</td>
<td>6/6</td>
<td>5/5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of stroke patients that are reviewed six months after leaving hospital</td>
<td>&gt;= 95%</td>
<td>91%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21/23</td>
<td>28/28</td>
<td>28/28</td>
<td>25/25</td>
<td>20/20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of patients supported by a stroke skilled ESD team</td>
<td>&gt;= 40%</td>
<td>34%</td>
<td>52%</td>
<td>54%</td>
<td>52%</td>
<td>50%</td>
<td>43%</td>
<td>60/140</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6/32</td>
<td>11/21</td>
<td>21/33</td>
<td>14/27</td>
<td>8/27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients who receive thrombolysis following an acute stroke</td>
<td>&gt;= 11%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>8/179</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0/37</td>
<td>0/25</td>
<td>2/39</td>
<td>4/40</td>
<td>2/38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2 - July 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>91.7%</td>
<td>91.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecological</td>
<td>100.0%</td>
<td>100.0%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>90.9%</td>
<td></td>
</tr>
<tr>
<td>Haematological</td>
<td>60.0%</td>
<td>60.0%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>100.0%</td>
<td></td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Head and Neck</td>
<td>25.0%</td>
<td>33.3%</td>
<td>87.5%</td>
<td>87.5%</td>
<td>100.0%</td>
<td></td>
<td>95.3%</td>
<td></td>
</tr>
<tr>
<td>Lower Gastrointestinal</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>100.0%</td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td>75.0%</td>
<td>60.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>100.0%</td>
<td>100.0%</td>
<td>66.7%</td>
<td>50.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarcoma</td>
<td>50.0%</td>
<td>50.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>100.0%</td>
<td>100.0%</td>
<td>93.3%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>91.4%</td>
<td></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>87.5%</td>
<td>77.8%</td>
<td>77.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urological</td>
<td>79.5%</td>
<td>79.5%</td>
<td>78.3%</td>
<td>78.3%</td>
<td>96.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>85.5%</td>
<td>84.8%</td>
<td>87.4%</td>
<td>89.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.2%</td>
<td></td>
</tr>
</tbody>
</table>

*Pre-validation - subject to change
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Admitted &lt;18Wks</th>
<th>Admitted 18Wks+</th>
<th>Total Admitted</th>
<th>Non Admitted &lt;18Wks</th>
<th>Non Admitted 18Wks+</th>
<th>Total Non Admitted</th>
<th>Incomplete &lt;18Wks</th>
<th>Incomplete 18Wks+</th>
<th>Total Incomplete</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>94</td>
<td>24</td>
<td>118</td>
<td>330</td>
<td>12</td>
<td>342</td>
<td>1561</td>
<td>121</td>
<td>1682</td>
</tr>
<tr>
<td>Urology</td>
<td>74</td>
<td>17</td>
<td>91</td>
<td>132</td>
<td>3</td>
<td>135</td>
<td>744</td>
<td>20</td>
<td>764</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>139</td>
<td>40</td>
<td>179</td>
<td>402</td>
<td>12</td>
<td>414</td>
<td>1458</td>
<td>72</td>
<td>1530</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>29</td>
<td>13</td>
<td>42</td>
<td>655</td>
<td>20</td>
<td>675</td>
<td>1072</td>
<td>71</td>
<td>1143</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>85</td>
<td>1</td>
<td>86</td>
<td>651</td>
<td>3</td>
<td>654</td>
<td>1422</td>
<td>8</td>
<td>1430</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>General Medicine</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>7</td>
<td>2</td>
<td>9</td>
<td>85</td>
<td>18</td>
<td>93</td>
<td>708</td>
<td>23</td>
<td>731</td>
</tr>
<tr>
<td>Cardiology</td>
<td>18</td>
<td>2</td>
<td>20</td>
<td>150</td>
<td>21</td>
<td>171</td>
<td>744</td>
<td>27</td>
<td>771</td>
</tr>
<tr>
<td>Dermatology</td>
<td>35</td>
<td>0</td>
<td>35</td>
<td>393</td>
<td>8</td>
<td>401</td>
<td>930</td>
<td>22</td>
<td>952</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>73</td>
<td>16</td>
<td>90</td>
<td>412</td>
<td>15</td>
<td>427</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>150</td>
<td>21</td>
<td>171</td>
<td>453</td>
<td>18</td>
<td>471</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>51</td>
<td>1</td>
<td>52</td>
<td>232</td>
<td>3</td>
<td>235</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>124</td>
<td>61</td>
<td>185</td>
<td>284</td>
<td>21</td>
<td>305</td>
<td>1119</td>
<td>170</td>
<td>1289</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>0</td>
<td>13</td>
<td>214</td>
<td>20</td>
<td>234</td>
<td>534</td>
<td>15</td>
<td>549</td>
</tr>
<tr>
<td>Total</td>
<td>626</td>
<td>160</td>
<td>786</td>
<td>3533</td>
<td>179</td>
<td>3712</td>
<td>11532</td>
<td>586</td>
<td>12198</td>
</tr>
</tbody>
</table>

**TARGETS**

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Investigation</th>
<th>&lt;6 weeks</th>
<th>≥ 6 weeks</th>
<th>Performance (% breaches)</th>
<th>Total WL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Imaging</strong></td>
<td>Magnetic Resonance Imaging</td>
<td>246</td>
<td>0</td>
<td>0.00%</td>
<td>246</td>
</tr>
<tr>
<td></td>
<td>Computed Tomography</td>
<td>341</td>
<td>0</td>
<td>0.00%</td>
<td>341</td>
</tr>
<tr>
<td></td>
<td>Non-obstetric ultrasound</td>
<td>1719</td>
<td>0</td>
<td>0.00%</td>
<td>1719</td>
</tr>
<tr>
<td></td>
<td>Barium Enema</td>
<td>0</td>
<td>0</td>
<td>#DIV/0!</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>DEXA Scan</td>
<td>96</td>
<td>0</td>
<td>0.00%</td>
<td>96</td>
</tr>
<tr>
<td><strong>Physiological</strong></td>
<td>Audiology - Audiology Assessments</td>
<td>431</td>
<td>0</td>
<td>0.00%</td>
<td>431</td>
</tr>
<tr>
<td></td>
<td>Cardiology - echocardiography</td>
<td>260</td>
<td>0</td>
<td>0.00%</td>
<td>260</td>
</tr>
<tr>
<td></td>
<td>Cardiology - electrophysiology</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Neurophysiology - peripheral neurophysiology</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respiratory physiology - sleep studies</td>
<td>26</td>
<td>0</td>
<td>0.00%</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Urodynamics - pressures &amp; flows</td>
<td>14</td>
<td>0</td>
<td>0.00%</td>
<td>14</td>
</tr>
<tr>
<td><strong>Endoscopy</strong></td>
<td>Colonoscopy</td>
<td>206</td>
<td>0</td>
<td>0.00%</td>
<td>206</td>
</tr>
<tr>
<td></td>
<td>Flexi sigmoidoscopy</td>
<td>31</td>
<td>0</td>
<td>0.00%</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Cystoscopy</td>
<td>75</td>
<td>0</td>
<td>0.00%</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Gastroscopy</td>
<td>307</td>
<td>0</td>
<td>0.00%</td>
<td>307</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>3752</td>
<td>0</td>
<td>0.00%</td>
<td>3752</td>
</tr>
</tbody>
</table>
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:

- Complaints responded to within the agreed timescale has reduced to 75%. This is linked to a low number of responses closed this month and will be monitored to ensure this does not reoccur next month.
- Of the 91 student nurses initially offered posts, 44 are currently expected to commence in September/October.
- As predicted last month, there has been a decrease in completion of Initial Health Assessments for Looked After Children within 20 days. Actions to address the need for further improvements in the level of performance continue.
- Preparations for the Care Quality Commission unannounced core services and announced Well Led inspections continue.
- Performance against infection control targets remains good.

Board action required: For noting
1.0 Harm Free Care

1.1 The Classic ‘Harm Free’ Care score for the Trust has decreased this month to 94.5% from 95.5% in July. This is still slightly above the national average score which is currently at 94%.

1.2 There has been an improvement in the combined harm free care Maternity score in August to 83.3% from 76.2% in July 2018. This remains above the national average score which is 76.5% for August.

2.0 Complaints

2.1 The Trust received 85 concerns (92 in July) and 33 formal complaints (21 in July) in the month of August. Of the formal complaints received 3% (1) was risk rated as red, 42% (14) as amber and 55% (18) as yellow.

2.2 Fourteen complaints were closed in August with 75% of written responses (6 of 8) being completed within 30 working days. The Patient Experience Team are liaising closely with Divisions to deliver an improved performance next month.

3.0 Friends and Family Test (FFT)

3.1 The Trust FFT positive scores for August were 97% for inpatients (96.9% in July) and 98.4% for day case (99.2% in July). The combined national average for these two areas remains at 96%. Maternity services achieved 99% in August (98.1% in July /97% national average), 97.6% for outpatients (96.2% in July/national average 94%). The Urgent and Emergency Care Centre achieved 94.1% (94.5% in July /national average 87%).

3.2 The Community positive score for August was 99.1% (97.8% in July/national average 95%).

4.0 Nurse Staffing Report

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

The improvement in RN fill rates can in part be attributed to the ward and staffing reconfigurations which took place in the Division of Medicine during July 2018; August being the first full month to include this. The revised planned staffing has been amended on the roster templates to reflect the reconfigurations and as a result fill rates have improved. In addition, actual staffing figures for unify have been collected from eRoster for the Division of Medicine for the first time. The data suggested an improved fill rate in the Division, this has been scrutinised and has highlighted some discrepancies in relation to the care staff to be included. Further work to understand this will take place during September and an update provided next month.

4.2 The overall vacancy rate has increased during August 2018; the largest number of vacancies continues to be in the Division of Medicine.
4.3 Of the 91 conditional offers made to soon-to-qualify nurses at the Trust recruitment open day and subsequent interviews, 46 of these have since withdrawn following successful interview at other local Trusts, 44 are due to qualify and start at TRFT in September 2018 and 1 is due to qualify and start in March 2019.

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

5.0 Looked After Children (LAC)

5.1 The number of Initial Health Assessments (IHA) completed within 20 working days (statutory) has decreased between July (87.5%) and August (62%). This decrease was predicted last month due to the inherent backlog for this service.

5.2 21 IHAs were completed in August, of which 13 were within 20 working days. Five appointments did not proceed because either the child was not brought or the appointment was cancelled at short notice. Rescheduling these appointments will therefore have a detrimental impact on future months’ compliance against the 20 working day target.

5.3 A meeting was held on the 10th September 2018, involving representatives from the Trust, Rotherham Metropolitan Borough Council and NHS Rotherham Clinical Commissioning Group regarding improving the access to Initial Health Assessments. The meeting was positive and 17 key actions were agreed to explore how improvements can be made on this issue. A follow up meeting is scheduled for the 12th November to evaluate these actions.

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

6.0 Care Quality Commission (CQC)

6.1 The Trust continues to prepare for the Well Led, Core Services and Use of Resources inspections. The Well Led inspection will take place from 22nd to 24th October 2018 with Core Services being inspected on an unannounced date prior to this. The Use of Resources inspection will take place on 28th September.

6.2 Executive colleagues, led by the Chief Executive have been asked to give a presentation to the CQC in Leeds on 11th October, in preparation for the Well Led inspection.

6.3 A range of activities continue in preparation for the inspections, NHS Improvement have assisted by undertaking a series of mock interviews and inspections of services. Additional mock inspections are currently being undertaken by internal teams.

6.4 There have been briefings for staff across the organisation and internal communications have been enhanced by the use of video messages from a range of staff explaining how they are preparing for the inspection.
6.5 Staff involved in the Well Led element of the inspection process will be receiving individual briefings, before they are interviewed.

7.0 Quality Assurance Committee Update

7.1 The Chief Nurse provided an update on the implementation of the recommendations from the Quality Governance review performed earlier this year.

7.2 The Committee received reports on three of the 2018/19 Quality Improvement Priorities, outlining the progress made during Quarter 1 and how the actions are being adjusted to ensure continued improvement. Reports presented this month related to safe and timely discharge, medication safety and improvement with compliance with the Mental Capacity Act.

7.3 There was discussion regarding the recent focused unannounced Care Quality Commission (CQC) inspection. Details of actions undertaken relating to this inspection were discussed.

7.4 Monthly reports were received and discussed regarding Infection Control, Looked After Children and Serious Incidents. The quarterly Patient Experience Report was also discussed.

7.5 The Deputy Chief Nurse presented the first version of a new quarterly report on patient safety. Which triangulated information from a number of sources including incidents, serious incidents, inquests and claims. The report highlighted some of the learning from incidents and how this was being addressed.

7.6 Annual reports were received and discussed in relation to water quality and hospital transfusion. It was noted that the committee were assured by the arrangements in place to oversee these two important safety issues.

7.7 There was a detailed discussion regarding Mortality. Concerns were raised regarding the Mortality Review Group not meeting recently and leadership of the mortality agenda. It was agreed to escalate concerns about progressing the Mortality agenda to the Board of Directors.

8.0 Hospital Acquired Infections

8.1 The 2018/19 trajectory is for zero cases of Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia. The Trust continue to report 1 hospital acquired case from April.

8.2 There has been a further case of Clostridium difficile infection reported this month, leaving the current total at 4. The annual trajectory is 25, so the Trust remains on track to meet this trajectory.

8.3 There has been no increase in the number of reported Gram negative bacteraemia infections this month. National mandatory surveillance of gram negative bacteraemia is for the specific organisms of E.coli, Klebsiella species and Pseudomonas aeruginosa. No trajectory for providers was set but Clinical Commissioning Groups (CCG) were challenged to reduce cases within each CCG by 10%.
8.4 Two cases of Tuberculosis (TB) are under current investigation as the probable TB was diagnosed after admission. Initial microbiology results indicate mycobacteria presence however the culture results and confirmation from a reference laboratory will give the final confirmation of the species. Both cases are being followed up as mycobacteria Tuberculosis with contact tracing planned.

9.0 Conclusion

9.1 The majority of areas are reporting similar performance to last month with some minor variation.

9.2 Whilst as expected there continues to be slight attrition (5) in expected numbers of newly qualified nurses to commence employment in the autumn, there are currently 44 due to join the Trust during the Autumn.

9.3 The Trust continues to prepare for the Care Quality Commission Well Led, Core Services and Use of Resources inspections.

Helen Dobson
Deputy Chief Nurse
September 2018
Nurse Staffing report

1. Registered Nurse/Midwife (RN/M) shift fill rates (daytime) were 90.2% in August 2018 compared to 85.9% in July 2018 and 93.6% on nights compared with 93.3%. Healthcare Support Worker HCSW) fill rates were 102.2% on days compared with 106.9% in July and for nights were 101.2% compared with 105.3%. The improvement in RN fill rates can in part be attributed to the ward reconfigurations which took place in the Division of Medicine during July 2018.

2. Eight in-patient areas had Registered Nurse fill rates (days) below 90%. These were A1, A2, A5, A7, Stroke Unit, B4, Fitzwilliam and Keppel. Of these, three had a day time shift fill rate less than 80% and these were; A5 at 74.4% compared with 63.3%, Stroke Unit at 72.7% compared with 66.7% and Keppel at 64.0% compared with 66.1% in July. The improvement in medical wards reflects a percentage shift due to the reconfiguration of staffing templates and does not reflect an actual increase in the number of available nurses.

3. One area had a fill rate below 80% on nights this was A2 at 65.8%.

4. Keppel ward have concluded a trial with a planned reduction of RNs on night shifts from three to two, this is now reflected in the eRoster template.

5. There were 0 shifts in the month with over 50% of RNs on duty being within the 12 month preceptorship period compared 1 in July. There has been an increase in the percentage of Registered Nurses/Midwives flexible staffing (internal bank) in the Division of Surgery and a reduction in the Divisions of Medicine and Family Health resulting in an overall reduction. RN agency usage has increased in the Divisions of Medicine and Surgery, there was no RN/M agency usage in the Division of Family Health during August. The percentage of shifts not staffed to plan has reduced to 22.43% in August as compared with 30.39% in July.

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

7. In the Community sickness absence has increased with 8.4% currently absent from work compared with 7.7% last month. The majority of which are long term sickness, maternity related sickness and colleagues having planned surgery/treatment.

8. 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 August the overall actual CHpPD remained the same as July at 7.2.

9. The overall nursing and HCSW vacancy remains in a negative position at -202.44 wte compared with -176.65 wte last month. The position when recruitment plans are included is -110.38 as at 31 August 2018 compared with -82.91 wte at 31 July 2018.

Overall band 5 vacancies have increased and remains in a negative position of -80.71wte compared with -75.26 at 31 July 2018. There are 40.65 wte nurses due to qualify in September 2018 in the recruitment process which will improve this position.

The band 2 vacancy is in a negative position at -46.54 wte, this remains high as a result of the reconfiguring of ward establishments in the Division of Medicine during July. Recruitment to these posts is currently underway.

The large number of vacancies 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 reported by the Trusts Datix system.

10. 91 conditional offers were made to soon-to-qualify nurses at the Trust recruitment open day on 24 March and subsequent interviews on 19 April. 46 of these have since withdrawn following successful interview at other local Trusts. 44 (headcount) are due to qualify and start at TRFT in September 2018 and 1 is due to qualify and start in March 2019.

11. A recruitment open day took place on 18 August 2018 particularly aimed at nurses due to qualify in March 2019. 20 conditional offers were made on the day and further interviews are planned to take place on 19 September 2018.
Purpose of this paper:

This report provides an update on the Trust's position on mortality and dementia and outlines research and development activity.

Summary of Key Points:

The HSMR is reported as 103 this month compared with 112.1 in July 2017, which is a significant decrease and improving mortality picture. The crude rate of mortality in proportion to discharges has also seen a significant decrease over the last few months. The Trust no longer sits in the upper quartile for mortality.

The diagnosis code which has alerted as requiring possible in-depth review is septicaemia except in labour, which has triggered as it has gone over 3 SD from previous position; this will be discussed at the forthcoming Mortality review group.

The number of recruits into clinical research studies on the NIHR Clinical Research Network portfolio at TRFT is 667, against a target of 550.

Board action required:

For noting
1.0 **Mortality**

1.1 The data is real time and, as such, is due to change at any point, but is correct at the time of writing. The data being reported is up to June 2018.

1.2 The trust is currently sitting with an HSMR of 103.6. The Trust has seen a decrease in the HSMR trend for many months running now and this month shows continued improvement, which is encouraging. The CUSUM chart shows this well. For comparison, the HSMR for July 2017 was 112.1.

1.3 The national peer rate is 99 following a rebasing of the figure. The Trust no longer sits in the upper quartile for mortality, which is again encouraging.

1.4 The crude rate of mortality in proportion to discharges has seen a significant decrease over the last few months and has remained the same this month compared to last month. This gives a crude percentage of 1.33% and a 3 month crude rate of 1.4%

1.5 Weekend crude rate is 2.83%. This has consistently been below 3% for a significant time now.

1.6 Of all the highest HSMR diagnosis codes, the number of observed deaths are less than the 20-25 to warrant a deeper review of these, as the number are not a significant cohort. On review of the CUSUM charts published by CHKS, there are a few alerts which need further discussion. The first diagnosis code which will be reviewed is the septicaemia except in labour; this shows a numerator of 136 cases and has triggered as it has gone over 3 SD from own previous position and may therefore warrant a deeper review. This will be discussed at the forthcoming Mortality review group.

1.7 Secondly, understanding regarding deficiency and other anaemia coding with 10 cases alerted.

1.8 Thirdly, the CUSUM scoring has alerted skin and subcutaneous tissue infections with 13 cases.

1.9 It is worthy of note that the small numbers, except septicaemia, may not warrant in depth case note review but rather ongoing observation of trends; however, without delving deeper into the meaning of these alerts it is difficult to ascertain.

1.10 The length of stay data has been considerably good with results borne from the considerable amount of focussed work in this area. The reports following this will focus on the days in between, i.e. 3-20 days stay, as this has not previously been looked into and may help to continue to improve our mortality position. On review of this data on all periods of length of stay, there has been less deaths observed than expected.
2.0 **Dementia, Delirium and Person-Centred Care**

2.1 A meeting of the Dementia, Delirium and Person-Centred Care Group was held on 21st August and there was good attendance. The next meeting is not yet scheduled but Board members will be advised of the date once confirmed, and Executive and Non-Executive Directors are welcome to attend.

2.2 The Trust’s lead frailty nurse was substantively appointed last month and will provide support for the spread of dementia, delirium and person-centred care training in the organisation. Appointments for the remainder of the frailty team are scheduled soon.

2.3 The National Audit of Dementia closes this month – the Trust is almost at the required 50 sets of notes. Staff response has been good, although there have been problems in obtaining relative or next of kin feedback; the Associate Medical Director for Person-Centred Care and Innovation is leading on boosting numbers.

2.4 The Associate Medical Director for Person-Centred Care and Innovation launched the new *This is Me* forms, which have been well received.

2.5 The Associate Medical Director for Person-Centred Care and Innovation led another session on dementia and delirium with F1 doctors; he also led a session on person-centred care with doctors working in acute medicine.

2.6 Version 8(10) of the Acute Medical Unit clerking proforma is now live.

2.7 An incident involving a patient sent home from hospital in a gown and red socks has led to an internal investigation and further training with staff to raise the importance of ensuring our patients are dressed and out of bed if possible; this links with the #EndPJParalysis campaign.

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

3.1 The number of recruits into clinical research studies on the National Institute for Health Research (NIHR) Clinical Research Network portfolio at The Rotherham NHS Foundation Trust is 667, including 320 for Yorkshire Health Study, against a target of 550 for the financial year 2018/19 [data cut 10 September 2018, taken from NIHR].

3.2 There are 84 studies that are currently active (recruiting or in follow up), listed in Appendix 1.

3.3 There are 15 new studies in set up, including 2 commercially sponsored studies.

3.4 Current funding for R&D includes the Clinical Research Network 17/18 allocation of £218,780, £20,000 Research Capability Funding, and commercial and non-commercial research income of £32,283 in the financial year 18/19 to date.
4.0 Hospital-Acquired Infections

4.1 *Methicillin Resistant Staphylococcus Aureus (MRSA)* bacteraemia: 1 case of hospital acquired MRSA bacteraemia was reported in April against the 2018/19 trajectory of zero cases. Three further cases were community-acquired.

- Q1- 1 case
- Q2- 0 cases to date

4.2 Blood culture contamination: as highlighted in previous reports, reduction in blood culture contamination is being monitored via the Infection Prevention and Control Committee. The National benchmark for blood culture contamination is a maximum of 3%; The Rotherham NHS Foundation Trust (TRFT) reported 5.15% for July. The August data wasn’t available at the time of writing. A review of line colonisation versus line contamination will be completed to ensure we are only reporting contaminated samples.

4.3 Identification of practitioners to provide educational and training support is continuing via the Vascular Access Team.

4.4 *Clostridium difficile (C.diff)* infection: the 2018/19 hospital trajectory is 25 cases.

4.5 The Public Health England (PHE) reporting algorithm changes for 2019/20 with cases reported as hospital acquired that occur after 2 days, not the current 3 days. There will be further identification based on health care intervention in the previous 3 months.

4.6 There has been 4 hospital acquired cases under the 2018/19 PHE reporting algorithm, which is what will be reported nationally.

4.7 There have been 6 hospital-acquired cases using the 2019/20 algorithm. All 6 cases have been investigated using the internal Root Cause Analysis (RCA) and Multi Disciplinary Team (MDT) process, and all cases for the year that meet the 19/20 timeline will be investigated in this way.

4.8 There have been 18 community-acquired cases to date; a number of these patients were admitted into hospital, which increases the risk of potential further cases of *C diff*. A review of all cases is completed with the Clinical Commissioning Group (CCG) and includes checking of ribotypes to identify if there is any suspicion of cross infection; to date there has been no identified cross infection concern.

- Q1- 3 cases
- Q2- 3 cases to date

4.9 Gram-negative bacteraemia: national mandatory surveillance of gram-negative bacteraemia is for the specific organisms of *E.coli*, *Klebsiella* species and *Pseudomonas aeruginosa*. No trajectory for providers was set but CCGs were challenged to reduce cases within each CCG by 10%.

4.10 *E.coli*: 97 reported through the laboratory, 4 of which are from CCGs other than Rotherham. 13 are hospital-acquired, 66 community-acquired.
4.11  *Klebsiella* species: 3 hospital-acquired, 11 community.

4.12  *Pseudomonas aeruginosa*: 0 hospital-acquired & 6 community-acquired case

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

4.15  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.

4.16  Tuberculosis (TB) - 2 cases are under current investigation as the probable TB was diagnosed after admission, but which are not hospital-acquired. Initial microbiology results indicate mycobacterial presence; however, the culture results and confirmation from a reference laboratory will give the final confirmation of the species. Both cases are being followed up as mycobacterial Tuberculosis with contact tracing commenced.

5.0  **In Summary**

Whilst there are still some key areas requiring ongoing focus, particularly surrounding mortality and sepsis, there have been some significant improvements made. Now that I am in post, it is an opportunity to review our current governance and patient safety structure, including the medical senior leadership sub-structure, to ensure that we have robust governance and scrutiny processes in place.

Dr Callum Gardner  
Interim Medical Director  
September 2018
### Appendix 1

#### NYT® Portfolio Studies

<table>
<thead>
<tr>
<th>RFT REF</th>
<th>TITLE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-06-02</td>
<td>Orthoheath Study</td>
<td>Public Health</td>
</tr>
<tr>
<td>17-05-02</td>
<td>Acute MIRCA</td>
<td>Infectious Diseases and Microbiology</td>
</tr>
<tr>
<td>18-07-02</td>
<td>Safety: a randomized controlled trial of a safer care intervention</td>
<td>Cardiac Surgery</td>
</tr>
<tr>
<td>17-05-02</td>
<td>Marker recruitment and progression of cancer</td>
<td>Cancer</td>
</tr>
<tr>
<td>18-04-02</td>
<td>CARTN</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>13-08-07</td>
<td>Trial 9, Test 5000 Follow-up study</td>
<td>Cancer</td>
</tr>
<tr>
<td>12-04-06</td>
<td>XANTAC</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>12-04-02</td>
<td>SILS</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>11-05-05</td>
<td>KLEED (Incident and high risk type 1 diabetes cohort)</td>
<td>Diabetology</td>
</tr>
<tr>
<td>12-05-05</td>
<td>Evaluating for Right Heart (EHR</td>
<td>Reproductive Health and Obstetrics</td>
</tr>
<tr>
<td>18-03-02</td>
<td>CART-NET (Diabetes)</td>
<td>Dermatology</td>
</tr>
<tr>
<td>18-06-04</td>
<td>Complex Care Burden: breddy (XBBH)</td>
<td>Geriatric Services</td>
</tr>
<tr>
<td>11-05-04</td>
<td>VMS</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>11-02-04</td>
<td>Vios-Austin</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>11-05-05</td>
<td>187</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>12-07-02</td>
<td>VIEF</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>12-08-02</td>
<td>The Adult Asthma Spectrum Cohort - UK</td>
<td>Mental Health</td>
</tr>
<tr>
<td>13-05-03</td>
<td>Walking the Mile to Breast Cancer</td>
<td>Cancer</td>
</tr>
<tr>
<td>13-04-12</td>
<td>PHEDON 2</td>
<td>Children</td>
</tr>
<tr>
<td>14-02-01</td>
<td>YKIDS</td>
<td>Cancer</td>
</tr>
<tr>
<td>14-03-05</td>
<td>180C</td>
<td>Cancer</td>
</tr>
<tr>
<td>17-08-01</td>
<td>BREF Impact</td>
<td>Sexual Health</td>
</tr>
<tr>
<td>18-11-05</td>
<td>SINAPIE</td>
<td>ENT</td>
</tr>
<tr>
<td>18-11-05</td>
<td>High Intensity Specialist Led Acute Care (HILAC) Project</td>
<td>Consultants Trust Wide</td>
</tr>
<tr>
<td>32-02-05</td>
<td>TRIALNET</td>
<td>Diabetes/Children</td>
</tr>
<tr>
<td>13-08-03</td>
<td>COP</td>
<td>Dermatology</td>
</tr>
<tr>
<td>17-12-04</td>
<td>Access and Hearing Arts online survey</td>
<td>Audiology</td>
</tr>
<tr>
<td>17-12-04</td>
<td>FACHP</td>
<td>Dermatology</td>
</tr>
<tr>
<td>17-09-04</td>
<td>FRA - Post Injury Rehabilitation</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>18-01-05</td>
<td>Investigation of wellbeing interventions in NHS Staff (HealthNET)</td>
<td>Trust Wide</td>
</tr>
<tr>
<td>13-02-05</td>
<td>The Flight Study</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>17-07-04</td>
<td>Outlining Cancer Research Breast-Cancer Improvement Program</td>
<td>Cancer</td>
</tr>
<tr>
<td>12-02-05</td>
<td>15-Rum Thor Facial Cleft Deformities</td>
<td>Cancer</td>
</tr>
<tr>
<td>17-07-02</td>
<td>National cohort study of role effects of Hodgkin lymphoma treatment</td>
<td>Cancer</td>
</tr>
<tr>
<td>18-01-05</td>
<td>Cohort: Senserio Breast Carcinoma</td>
<td>Sarcoid &amp; Complex Diseases</td>
</tr>
<tr>
<td>11-01-05</td>
<td>Publication: 2nd Worldwide Food Study</td>
<td>Gastroenterology</td>
</tr>
</tbody>
</table>

**Total: 28**

#### In Follow Up

<table>
<thead>
<tr>
<th>RFT REF</th>
<th>TITLE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>08-08-05</td>
<td>REACT</td>
<td>Cancer</td>
</tr>
<tr>
<td>02-11-08</td>
<td>ADBS</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>01-05-02</td>
<td>DIA</td>
<td>Diabetes</td>
</tr>
<tr>
<td>12-12-05</td>
<td>DISEA</td>
<td>Dermatology</td>
</tr>
<tr>
<td>12-10-06</td>
<td>DIP</td>
<td>Dermatology</td>
</tr>
<tr>
<td>14-09-05</td>
<td>DIP</td>
<td>Dermatology</td>
</tr>
<tr>
<td>17-07-06</td>
<td>DIP</td>
<td>Neurology</td>
</tr>
<tr>
<td>18-11-05</td>
<td>impatient, impact &amp; costs of procedures for safe staffing (no C&amp;C but counts towards overall)</td>
<td>Health Services and Delivery Research</td>
</tr>
<tr>
<td>18-11-05</td>
<td>K</td>
<td>Neurology</td>
</tr>
</tbody>
</table>

**Total: 28**

#### Participant Identification Centre (PIC)

<table>
<thead>
<tr>
<th>RFT REF</th>
<th>TITLE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>06-09-10</td>
<td>RAP</td>
<td>Cancer</td>
</tr>
<tr>
<td>05-07-11</td>
<td>CODES</td>
<td>Neurology</td>
</tr>
<tr>
<td>06-04-02</td>
<td>The ECUTEC Trial</td>
<td>Children</td>
</tr>
<tr>
<td>07-05-05</td>
<td>Getting your Health and Weigh it</td>
<td>Trust Wide</td>
</tr>
<tr>
<td>06-02-04</td>
<td>Improving clinical practice for babies with hearing loss</td>
<td>ENT</td>
</tr>
<tr>
<td>11-11-07</td>
<td>Farfield City Major Health Ltd Trial</td>
<td>Mental Health</td>
</tr>
<tr>
<td>08-04-01</td>
<td>KIDS</td>
<td>Cancer</td>
</tr>
<tr>
<td>05-12-09</td>
<td>Head of vascular surgery for quality of life</td>
<td>Cardiovascular</td>
</tr>
</tbody>
</table>

**Total: 13**

#### Non-Portfolio Studies

<table>
<thead>
<tr>
<th>RFT REF</th>
<th>TITLE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-07-04</td>
<td>Assessing the age extension to the NHS breast screening programme</td>
<td>Cancer</td>
</tr>
<tr>
<td>15-10-03</td>
<td>event EPDI</td>
<td>Respiratory</td>
</tr>
<tr>
<td>17-10-06</td>
<td>Ive Linkage for urgent care data</td>
<td>Emergency Services</td>
</tr>
<tr>
<td>17-08-04</td>
<td>Vitamin D and intumescence response in haematological stem cell transplant</td>
<td>Haematology</td>
</tr>
</tbody>
</table>

**Total: 6**

#### Supporting Post Graduate Qualifications

<table>
<thead>
<tr>
<th>RFT REF</th>
<th>TITLE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-07-05</td>
<td>Attending with Gestational Diabetes</td>
<td>Health Services and Delivery Research</td>
</tr>
<tr>
<td>17-11-05</td>
<td>Management of Hypogonadism</td>
<td>Endocrinology</td>
</tr>
<tr>
<td>18-03-03</td>
<td>Cardiac Rehabilitation Study</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>18-04-02</td>
<td>The role of evidence based practice for patients</td>
<td>Epidemiology</td>
</tr>
<tr>
<td>18-03-03</td>
<td>Role of self perception in patients and related adjustment and wellbeing</td>
<td>Dermatology</td>
</tr>
<tr>
<td>18-11-05</td>
<td>Evaluation of Markers for Early Diagnosis for the Development of the Segol Panel</td>
<td>Biomedical Science</td>
</tr>
</tbody>
</table>

**Total: 7**

#### Sponsored by RFT

<table>
<thead>
<tr>
<th>RFT REF</th>
<th>TITLE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-06-01</td>
<td>Pharmacogenetics</td>
<td>Pharmaceutical Science</td>
</tr>
<tr>
<td>13-04-01</td>
<td>Asthma in Early Infancy</td>
<td>Pulmonology</td>
</tr>
<tr>
<td>13-08-02</td>
<td>Improving quality of life for patients and carers living with interstitial lung disease</td>
<td>Respiratory</td>
</tr>
<tr>
<td>13-07-10</td>
<td>RRT Emoticon Field Study</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>18-02-06</td>
<td>Secondary Infection Research Fund in Generalist Bladder patients (BR) Study</td>
<td>Renal and Urology</td>
</tr>
<tr>
<td>18-04-01</td>
<td>Secondary nerve block vs combined sympathetic nerve block: Effect on respiratory function in patients undergoing shoulder surgery</td>
<td>Anesthesiology, Perioperative Medicine and Pain Management</td>
</tr>
</tbody>
</table>

**Total: 5**

#### No & C&C Studies

<table>
<thead>
<tr>
<th>RFT REF</th>
<th>TITLE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-05-02</td>
<td>Donor gene expression in flow cytometry</td>
<td>Obstetrics and Gynaecology</td>
</tr>
<tr>
<td>11-06-01</td>
<td>Clinical care’s views on the usefulness of patient survey question</td>
<td>Trust Wide</td>
</tr>
<tr>
<td>15-07-05</td>
<td>Evaluating the ten year impact of the Positive Ward</td>
<td>Trust Wide</td>
</tr>
<tr>
<td>17-04-06</td>
<td>Thr bust for NHS FYI: the role of evidence based practice</td>
<td>Emergency Services</td>
</tr>
<tr>
<td>17-08-03</td>
<td>SPAN: Optimising routine service provision for patient babies (1-2 weeks)</td>
<td>Children</td>
</tr>
<tr>
<td>18-01-02</td>
<td>Attention Control Screen Survey</td>
<td>Infectious Diseases and Microbiology</td>
</tr>
<tr>
<td>18-02-02</td>
<td>Pharmacy professionals perception of patient medicines medicines</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>11-11-07</td>
<td>National survey of patient experience leads</td>
<td>Trust Wide</td>
</tr>
</tbody>
</table>

**Total: 8**

**Grand Total: 84**
BOARD MEETING: 25 September 2018

Agenda item: 353/18(c)

Report: Operational Performance Report
Presented by: George Briggs, Chief Operating Officer
Author(s): As above

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

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

Risk Reference:
- BAF: B1, B2, B4
- Corporate Risk Register: As appropriate

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

Summary of Key Points:

Sustainability and Transformation Standards

- Emergency 4-hour Access target – August 2018 position: 87.7% the submitted trajectory was 88.2%. The year to date position is 87.8% down from 88.7% previous month.
- The Rotherham Cancer 62 Day position for quarter 1 2018 is 83.7% after reallocations quarter 2 is showing 84.6% un-validated against the 85% compliance target.
- Diagnostics (DMO1) – the un-validated position for DMO1 for August 2018 is 0% this reflects 0 breach.
- 18-week Referral To Treatment incomplete pathway – un-validated position for August 2018 is sustained at 94.7%.

Board Action Required:
For noting.
1.0 Introduction:

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

2.0 Four-hour emergency access target

2.1 Performance for August 2018 against the 4-hour access target was 87.7% this shows a deterioration in the last month. The trajectory is 88.2% we are slightly below our locally agreed trajectory.

Key issues are:
- ED staffing specifically in Primary care GP’s ANPs
- High numbers of complex delays
- Flow across both surgical and medical emergency areas linked to high numbers of medically unstable patients.

2.2 The year to date position is at 87.8% (as at end of August 2018).

2.3 The initial results for September show we continue to struggle to maintain performance.

2.4 Performance has been linked to staff rota compliance which has been compromised over the last 3 months. Junior doctors are now in place and developing the familiarity and skills required to support the department and the wards. Analysis has shown an increase in activity throughout June and July along with a large increase in breaches. Activity settled down in August to expected levels.
2.5 The present tolerance based on average September numbers is 22-24 Breaches per day as of 7th September which will allow us to hit 90% September 2018.

3.0 Cancer

3.1 The Rotherham 62-day cancer position for Quarter 1 is 83.7% after reallocations above trajectory against the local ICS target of 80%. Quarter 2 is but will remain below the national 85% compliance target.

3.2 The current forecast position against the 62-day cancer pathway is that Quarter 2 (Q2) will achieve the 85% compliance target. The position is complex and reliant upon a number of factors. We are half way through the quarter and have un-validated 16.5 breaches. The best prediction is 9 more potential breaches.

25.5 breaches require a denominator of 170 to be compliant. Q2 is particularly busy, and we have seen an increase in numbers of patients over the last 3-4 months our prediction is that we will achieve the denominator.

The biggest internal risk is remains delays with histopathology.

Summary – We as per last month are on the limit of Q2 being achievable. The highest level of proactive escalation remains in place with most specialties on deep dive level review through weekly waiting list.

3.3 Recovery Actions
- Increased support for cancer trackers. Additional staff advertised for and staff working overtime at weekends
- Additional MRI facility 5 days per week commenced 14th May
- Histopathology Trackers (recruitment commenced)
• Collective work of the cancer trackers
• Daily scrutiny of the PTL
• Weekly PTL meetings and updates
• Bring forward 10-12 patients from all areas

4.0 18 Week RTT Incomplete

4.1 The un-validated position for August 2018 is 94.7% against the 92% 18 week RTT Incomplete target. This represents a continued strong operational performance against this performance metric.

4.2 This puts TRFT in the upper quartile performance in the country. Over 60% of Trusts are failing the standard nationally

4.3 Gynaecology

Gynaecology is the main area of concern within our 18-week program 200 patients are showing at 18 weeks plus with a performance of 84.4% The service has implemented the following actions to ensure recovery.

• The additional full day list has continued on alternate weeks within our theatres which has maintained the long waits without deterioration but has not markedly reduced the numbers.
• The Gynaecology team are planning on additional sessions on Saturdays
  o Targeted long wait patient’s day case patients
  o Reduce the list over 6 weekends by over 60 patients

We are commencing the additional lists on Saturday the 22nd September 2018.

4.4 Cancelled operations

22 patients had a cancellation in August 2018 (27 in July)

5.0 6 Week Wait Diagnostic Tests

5.1 The un-validated position for DMO1 for August 2018 is 0%, which shows 0 people waited 6 weeks or longer for diagnostic tests.
## Operational Objectives update July 2018

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

7.1 The Trust continues in its “Action on AE” program with a focus on Home first “Why not today why not now”. Recruitment is starting this month of therapists and nursing staff.

7.2 After the auditing of the wards re compliance with planned improvements an Operational delivery meeting has been set up with Divisional teams operational site teams and clinical leads invited. This will manage delivery of:

- Safer bundles
- The operational delivery of the winter plan
- The creation of a winter action team
- Plans for weekends and key times of stress Christmas Easter etc.
- Annual leave
- Internal waits

8.0 Conclusion

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

8.2 Performance against the Cancer 62-day target has remained under the national standard a result of both activity demand and access across a number of pathways delays. Whilst action is underway, to achieve quarter 2 as per revised plan this remains a high risk.

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

George Briggs
Chief Operating Officer
September 2018
Board Meeting: 25 September 2018

Agenda item: 353/18(d)

Report: Workforce Report

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

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

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

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

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

Summary of Key Points:

- Staff in post in August 2018 is 3707.15 whole time equivalent (WTE), an increase of 27.10 WTE compared to July 2018.
- A strong performance in relation to this month’s sickness absence, 3.55% for August 2018, this is 0.40% below the 3.95% target.
- The overall Personal Development Review (PDR) compliance for the organisation is 73.79%; target is to achieve 90% by the end of September.
- The Trust’s overall Mandatory and Statutory Training (MaST) performance is 88% against the 85% target.
- As part of the new occupational health provision the Employee Assistance Programme (EAP) will be launched on 01 October 2018.
- National Staff Survey (NSS) launches on the 08 October 2018.
- Flu campaign is expected to commence during the second week of October.

Board action required: For Noting
1.0 Recruitment and Retention

1.1 Turnover in August 2018 is 0.41% (99.59% retention), 0.14% improvement against August 2017. The Trust’s staff retention rates compare favourably with national benchmarks.

1.2 Family Health have had the most leavers in August 2018, 10 (8.04 WTE) followed by Corporate Services, 9 (6.16 WTE). The most popular leaving reason was relocation, 8 (6.61 WTE).

2.0 Sickness Absence

2.1 The Trust’s sickness absence for August 2018 is 3.55%, which is below the 3.95% target. The Trust continues to perform well in comparison with peer and national averages.

2.2 Short term absence has decreased to 0.92% from previous month (1.14%) and long term sickness absence has increased slightly to 2.63% from (2.58%).

2.3 Compared with August 2017 the rolling 12 month sickness absence has decreased by 0.22%.

3.0 Mandatory and Statutory Training (MaST)

3.1 The Trust core MaST compliance has increased by 1% (88%), 3% above the Trust target of 85%.

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

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>91.65</td>
</tr>
<tr>
<td>Corporate Operations</td>
<td>90.31</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>89.92</td>
</tr>
<tr>
<td>Family Health</td>
<td>92.08</td>
</tr>
<tr>
<td>Medicine</td>
<td>84.26</td>
</tr>
<tr>
<td>Surgery</td>
<td>86.40</td>
</tr>
</tbody>
</table>

3.3 The table below highlights the Trust’s mandatory and statutory core training compliance for each subject by division at the end of August 2018. Information Governance (IG) RAG rating is based upon divisional performance against the national target of 95%.
3.4 Compliance remains above the Trust target of 85%. Information Governance has remained at 88%. To avoid the expected high volume of IG renewals in March 2019, the IG team will work with HR to accelerate the 95% IG target to December 2018; which will provide an element of contingency to deliver this objective.

3.5 Two new competencies (Health, Safety and Welfare and Freedom to Speak Up) will be required from 01 April 2019. If these two new competencies were included in the target now the MaST compliance rate would be 82.23%. (Improved from 80% last month).

4.0 Personal Development Review (PDR)

4.1 The Personal Development Review (PDR) compliance is now at 73.79% for the Trust. The table below shows overall PDR compliance by division at the end of August 2018 against the 90% target.

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance %</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>78.16</td>
<td></td>
</tr>
<tr>
<td>Corporate Operations</td>
<td>84.21</td>
<td></td>
</tr>
<tr>
<td>Corporate Services</td>
<td>84.17</td>
<td></td>
</tr>
<tr>
<td>Family Health</td>
<td>73.89</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>64.07</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>72.17</td>
<td></td>
</tr>
</tbody>
</table>

4.2 All the divisions continue to review their outstanding PDR data at their respective Clinical Service Unit (CSU) performance meetings. The divisional leadership teams are ensuring that planned PDR dates are in place for colleagues not yet appraised.

5.0 Leadership, Culture and Engagement

5.1 The latest Leadership, Exploration and Discovery (LEAD) Forum event took place on 04 September with a focus on Quality Improvement. The Chief Nurse opened the session followed by a presentation from the Director of Nursing from the Improvement Academy Yorkshire and the Humber. 25 colleagues attended this forum event.

5.2 Learning and Development supported bespoke interventions in Sterile Services, Health Informatics, the UECC and the Senior Community Adult Nursing Team in the last month to improve teamwork and support their organisational development.
5.3 The Trust’s Bi-Monthly Coaching Forum will be held on 10 September. The table below shows the Trust’s coaching activity for August 2018.

<table>
<thead>
<tr>
<th>Number of Clients</th>
<th>Number of Hours of Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>11</td>
</tr>
</tbody>
</table>

5.4 Delivery plans are being finalised for the Senior Clinical Leadership Development Programme which will be jointly launched at the Lunchtime Lecture on 25 September by the Trust and Maguire (provider). Pre-joining evaluation of delegates will be undertaken by Maguire to capture aspirations, goals and identify specific situations to address during the programme. Our application review will aim to build cohorts that have synergy to co-create change, a key programme outcome.

6.0 Medical Workforce

6.1 Analysis of Allocate e-Job Plan shows 156 job plans on the system in the following stages:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Total</th>
<th>Draft</th>
<th>Discussion</th>
<th>Awaiting 1st Sign-Off</th>
<th>Awaiting 2nd Sign-Off</th>
<th>Locked Down</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>122</td>
<td>0</td>
<td>79</td>
<td>25</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>SAS</td>
<td>34</td>
<td>0</td>
<td>24</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

6.2 5 doctors have now arrived from India (2 x Emergency Department and 3 x Acute Medicine). They have commenced a structured induction programme and orientation into the Trust with a view to being fully operational in 6 – 8 weeks depending upon progress. A further 7 doctors are at various stages of pre-employment including obtaining GMC registration and visas; it is expected they will start to arrive in October.

7.0 Communications channels

7.1 More than 100 colleagues shared their views on the Trust’s communications channels, and their frequency, as part of a recent survey. The results will now be used to propose a refreshed and streamlined communications offering to colleagues, ensuring they are able to quickly and easily access the information they need. Some initial key themes include reducing the frequency of some bulletins, and increasing the use of social media as an internal communications channel.

7.2 The Communications Team worked with the Programme Management Office to host the Trust’s second annual Innovation Week (10-14 September). A series of workshops, information stands and daily communications messages were issued as part of the week. Colleagues were also encouraged to share their ideas for how they could work differently to work more efficiently and effectively. 25 entries have been received so far, and all will be considered for implementation with an overall winner being announced as part of the Proud Awards in November.
8.0 **Engagement & Wellbeing**

8.1 The national staff survey (NSS) launches on the 08 October 2018. Completion of the survey will be mixed mode, online and paper. The supporting communications will stress why it is really important to ‘join the national conversation’. Information will be on the hub about what the Trust has achieved since last year’s results; along with FAQ’s. Emphasis will be given that colleague views should be based on the past year and not only on the day it’s completed.

8.2 The seasonal Flu campaign is expected to commence in the second week of October (currently there is a delay in getting the vaccines). Following the successful campaign last year we are training our colleagues as peer vaccinators. This makes it easier to offer vaccination to all staff not just frontline workers. Supporting information will be on hub and prizes will be available to encourage colleagues to be vaccinated before 30 November 2018.

8.3 As part of this new OH provision the Employee Assistance Programme (EAP) will be launched on 01 October - roadshows, posters, FAQ, HUB information, APPS are available to support the launch.

8.4 Arrangements in place to hold a quarterly meeting across Rotherham to share H&WB ideas; it will include RDASH, CCG, RMBC, TRFT with the aim to maximise Input, widen participation through shared events.

**Paul Ferrie**  
Interim Director of Workforce  
September 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 August, year to date, and forecasting delivery of the year-end financial plan.
- An overall deficit of £1,706k in month (August) which is £22k favourable to the planned deficit.
- A year to date favourable position of £195k against the £9,983k deficit plan
- The Trust is underspent against the capital programme in August. A year end monthly forecast re-profile has been requested by the Director of Finance for the end of Q2.
- The Trust is ahead of its Cost Improvement Programme at the end of August and forecasting delivery in excess of the year-end target, £9.7m
- The Trust ended August 2018 with a cash balance of £1.45m compared to a planned level of £1.35m which is an £0.10m favourable variance
- At the end of August 2018 the Trust incurred agency costs of £5,108k inclusive of supporting the additional capacity. This year to date spend is marginally in excess of the internal budget and significantly above the NHSI agency ceiling. Actions to support delivery of the agency budget are detailed in the report.

Board action required:
For noting of the financial position
1. **Key Financial Headlines**

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

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

<table>
<thead>
<tr>
<th>I&amp;E Performance</th>
<th>In Month Plan £ms</th>
<th>In Month Actual £ms</th>
<th>Variance £ms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1.73)</td>
<td>(1.71)</td>
<td>0.02</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRFT Agency Spend</th>
<th>In Month Plan £ms</th>
<th>In Month Actual £ms</th>
<th>Variance £ms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.94</td>
<td>1.07</td>
<td>(0.13)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHSI Agency Ceiling</th>
<th>In Month Plan £ms</th>
<th>In Month Actual £ms</th>
<th>Variance £ms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.72</td>
<td>1.07</td>
<td>(0.35)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Efficiency Programme (CIP)</th>
<th>In Month Plan £ms</th>
<th>In Month Actual £ms</th>
<th>Variance £ms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.63</td>
<td>0.87</td>
<td>0.24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capital Expenditure</th>
<th>In Month Plan £ms</th>
<th>In Month Actual £ms</th>
<th>Variance £ms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.67</td>
<td>0.16</td>
<td>0.51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash Balance</th>
<th>In Month Plan £ms</th>
<th>In Month Actual £ms</th>
<th>Variance £ms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.35</td>
<td>1.45</td>
<td>0.09</td>
</tr>
</tbody>
</table>

1.2. As at the end of 31 August 2018 (month 5) the Trust is reporting favourable variances against all of the key metrics with the exception of agency spend. The following sections provide further information against these financial metrics.

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

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

2.2. Month 5 performance is shown in the table below

**Table 1 – Income & Expenditure (April 2018-March 2019)**

<table>
<thead>
<tr>
<th>Summary Income and Expenditure</th>
<th>18/19 Annual Plan</th>
<th>Monthly Position (August - Month 5)</th>
<th>Year to Date Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>£000s</td>
<td>Plan £000s</td>
<td>Actual £000s</td>
</tr>
<tr>
<td>Total NHS Clinical Income</td>
<td>225,549</td>
<td>19,828</td>
<td>18,972</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>19,215</td>
<td>1,991</td>
<td>1,615</td>
</tr>
<tr>
<td>Provider Sustainability Fund (PSF)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>244,764</td>
<td>21,818</td>
<td>20,587</td>
</tr>
<tr>
<td>EXPENDITURE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Pay Costs</td>
<td>(177,151)</td>
<td>(16,656)</td>
<td>(15,654)</td>
</tr>
<tr>
<td>Total Non Pay Costs</td>
<td>(74,163)</td>
<td>(6,505)</td>
<td>(6,289)</td>
</tr>
<tr>
<td><strong>Total Operating Costs</strong></td>
<td>(251,315)</td>
<td>(23,160)</td>
<td>(21,943)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>(6,550)</td>
<td>(1,342)</td>
<td>(1,356)</td>
</tr>
<tr>
<td>Non Operating Costs</td>
<td>(10,510)</td>
<td>(866)</td>
<td>(873)</td>
</tr>
<tr>
<td>Central Costs</td>
<td>(4,276)</td>
<td>502</td>
<td>501</td>
</tr>
<tr>
<td><strong>RETAINED SURPLUS / (DEFICIT)</strong></td>
<td>(20,345)</td>
<td>(1,706)</td>
<td>(1,728)</td>
</tr>
<tr>
<td>Agency % Total Pay</td>
<td>6.5%</td>
<td>6.4%</td>
<td>6.0%</td>
</tr>
<tr>
<td>EBITDA % Income</td>
<td>(2.7%)</td>
<td>(2.2%)</td>
<td>(2.6%)</td>
</tr>
<tr>
<td>Net Deficit % Income</td>
<td>(8.3%)</td>
<td>(7.8%)</td>
<td>(8.4%)</td>
</tr>
</tbody>
</table>
2.3. The key points to highlight to the Board at the end of August are:

- An overall deficit of £1,706k in month (August) which is 22k favourable to the planned deficit.
- A year to date favourable position of £195k against the £9,983k deficit plan

**Clinical Income & Activity**

- Clinical income is £1,365K favourable to Plan at the end of August. Adjusting for the additional pay award funding and GP schemes (see Pay and Non Pay section), the Trust is showing a small over-performance to date (£130k)

- The activity performance year to date is shown in the table below. The key points to draw from the table are;
  - For the main points of delivery, elective, non-elective and ED attendances, the Trust is on Plan at the end of August. This reflects the robust planning process and profiling by the clinical management teams.
  - Under performance on critical care, both paediatrics and adults.
  - Over-performance on outpatients and assessments – these areas continue to be the focus for ongoing discussions and actions with the internal teams and Rotherham CCG, linked to referral trends.
  - For month 6, there will also be metrics showing Community activity

<table>
<thead>
<tr>
<th>YTD Activity</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Diff. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Inpatient</td>
<td>2,238</td>
<td>2,244</td>
<td>6</td>
<td>0%</td>
</tr>
<tr>
<td>Elective Day case</td>
<td>11,111</td>
<td>11,325</td>
<td>214</td>
<td>2%</td>
</tr>
<tr>
<td>Non Elective</td>
<td>10,933</td>
<td>10,882</td>
<td>(51)</td>
<td>0%</td>
</tr>
<tr>
<td>ED Attendance</td>
<td>41,893</td>
<td>42,013</td>
<td>120</td>
<td>0%</td>
</tr>
<tr>
<td>Outpatient New</td>
<td>24,041</td>
<td>23,982</td>
<td>(59)</td>
<td>0%</td>
</tr>
<tr>
<td>Outpatient FU (CL)</td>
<td>43,832</td>
<td>46,123</td>
<td>2,291</td>
<td>5%</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>22,216</td>
<td>23,786</td>
<td>1,571</td>
<td>7%</td>
</tr>
<tr>
<td>Adult Critical Care</td>
<td>1,663</td>
<td>1,559</td>
<td>(104)</td>
<td>(6)</td>
</tr>
<tr>
<td>Paediatric Critical Care</td>
<td>2,091</td>
<td>1,837</td>
<td>(254)</td>
<td>(12)</td>
</tr>
<tr>
<td>Assessments</td>
<td>4,826</td>
<td>7,234</td>
<td>2,408</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Pay and Non Pay**

- Pay costs are showing an overspend of £835k year to date. However, the following factors must be noted;
  - The pay arrears, £860k, for Agenda for Change (AfC) colleagues was paid in August with the Trust receiving additional income above the planned level to fund this. This was in addition to the new pay rates being paid in July.
• The Trust is now the lead employer for the GP Vocational Training Scheme. This is fully funded for the pay costs incurred, £160k per month.

The total impact of the 2 factors above year to date is £1,235k. In line with the agreed financial reporting budgets are fixed for the financial year to align with the 2018/19 submitted financial and operational plan, and so the £1,235k is showing as an over-performance on income. Adjusting for these factors would say the pay position being favourable to budget.

• Non pay costs are showing an adverse position, £1,100k against budget predominately due to excluded drugs and devices and premises, which is offset by income.

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

2.5. These meetings with Divisional teams have focused on;

• Year-end forecast including risks and opportunities. These risks and opportunities, including actions to mitigate the risk or secure the opportunity have been discussed at the Finance & Performance Committee.
• Clear actions required to improve performance and/or mitigate any risks.
• Escalation of any issues to the Executive Management Committee

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

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

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

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

2.4. At the end of August 2018 the Trust incurred costs of £5,108k inclusive of supporting the additional capacity. This year to date spend is slightly above the internal budget, £184k, and £1.4m adverse to the NHSI ceiling.

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

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

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

3. **Cost Improvement Programme**

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

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

- Performance in August of £873k, £243k favourable to plan.
- Year to date performance £883k above the plan of £2,553k
3.3. In addition to the in-month performance, continued focus and action is being taken to secure the £9.7m in year target and the full year effect of £13.1m.

3.4. At the time of writing the Trust has identified schemes with a risk adjusted value of £10.0m, an increase of £0.3m from last month. Total schemes identified for 2018/19 are now £10.7m in excess of the annual target.

4. Capital

- Total capital expenditure plans have been produced in accordance with the maximum internally generated funds available to the Trust and in conjunction with appropriate colleagues throughout the Trust.
- The Trust has a planned capital expenditure programme for 2018/19 of £5,800K.
- Expenditure year to date (to 31 August 2018) is £520K representing an under-spend of £1,108K against the year to date budget. Lead officers have been asked to provide a monthly profiled year-end forecast as at the end of September 2018 to provide assurance the capital programme will be fully delivered.
- The Trust as part of the South Yorkshire & Bassetlaw Integrated Care System is currently awaiting feedback on several draft business cases as part of the national capital programme.
- Work continues to produce a longer-term view of capital requirements together with subsequent funding options that will be used to inform the Trust’s five-year financial planning outlook. This will be reported to the Board in line with the agreed timetable.

5. Cash

- The trust ended August 2018 with a bank balance of £1.45m compared to a planned level of £1.35m which is an £0.10m 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
September 2018
Board Meeting: 25 September 2018

Agenda item: 354/18

Report: Data Quality Report

Presented by: Chris Holt, Director of Strategy and Transformation
Author(s): Monica Jones, Associate Director of Information Services

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
NHS Digital: IGTK Information Governance Standard 500
CQC Domain: safe / effective / caring / responsive / well led

Risk Reference:
BAF: B8
Corporate Risk Register: None

Purpose of this paper:
To present to the TRFT Board Meeting details of activity related to progress with developments in data quality.

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

- Since the last update, all new indicators in the IPR have now been updated and assurance assessments are now complete. They are ready for Exec Director sign off. (see Appendix 1)
- The Data Quality Assurance (DQA) process is now embedded in to Business as Usual practices at TRFT and continues to involve full data quality review of all Trust Board performance (including constitutional KPIs) indicators.
- Since the last update, divisional IPR indicators have now been confirmed and defined and the KPIs assessment process is underway. Plans are in place to have fully completed by March 2019.
- The DQ Team continue to work with services to identify and improve on operational data quality.
- Divisional Governance Leads have been briefed on the 10th of August, of their DQ role and responsibilities.

Board action required: For noting
1.0 Introduction

1.1 This paper provides an update on the data quality assurance processes undertaken to provide assurance that the indicators reported to the TRFT Board of Directors and externally to NHS regulators follow national guidance and are reported and monitored accordingly.

2.0 Data Quality

2.1 From the last update to the board where we covered the data quality assurance process for the Integrated Performance Report (IPR) and the annual refresh of IPR indicators we are pleased to report that all the new indictors have now been assured. Over the last three months the updated statements for each indicator have been loaded onto the DQ section of the Corporate Intranet site: The Hub.

2.2 The DQ assurance process includes:
- All indicators then have two documents for sign off
  1. A clear definition on how the indicator is constructed, with numerators / denominators, inclusions / exclusions etc. referencing national guidance where applicable
  2. A clear explanation of the process on how the indicator is created and ultimately presented, with a risk assessment against the 6 criteria:
     - Granularity
     - Contemporaneous
     - Completeness
     - Signoff
     - System / data source
     - Audited process
- These documents then get signed off by the Exec Lead – with the action plan having clear named owners.

2.3 From a DQ perspective in the last quarter, it has been Business As Usual (BAU). The Data Quality Team is responsible for providing Data Quality/Information reports required by Trust Directors and Managers, CSUs, CCGs and internal management groups in order to validate and correct data as required and the Business Engagement Team to feed into Dashboard reports. The risk associated with poor data quality includes sub-standard patient care or harm to patients, loss of income and poor management decisions. It is The Data Quality Teams responsibility to work with Heads of Service, Line Managers and all Health Professionals to ensure that staff are supported to enable accurate and complete input of data and have an understanding of the importance of Data Quality as it relates to them, when inputting on to the appropriate Trust Systems.

2.4 During this quarter a briefing was given to all divisional governance leads on Friday 10 August 2018 to agree their roles and responsibility ref DQA. This was followed up with 1:1 meetings for those who were unable to attend. Risks associated with DQ will now be included on a regular basis in divisional governance meetings.
3.0 Conclusion

3.1 The Trust has committed to fully implementing the quality assurance process for the Integrated Performance Report (IPR). This provides the Trust with a robust process for quality assuring all indicators report on the IPR.

3.2 An on-going process of review by data owners, Head of Governance and internal / audit has happened and as per the action plans the issues identified are being identified, addressed and will be resolved with executive leadership to ensure completion.

Chris Holt
Director of Strategy and Transformation
September 2018
## Appendix 1 Indicator Status

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Exec Lead</th>
<th>Executive Signoff</th>
<th>Last update</th>
<th>Data QA Rating</th>
<th>Assurance Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E % Left without being seen</td>
<td>George Briggs</td>
<td></td>
<td>01/08/2018</td>
<td>20 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>IP Friends &amp; Family Test (% Positive)</td>
<td>Chris Morley</td>
<td></td>
<td>08/06/2018</td>
<td>26 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>% LAC assessments reported &lt;20 days</td>
<td>Chris Morley</td>
<td></td>
<td>31/07/2018</td>
<td>27 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>New Complaints per WTE</td>
<td>Chris Morley</td>
<td></td>
<td>08/08/2018</td>
<td>28 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Ambulance Turnaround Times % &gt; 60 mins</td>
<td>George Briggs</td>
<td></td>
<td>09/08/2018</td>
<td>29 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Cancelled Operations</td>
<td>George Briggs</td>
<td></td>
<td>19/06/2018</td>
<td>28 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Delayed Transfer of care</td>
<td>George Briggs</td>
<td></td>
<td>19/06/2018</td>
<td>31 / 36</td>
<td>Substantial</td>
</tr>
<tr>
<td>Dementia Assessment</td>
<td>Callum Gardner</td>
<td></td>
<td>08/06/2018</td>
<td>22 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Hip Fracture Best Practice Compliance</td>
<td>George Briggs</td>
<td></td>
<td>08/08/2018</td>
<td>20 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Mortality (SHMI Rolling 12 Month)</td>
<td>Callum Gardner</td>
<td></td>
<td>09/08/2018</td>
<td>24 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Stroke: admitted to ward within 4 hours</td>
<td>George Briggs</td>
<td></td>
<td>19/06/2018</td>
<td>28 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Urgent Care (4 Hour)</td>
<td>George Briggs</td>
<td></td>
<td>08/06/2018</td>
<td>24 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Cancer Standards 62 Day</td>
<td>George Briggs</td>
<td></td>
<td>26/07/2018</td>
<td>27 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Cancer Standards 62 Day Screening</td>
<td>George Briggs</td>
<td></td>
<td>26/07/2018</td>
<td>27 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Diagnostics (DM01)</td>
<td>George Briggs</td>
<td></td>
<td>19/06/2018</td>
<td>28 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>18 weeks (RTT Incomplete)</td>
<td>George Briggs</td>
<td></td>
<td>19/06/2018</td>
<td>25 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>e-Referral Slot Issues Rate</td>
<td>George Briggs</td>
<td></td>
<td>08/08/2018</td>
<td>19 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Access to Antenatal Services within 90 days</td>
<td>Chris Morley</td>
<td></td>
<td>05/07/2018</td>
<td>24 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>C.Diff incidence rate per 100,000 bed days</td>
<td>Chris Morley</td>
<td></td>
<td>27/07/2018</td>
<td>29 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Emergency Caesarean Section Rate</td>
<td>Chris Morley</td>
<td></td>
<td>08/08/2018</td>
<td>20 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Harm Free Care</td>
<td>Chris Morley</td>
<td></td>
<td>31/07/2018</td>
<td>30 / 36</td>
<td>Substantial</td>
</tr>
<tr>
<td>MRSA bacteraemia rate per 100,000 bed days</td>
<td>Chris Morley</td>
<td></td>
<td>27/06/2018</td>
<td>30 / 36</td>
<td>Substantial</td>
</tr>
<tr>
<td>Potential under reporting of incidents</td>
<td>Chris Morley</td>
<td></td>
<td>31/07/2018</td>
<td>23 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Readmissions (Non Elective 28 day)</td>
<td>George Briggs</td>
<td></td>
<td>19/06/2018</td>
<td>21 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>VTE Assessment Completion %</td>
<td></td>
<td></td>
<td>08/06/2018</td>
<td>24 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Incident Reporting Culture - % Incidents Severe</td>
<td>Chris Morley</td>
<td></td>
<td>31/07/2018</td>
<td>23 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>I&amp;E Margin</td>
<td>Simon Shepherd</td>
<td></td>
<td>03/08/2018</td>
<td>33 / 36</td>
<td>Substantial</td>
</tr>
<tr>
<td>Proportion of Temporary Staff</td>
<td>Paul Ferrie</td>
<td></td>
<td>08/08/2018</td>
<td>34 / 36</td>
<td>Substantial</td>
</tr>
<tr>
<td>Sickness Rates (12 Month Rolling)</td>
<td>Paul Ferrie</td>
<td></td>
<td>23/08/2017</td>
<td>22 / 36</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Staff Turnover</td>
<td>Paul Ferrie</td>
<td></td>
<td>08/08/2018</td>
<td>22 / 36</td>
<td>Reasonable</td>
</tr>
</tbody>
</table>
Board Meeting: 25 September 2018

Agenda item: 355/18

Report: Governance Report

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

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

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

Risk Reference:
BAF: B6
Corporate Risk Register: none

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

Summary of Key Points:
- Professional regulation supported by Managers in Partnership union
- Government publishes 25 technical notices on preparation for exit from the EU without a deal, 5 of which relate to healthcare
- Only 5% of acute trusts and 20% of community and mental health trusts complied with contractual obligation to publish their registers of staff interests
- NHS Providers publish a new report ‘The journey to integrated care systems’
- Lord David Prior announced as the Government’s chosen candidate to take on Chairmanship of NHS England
- ‘Charlie’s law’ begins its legislative journey
- Four events planned for autumn 2018 to share learning from the CQC’s local system reviews
- Details provided of open public consultations
- A number of briefings issued in month by NHS Providers, and

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-August 2018.

2.0 Professional Regulation for NHS Managers

2.1 It has been reported (HSJ) that a recent survey by the union Managers in Partnership resulted in 91% of the 80 senior managers who replied supporting the principle of professional regulation for NHS managers.

2.2 In addition two thirds of respondents indicated they were not confident that the current fit and proper person test would be fairly and objectively implemented. The union has submitted the results to the Government for review.

3.0 Government Brexit Briefings

3.1 On 24 August 2018 25 technical notices were published which detailed the preparations being made by the Government as part of their planning for the scenario of Britain existing the European Union with no deal.

3.2 Five of the technical notices relate to healthcare: medicines, medical devices and clinical trials; regulatory information on medical products; batch testing of medicines; quality and safety of organs, tissues and cells; and safety of blood and blood products.

3.3 On 13 September 28 further technical notices were published by the Government. Whilst none of these technical notices were published by the Department of Health & Social Care, seven could have an impact on the health sector: Trading in drug precursors; Accessing public sector contracts; Data protection; European Social Fund (ESF) grants; Common Travel Area; Trading under the mutual recognition principle and Trading goods regulated under the ‘New Approach’ Goods.

4.0 Publication of Staff Register of Interests

4.1 A recent survey undertaken by NHS England revealed that only 5% of acute Trusts and 20% of community and mental health Trusts had published their registers of staff interests. As a result, all Trusts were reminded by NHS Improvement of their contractual obligation to comply with NHS England’s Conflicts of Interest guidance which came into force in June 2017 and requires the publication of the interests of ‘decision making staff’ at least annually.

4.2 The Trust has complied with the guidance publishing the required registers in October 2017 and April 2018. The register is being updated again for publication in October 2018.

5.0 NHS Providers report ‘The journey to integrated care systems’

5.1 This is the third in NHS Providers ‘Provider Voices’ series and it details the opportunities and challenges presented by Sustainability & Transformation Partnerships and Integrated Care Systems.

5.2 Contributors include Andy Burnham, mayor of Greater Manchester and former health secretary and Professor Sir Chris Ham, Chief Executive of The King’s Fund.
6.0 **New Chair of NHS England**

6.1 It was reported (National Health Executive) that the Government’s chosen candidate to take over from Sir Malcolm Grant as Chair of NHS England is Lord David Prior. Lord Prior is a former health minister with experience of leadership roles in the NHS for example as Chairman of the University College London Hospital NHS Trust. Lord Prior will take over from Sir Grant in the autumn of 2018.

6.2 The Health Select Committee endorsed Lord Prior’s appointment recommending that he resigned as Conservative Party whip in the House of Lords.

7.0 **Charlie’s Law**

7.1 Lord Mackay of Clashfern tabled an amendment to the Mental Capacity Bill in early September which was debated in the Lords. Nicknamed ‘Charlie’s Law’ after the case of Charlie Gard, if it passes into legislation the new law would compel hospitals to offer mediation to parents before going to court and change the decision-making process to enable parents to be able to make decisions as to what medical treatment is in their child’s best interests, unless this would be likely to cause the child significant harm.

8.0 **Learning from CQC’s Local System Reviews**

8.0 The Local Government Association plans to run four events during autumn 2018 for senior health and social care system leaders looking to learn from the CQC’s local system reviews. In addition to hearing from the CQC and colleagues who have already experienced a review, the way in which the review methodology could be used to drive sector-led improvement will also be explored.

9.0 **Department of Health & Social Care ‘Talk Health & Care’ digital platform**

9.1 A new national engagement exercise for staff within health and care was launched in mid-September by the Secretary of State for Health & Social Care, Matt Hancock, who described it as the largest exercise of its type in health and care history. The digital platform is intended for staff to quickly and easily post ideas, questions and challenges for government.

9.2 Workforce is the first priority and comments on the five challenges posted have been invited and will be used to shape the development of the long term plan for the NHS and the Social Care Green Paper.

10.0 **Consultations**

10.1 The following public consultations are currently open:

- The design principles of the programme **Evidence based interventions**, NHSE, Academy of Medical Royal Colleges, NICE, NHS Clinical Commissioners and NHSI, closing on 28 September 2018. 

- Contracting arrangements for integrated care providers (ICPs), NHS England, closing on 26 October 2018.
Priorities for research to help make care safer for adults with complex health needs, NIHR Imperial Patient Safety Translational Research Centre and the James Lind Alliance closing on 15 October 2018. 
Link: https://imperial.eu.qualtrics.com/jfe/form/SV_dd4LawvmKayAyVf

Developing the long term plan for the NHS, NHS England closing on 30 September 2018
Link: https://www.engage.england.nhs.uk/consultation/developing-the-long-term-plan-for-the-nhs/

11.0 Briefings

11.1 The following briefings have been issued in month by NHS Providers (NHSP) and can be found on the NHSP website

- Two briefings on UK government's preparations for a 'no deal' scenario
- NHSP’s response to NHS England’s invitation to provide ideas about the design of the NHS Assembly
- Briefing for governors setting out the government's priorities for the NHS long term plan and funding settlement
- A briefing for parliamentarians on aspects of the Mental Capacity (Amendment) Bill ahead of the Lords committee stage
- Key changes set out in the new UK corporate governance code which comes into force from 1 January 2019
- Five tests for the NHS long term plan
- Winter planning 2018/19
- Briefing on NHS Improvement's 2018/19 Quarter 1 finance and performance figures

Lisa Reid
Head of Governance
September 2018
BOARD MEETING: 25 September 2018


Presented by: Lisa Reid, Head of Governance
Author(s): Lisa Reid, Head of Governance

Strategic Objective: Governance: Trusted, open governance

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

Risk Reference:
BAF: B4
Corporate Risk Register: 2978, 4762, 4959, 3520, 3908, 4740, 5442, 4064, 2978 and 4959

Purpose of this paper:
As part of the oversight of the Board Assurance Framework for 2018/19 the rewording of BAF item B4 is proposed by the Strategic Workforce Committee.

Summary of key points:
- It is proposed that the wording of the risk identifier for B4 is changed from:
  - The Trust's Plan cannot be delivered due to insufficient workforce capability and / or capacity; to
  - The Trust cannot deliver the range of services it is commissioned to deliver due to insufficient workforce capability and / capacity

Board action required: For approval.
1.0 Introduction

1.1 As part of the oversight of the Board Assurance Framework for 2018/19, during the discussion of the update for Q1 the Strategic Workforce Committee concluded that a review of the wording of the risk identifier for item B4 was warranted.

2.0 Outcome of Review

2.1 The wording of the risk identifier for BAF item B4 was discussed by the Strategic Workforce Committee at its meeting on 21 September 2018.

2.2 Given that the Committee met after the papers for the Board of Directors meeting were circulated a verbal update on any changes to the suggested wording will be provided by the Head of Governance at the Board of Directors’ meeting.

3.0 Recommendation from Strategic Workforce Committees

3.1 The **Strategic Workforce Committee** recommended the following:

- **B4**: It is proposed that the wording of the risk identifier for B4 is changed from:
  - The Trust's Plan cannot be delivered due to insufficient workforce capability and / or capacity; to
  - The Trust cannot deliver the range of services it is commissioned to deliver due to insufficient workforce capability and / capacity

- **B5**: No change to the wording of the risk identifier.

Lisa Reid
Head of Governance
September 2018
Report: How We Learn from Deaths Report

Presented by: Dr Callum Gardner, Interim Medical Director
Author(s) Dr C Kelly, Consultant Anaesthetist

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 is the fourth report on learning from deaths following the initial introductory report in September 2017. This report will be used to reiterate to the Board the mortality process and the current position.

Summary of Key Points:
The trust continues to review mortality cases in each division. The mortality policy has been published for clinicians to follow. The Trust has very few recorded avoidable deaths, although this metric will potentially no longer be used in the future. There is continued learning from deaths, however the aim is to make this more robust across the divisions.

Board action required:
For approval
1.0 Background:

1.1 The Trust has developed the mortality governance to be structured in a way that issues can be highlighted and acted upon, and so both the Medical Director and the Board have visibility of all aspects of mortality within the Trust.

1.2 The mortality policy has been published, which highlights the review process, the escalations required of divisions following the review, and the actions to be taken if problems have been identified. This policy includes the process of learning from those deaths and the dissemination of the actions taken across the organisation.

1.3 The national guidance on learning from deaths and the Serious incident framework are complementary. When a death meets serious incident criteria, the onset of the investigation is not be delayed by a case record review. A review of the record will inevitably be undertaken as part of the investigation process.

2.0 Trust Process

2.1 The Trust currently aims to review all mortality cases by using the case record review; these processes have a significant resource attached to it and at present can only review a proportion of the cases in depth. Certain divisions have reviewed all cases due to reduced numbers of mortality in these divisions, such as maternity and surgery. As most deaths occur in the division of integrated medicine, it is a significant challenge to review all. In this situation it has been deemed appropriate that a proportion can be reviewed; however, all identified serious incidents and inquests are reviewed and when diagnosis codes trigger a review in depth review, such as myocardial infarction reported in the previous report.

2.2 All paediatric deaths are reviewed within the division and the wider paediatric community for areas of improvement and learning and does not follow the same process currently as the adult population within the Trust. There is to be a national review of the paediatric process at a later date, which the Trust will endeavour to follow as appropriate guidance is published.

2.3 The Learning from death review in learning disabilities patients has been introduced within the Trust and there are currently eight active cases out for review by the local areas reviewers. The learning disabilities review is a more in depth review than simply the hospital admission and medical management. It involves all services from birth to death, including families and carer’s opinions. Once reviewed, it should provide invaluable learning for the wider health economy.

2.4 The Trust uses the Preventable incidents, survival and mortality (PRISM) scoring system, which scores “avoidability” at PRISM 6; the Royal College of Physicians (RCP) score avoidability on the same scale as 1. PRISM scoring:

1. Definitely not preventable
2. Slight evidence for preventability.
3. Possibly preventable but not very likely, less than 50–50 but close call.
4. Probably preventable, more than 50-50 but close call.
5. Strong evidence for preventability.
6. Definitely preventable.
2.5 RCP scoring

1. Definitely preventable
2. Strong evidence of preventability
3. Probably preventable, more than 50:50 but close call
4. Possibly preventable but not very likely, less than 50:50 but close call
5. Slight evidence of preventability
6. Definitely not preventable

2.6 It is worthy of note that the Improvement Academy has been lobbying the Department of Health to try to remove the concept of “avoidability”, as this is not seen to be a helpful indicator; as such, the Department of Health have agreed in principle. The Improvement Academy Mortality Programme, of which the Trust has played a role, was nominated for the BMJ Awards under the Patient Safety Category.

2.7 The Trust also reviews the case notes and scores using the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) scoring, looking at any required improvements in standards of care.

NCEPOD SCORING:

1: Good practice: A standard that you would accept from yourself, your trainees and your institution.
2: Room for improvement: Aspects of clinical care that could have been better.
3: Room for improvement: Aspects of organisational care that could have been better.
4: Room for improvement: Aspects of both clinical and organisational care that could have been better.
5: Less than satisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.

2.8 NHS England have not mandated publication of the cases using this scoring. The Trust feels that this is the more valuable exercise, as it helps with the learning that should be taken from the cases reviewed.

3.0 Learnings from Reviews

3.1 The previous report highlighted where the reviews had taken place in the event of NCEPOD and PRISM scoring falling below the standard the Trust would expect. The themes from those cases were: poor communication; failure to recognise a deteriorating patient; lack of advance care planning; and delayed/missed diagnosis. These work streams are continuing throughout the Trust.

3.2 These themes have therefore been taken on board as quality improvement targets. There has been a significant amount of work with the deteriorating patient and the acute kidney injury care pathway. There is now functioning electronic recording of observations in some areas of the Trust, especially in the surgical division. An evaluation of the effects and outcomes of this, with an aim to reduce incidents, will be presented to the Board in due course. The palliative care team have worked
extremely hard with the advance care planning, which has shown a marked improvement in the mortality data related to length of stay.

3.3 Themes from other cases also highlight communication issues between junior doctors and senior clinicians, and interdivisional lack of communication. There is work ongoing regarding handover processes to improve this for the future.

3.4 Some of the cases have highlighted unexpected admissions into critical care and this is subject to continuous scrutiny by the critical care team and outreach. These cases are reported to the weekly Harm Free meetings in the Trust.

3.5 Sepsis and the timely use of antibiotics has been an emerging theme and this is triangulated with missing the Commissioning for Quality and Innovation (CQUIN) target. There has also recently been an alert issued by CHKS regarding septicaemia and those cases will be reviewed to determine where improvements can be made. A task and finish group for sepsis has been working on a number of initiatives, including the introduction of sepsis boxes across the Trust. There has been further guidance issued regarding the sepsis tool and this is being built into Meditech, which will alert clinicians on deterioration and actions required. This hope is that this prompt will reduce the number of incidents occurring across the Trust. Antibiotics have been also now been classified as “critical medicine”, which should trigger actions out of hours if not available.

3.6 The previous reports on learning from deaths highlights the specific diagnosis codes which have been subject to scrutiny, such as pneumonia. The hip fracture review highlighted the need for increased support in the form of orthogeriatricians. This has been actioned and the orthopaedic patients are being more frequently reviewed, as there has been an increase in resource.

3.7 The intestinal obstruction without hernia review revealed no material issues with the surgical care and that these patients had received appropriate care.

3.8 There has been an in depth review of 30 day mortality following emergency surgery and 30 day mortality following elective surgery. These cases did not represent failures in surgical or medical care. These patients were often elderly with multiple comorbidities that led to expected non-surgical deaths.

3.9 Following the alert from both CHKS and from NHS Improvement (NHSi) regarding myocardial infarction within the Trust in the previous year, the cardiologists reviewed the cases involved and reported 43% of deaths were directly attributable to myocardial infarction, and therefore a significant proportion were not directly related to a myocardial infarction. However, all of the patients had significant numbers of comorbidities and were of an elderly population, as would be expected. Only one of the cases reviewed had a potentially preventable cardiac death. This information has been shared with the Care Quality Commission (CQC) and they are satisfied that the Trust process has highlighted the correct information going forward.

3.10 With the help of the bereavement and Patient Experience team, the Trust can now capture the views of the patient’s families if they wish to comment on the patient’s admission before death. This is captured on a comment card, rather than through a formal complaint, and will add valuable information to the review process and the
learning that should be from every death within the hospital. It will also help capture positive experiences, which has previously not been recorded.

3.11 It is worthy of note that the mortality group has not met to review the position. It is with anticipation that the group will be invigorated with the introduction of the new Medical Director. The Trust may look to appoint a Trust Mortality lead to drive the agenda forwards

4.0 In summary

4.1 The concept of reviewing deaths and reporting to NHS improvement with a national framework for case record reviews is embedded within the trust now. The improvement within the mortality data has shown that by concentrating on themes and trends and continual review of the mortality data that the national mortality picture can be improved. As the national mortality picture is improving the Trust needs to be conscious that other areas may be making faster improvements and, although the data is encouraging, the Trust may remain in the upper quartile. The learning is becoming a more integral part of the process and will continue to develop and flourish. The opinions of families can be captured in the mortality review in the same way as in the learning difficulties reviews.

4.2 The next steps are to quality assure the reviews and the scoring accuracy. There will be rolling training programmes for reviewers to ensure reviews are within reasonable boundaries, taking into account that differing reviewers will have differing considerations to the case record review. The scoring should not deter from the learning, which is the key to the process and should have the greatest focus.

Dr Carrie Kelly
Consultant anaesthetist
September 2018
Report: Trust Constitution – reviewed and revised

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

Strategic Objective: Governance: Trusted, open governance

Regulatory relevance:
Monitor: Licence Condition FT4 / Single Oversight Framework
CQC Domain: Well-Led

Risk Reference:
BAF: B6
Corporate Risk Register: None

Purpose of this paper:
A revised version of the Trust’s Constitution is provided for approval by the Board of Directors.

Summary of Key Points:

- The revised version of the Trust’s Constitution has been updated to reflect the standard template provided by the regulator, which most foundation trusts have now adopted;

- Whilst the new document has been put into a new format, the content remains largely the same as previous versions, with one exception, that being the composition of the staff member classes;

- The effect of this means that the same number of staff governors are proposed (5 in total) but from only one overall constituencies, rather than five. It is proposed that all current classes become merged to provide one class which shall have five Governors in total.

- Further to approval by the Board, it is proposed that the document be taken, with any required refinements, to the Council of Governors’ meeting to be held on 10 October 2018 for final approval.

Board action required: For approval.
Constitution of

The Rotherham NHS Foundation Trust

September 2018
The Rotherham NHS Foundation Trust
Constitution

TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interpretation and definitions</td>
<td>4</td>
</tr>
<tr>
<td>2. Name</td>
<td>6</td>
</tr>
<tr>
<td>3. Principal purpose</td>
<td>6</td>
</tr>
<tr>
<td>4. Powers</td>
<td>6</td>
</tr>
<tr>
<td>5. Membership and constituencies</td>
<td>7</td>
</tr>
<tr>
<td>6. Application for membership</td>
<td>7</td>
</tr>
<tr>
<td>7. Public Constituency</td>
<td>7</td>
</tr>
<tr>
<td>8. Staff Constituency</td>
<td>7</td>
</tr>
<tr>
<td>9. Automatic membership by default - staff</td>
<td>8</td>
</tr>
<tr>
<td>10. Restriction on membership</td>
<td>8</td>
</tr>
<tr>
<td>11. Annual Members’ Meeting</td>
<td>8</td>
</tr>
<tr>
<td>12. Council of Governors – composition</td>
<td>8</td>
</tr>
<tr>
<td>13. Council of Governors – election of governors</td>
<td>8</td>
</tr>
<tr>
<td>15. Council of Governors – disqualification and removal</td>
<td>9</td>
</tr>
<tr>
<td>17. Council of Governors – meetings of governors</td>
<td>9</td>
</tr>
<tr>
<td>18. Council of Governors – standing orders</td>
<td>10</td>
</tr>
<tr>
<td>19. Council of Governors – referral to the Panel for advising NHS foundation trust Governors</td>
<td>10</td>
</tr>
<tr>
<td>20. Council of Governors - conflicts of interest of governors</td>
<td>10</td>
</tr>
<tr>
<td>22. Council of Governors – additional provisions</td>
<td>10</td>
</tr>
<tr>
<td>23. Board of Directors – composition</td>
<td>10</td>
</tr>
<tr>
<td>24. Board of Directors – general duty</td>
<td>11</td>
</tr>
<tr>
<td>25. Board of Directors – qualification for appointment as a Non-Executive Director</td>
<td>11</td>
</tr>
<tr>
<td>26. Board of Directors – appointment of Chairman and other Non-Executive Directors</td>
<td>11</td>
</tr>
</tbody>
</table>
27. Board of Directors – removal of Chairman and other Non-Executive Directors ................................................................. 11
28. Board of Directors – appointment of deputy Chairman ......................................................... 11
29. Board of Directors - appointment and removal of the Chief Executive and other executive directors .............................................. 11
30. Board of Directors – disqualification .................................................................................. 12
31. Board of Directors – meetings ...................................................................................... 13
32. Board of Directors – standing orders ............................................................................... 13
33. Board of Directors - conflicts of interest of directors ........................................................................ 13
34. Board of Directors – remuneration and terms of office ....................................................... 14
35. Registers ......................................................................................................................... 14
36. Registers – inspection and copies ..................................................................................... 14
37. Documents available for public inspection .......................................................................... 14
38. Auditor .......................................................................................................................... 15
39. Audit committee .............................................................................................................. 15
40. Accounts ........................................................................................................................ 15
41. Annual report, forward plans and non-NHS work ............................................................... 16
42. Presentation of the annual accounts and reports to the governors and members ................................................................. 16
43. Instruments ...................................................................................................................... 17
44. Amendment of the Constitution .......................................................................................... 17
45. Mergers etc. and significant transactions............................................................................ 17
45. The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the council of governors .............................................................................................................. 17

ANNEX 2 – THE STAFF CONSTITUENCY ............................................................................ 20
ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS ............................................ 22
ANNEX 5 – THE MODEL ELECTION RULES 2014 ............................................................... 25
ANNEX 6 – THE COUNCIL OF GOVERNORS - ADDITIONAL PROVISIONS .......................... 75
ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS .................................................................................................................. 82
ANNEX 9 – FURTHER PROVISIONS – BOARD OF DIRECTORS ........................................ 83
[ANNEX 10 – ANNUAL MEMBERS MEETING] ....................................................................... 84
1. **Interpretation and definitions**

   Unless otherwise stated, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

   Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

   “2006 Act” means the NHS Act 2006;

   “2012 Act” means the Health and Social Care Act 2012;

   “Accounting Officer” means the person who from time to time discharges the functions specified in paragraph 25 of Schedule 7 to the 2006 Act;

   “Board of Directors” means the Board of Directors as constituted in accordance with this Constitution;

   “Chairman” means the Chairman of the Trust;

   “Co-optee” means an individual nominated in accordance with the provisions of paragraph 9.0 of Annex 6 of this Constitution and formally appointed by resolution of the Council of Governors to advise the Council of Governors at meetings of the Council of Governors in an advisory and non-voting capacity;

   “Council of Governors” means the Council of Governors as constituted in accordance with this Constitution;

   “Chief Executive” means the Chief Executive and Accounting Officer of the Trust;

   “Director” means a director on the Board of Directors;

   “Executive Director” means an Executive Director of the Trust appointed in accordance with paragraph 23 of the Constitution;

   “Financial Year” means the annual twelve-month period beginning on 1st April and ending on 31st March.

   “Governor” means a member of the Council of Governors;

   “Local Authority Governors” means a Member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of an area specified in Annex 1 as an area for a Public Constituency;

   “Member” means a Member of the Trust;

   "Monitor" means the body corporate known as Monitor referred to in section 61 of the 2012 Act;

   “Nolan Principles” means the seven principles of conduct for holders of public office enunciated by the Nolan Committee in its Report on Standards in Public Office;
“Other Partnership Governors” means a member of the Council of Governors appointed by a Governor partnership organisation other than a Clinical Commissioning Group or university providing a medical or dental school to the Trust and as specified in Annex 3, paragraph 5.1;

“Principle Principal Purpose” means the provision of goods and services for the purposes of the health service in England;

“Public Governor” means a member of the Council of Governors elected by the Members of a Public Constituency;

“Public Constituency” means the constituency of the Trust constituted in accordance with paragraph 7 of this Constitution;

“Registered Dentist” means a dentist within the meaning of the Dentists Act 1984;

“Registered Medical Practitioner” means a medical practitioner within the meaning of the Medical Act 1983 who holds a licence to practice under that Act;

“Rotherham Ethnic Minority Alliance” means the organisation established to promote positive change for Rotherham’s diverse minority ethnic communities;

“Rotherham Partnership” means the organisation which is from time to time established as the local accredited partnership for the Rotherham area and which brings together public, private, voluntary and community sector organisations for the benefit of the population of Rotherham;

“Secretary” means the secretary of the Trust or any other person appointed to perform the duties of the secretary of the Trust, including a joint, assistant or deputy secretary;

“Staff Governor” means a member of the Council of Governors elected by the Members of a Staff Class;

“Staff Class” means those classes of staff as classified by the relevant staff grouping described in paragraph 8;

“Staff Constituency” means the constituency of the Trust constituted in accordance with paragraph 8 of this Constitution;

“Trust” means The Rotherham NHS Foundation Trust;

"Vice Chairman" means the Vice Chairman of the Trust appointed pursuant to paragraph 17.1 of this Constitution;

"Voluntary Action Rotherham" means the body established for supporting, developing and promoting the voluntary and community sector in the Borough of Rotherham;

“Zero Tolerance Policy” means the Trust’s policy from time to time directed towards discouraging violence towards its staff.
1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act.

1.2 References in this Constitution to legislation include all amendments, replacements, or re-enactments made.

1.3 References to legislation include all regulations, statutory guidance or directions.

1.4 Headings are for ease of reference only and are not to affect interpretation.

1.5 Words importing the masculine gender only shall include the feminine gender.

1.6 Words importing the singular shall include the plural and vice-versa.

1.7 All Annexes referred to in this Constitution form part of it.

2. Name

2.1 The name of the foundation trust is The Rotherham NHS Foundation Trust.

3. Principal purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:
(a) the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
(b) the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.
5. **Membership and constituencies**

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:
   (i) a public constituency
   (ii) a staff constituency.

5.2 An individual who is a member of a constituency, or of a class within a constituency, may not, while membership of that constituency or class continues, be a member of any other constituency or class.

6. **Application for membership**

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust.

7. **Public Constituency**

7.1 Members of the Trust who are members of a public constituency, are to be individuals:
   (i) who live in an area specified in the column marked “Area (Wards)” of Table 1 Annex 1 and who have attained the age of 16 years of age at, or before, the time of their application for membership; and
   (ii) who are not eligible to become a member of the Staff Constituency; and
   (iii) who have each made application for membership to the Trust.

7.2 The minimum number of members in each Public Constituency, as specified in Table 1 in Annex 1, is 10 per each Public Constituency.

7.2 For the avoidance of doubt, those individuals who live in an area specified in the Constitution as an area for any Public Constituency, are referred to collectively as a Public Constituency in accordance with paragraph 4(2) of Schedule 7 of the 2006 Act.

8. **Staff Constituency**

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:
   (i) he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
   (ii) he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.3 At least three members of the Council must be elected by the Staff Constituency, or where there are classes within it, at least one member of the Council must be elected by each class, and at least three members must be elected altogether.

8.4 The Staff Constituency shall be divided into 51 class of individuals who are eligible for membership of the Staff Constituency. The description of
individuals making up each of the five one classes is specified within Annex 2 and are referred to as members of a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. **Automatic membership by default - staff**

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and;

9.1.2 invited by the Trust to become a member of the Staff Constituency shall become a member of the Trust as a member of the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so.

10. **Restriction on membership**

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not, while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become, or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 16 years old to become a member of the Trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 9 – Further Provisions.

11. **Annual Members’ Meeting**

11.1 The Trust shall hold an annual meeting of its members (‘Annual Members’ Meeting’). The Annual Members’ Meeting shall be open to members of the public.

12. **Council of Governors – composition**

12.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

12.2 The composition of the Council of Governors is specified in Annex 3.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

13. **Council of Governors – election of governors**

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules 2014. A copy of the Model Election Rules is attached at Annex 5.

13.2 The Model Election Rules as published from time to time by the Department of Health form part of this Constitution.

13.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 44 of the Constitution (amendment of the
Constitution).

13.4 An election, if contested, shall be by secret ballot.

14. **Council of Governors - tenure**

14.1 An elected governor may hold office for a period of up to 3 years.

14.2 An elected governor shall be eligible for re-election at the end that term.

14.3 An elected governor may, in exceptional circumstances\(^1\), serve longer than 9 years, but will be subject to annual re-election up to a total of 12 years maximum – and if contested, such election shall be held by secret ballot.

14.4 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

14.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

14.6 An appointed governor shall be eligible for re-appointment at the end of his term, subject to limitations described in paragraphs 4.2 or 5.3 of Annex 3.

15. **Council of Governors – disqualification and removal**

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

15.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

15.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 9.

16. **Council of Governors – duties of governors**

16.1 The general duties of the Council of Governors are

16.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and to represent the interests of the members of the Trust as a whole and the interests of the public.

16.1.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. **Council of Governors – meetings of governors**

17.1 The Chairman of the Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 23.2.1 below) or, in his absence, the Trust **Deputy Vice Chair** shall preside at meetings of the Council of Governors.

\(^1\) “Exception circumstances” shall be determined by the Council of Governors in a general meeting.
17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

17.3 For the purposes of obtaining information about the Trust’s performance of its functions or the directors’ performance of their duties (and deciding whether to propose a vote on the Trust’s or directors’ performance), the Council of Governors may require one or more of the directors to attend a meeting.

18. Council of Governors – standing orders
18.1 The standing orders for the practice and procedure of the Council of Governors are attached at Annex 7.

19. Council of Governors – referral to the Panel for advising NHS foundation trust Governors
19.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the Trust has failed or is failing—
   19.1.1 to act in accordance with its Constitution, or
   19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.
19.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - conflicts of interest of governors
20.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

22. Council of Governors – additional provisions
22.1 Further provisions with respect to the Council of Governors are set out in Annex 6.

23. Board of Directors – composition
23.1 The Trust is to have a Board of Directors, which shall comprise both executive and Non-Executive Directors.
23.2 The Board of Directors is to comprise
   23.2.1 a non-executive Chairman
   23.2.2 at least five other Non-Executive Directors; and
   23.2.3 at least five executive directors.
23.3 One of the executive directors shall be the Chief Executive.
23.4 The Chief Executive shall be the Accounting Officer
23.5 One of the executive directors shall be the finance director.
23.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).
23.7 One of the executive directors is to be a registered nurse or a registered midwife.
23.8 Notwithstanding the details provided in section 23.2, at least half of the board of directors, excluding the Chairman, shall be Non-Executive Directors.

24. **Board of Directors – general duty**
24.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25. **Board of Directors – qualification for appointment as a Non-Executive Director**
25.1 A person may be appointed as a Non-Executive Director only if –
   (i) he is a member of a Public Constituency, or and
   (ii) he is not disqualified by virtue of paragraph 30 below.

26. **Board of Directors – appointment of Chairman and other Non-Executive Directors**
26.1 The Council of Governors shall establish a Nominations Committee whose membership which shall comprise the Trust Chairman, two Public Governors, two Staff Governors and two Governors who shall not be from a Public Constituency or a Staff Constituency, to consider candidates for appointment as Non-Executive Directors against an agreed person specification.

26.2 The said Nominations Committee shall shortlist from those candidates meeting the specified criteria, those candidates whom it wishes to interview and shall conduct interviews with the said candidates and thereafter make its recommendation as to who should be appointed. This recommendation shall be submitted to a meeting of the Council of Governors for its consideration and decision.

26.3 The validity of any act of the Trust shall not be affected by any vacancy among the Directors or by any defect in the appointment of any Director.

27. **Board of Directors – removal of Chairman and other Non-Executive Directors**
27.1 Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the total number of members of the Council of Governors.

28. **Board of Directors – appointment of deputy Chairman**
The Council of Governors at a general meeting of the Council of Governors may appoint one of the Non-Executive Directors as a deputy Chairman (of the Council of Governors).

29. **Board of Directors - appointment and removal of the Chief Executive and other executive directors**
29.1 The Non-Executive Directors shall appoint or remove the Chief Executive.
29.2 The appointment of the Chief Executive shall require the approval of the
Council of Governors.

29.3 A committee consisting of the Chairman, the Chief Executive and other Non-Executive Directors shall appoint or remove the other executive directors.

30. **Board of Directors – disqualification**

30.1 The following may not become or continue as a member of the Board of Directors:

(i) a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

(ii) a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

(iii) a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

(iv) in the case of a Non-Executive Director, he no longer satisfies the requirements of paragraph 25.1;

(v) he is a person whose tenure of office as a Chairman or as a Member or Director of a health service body has been terminated on the grounds that his appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

(vi) he has had his name removed from any list prepared pursuant to paragraph 10 of the National Health Service (Performers List), Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere) and has not subsequently had his name included on such a list;

(vii) he has been dismissed otherwise than by reason of redundancy from any paid employment with a health service body;

(viii) Monitor has exercised its powers under the 2006 Act to remove that person as a Director of the Trust or any other NHS foundation trust within his jurisdiction or has suspended him from office or has disqualified him from holding office as a Director of the Trust or of any other NHS foundation trust for a specified period.

(ix) he is an executive or Non-Executive Director or Governor or Chief Executive of another NHS Trust or foundation trust;

(x) he is incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs;

(xi) he is registered as a sex offender pursuant to Part I of the Sex Offenders Act 1997;

(xii) he has been identified as a vexatious complainant and has been notified to the effect by notice in writing given by the Chief Executive;

(xiii) he is a member of the Rotherham Metropolitan Borough Council Health Overview and Scrutiny Committee;

(xiv) he has been unable to dedicate adequate time to the role and responsibilities of a Director of the Trust; or

(xv) he has been identified as a person who has failed to comply with or otherwise contravened the Trust's Zero-Tolerance Policy (as amended from time to time) and has been given notice to that effect by the Chief Executive.
The Board of Directors may in their discretion appoint a Committee of the Board of Directors to enquire into any such matter as may be raised in connection with paragraph 30.1 above in accordance with terms of reference as determined by the Board of Directors and to make recommendations to the Board of Directors in respect thereof.

31. Board of Directors – meetings
31.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.
31.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

32. Board of Directors – standing orders
32.1 The standing orders for the practice and procedure of the Board of Directors, as may be amended from time to time, are attached at Annex 8.

33. Board of Directors - conflicts of interest of directors
33.1 The duties that a director of the Trust has by virtue of being a director include in particular –
   33.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.
   33.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.
33.2 The duty referred to in sub-paragraph 33.1.1 is not infringed if –
   33.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or
   33.2.2 The matter has been authorized in accordance with the Constitution.
33.3 The duty referred to in sub-paragraph 33.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.
33.4 In sub-paragraph 33.1.2, “third party” means a person other than –
   33.4.1 The Trust, or
   33.4.2 A person acting on its behalf.
33.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.
33.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.
33.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.
33.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.
33.9 A director need not declare an interest –
   33.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest
   33.9.2 If, or to the extent that, the other directors are already aware of it;
   33.9.3 If, or to the extent that, it concerns terms of the director’s
appointment that have been or are to be considered –
33.9.3.1 By a meeting of the Board of Directors, or
33.9.3.2 By a committee of the directors appointed for the purpose under the Constitution.

34. Board of Directors – remuneration and terms of office
34.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other Non-Executive Directors.
34.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

35. Registers
35.1 The Trust shall have:
35.1.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;
35.1.2 a register of members of the Council of Governors;
35.1.3 a register of interests of governors;
35.1.4 a register of directors; and
35.1.5 a register of interests of the directors.
35.1.6 a register of interests for all staff

36. Registers – inspection and copies
36.1 The Trust shall make the registers specified in paragraph 35 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.
36.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if he so requests
36.3 So far as the registers are required to be made available:
36.3.1 they are to be available for inspection free of charge at all reasonable times; and
36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.
36.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37. Documents available for public inspection
37.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:
37.1.1 a copy of the current Constitution,
37.1.2 a copy of the latest annual accounts and of any report of the auditor on them
37.1.3 a copy of the latest annual report
37.1.4 a copy of the latest information as to its forward planning; and
37.1.5 a copy of any notice given under section 52 of the 2006 Act.
37.2 The Trust shall also make the following documents relating to a special
administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

37.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State’s rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

37.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

37.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

37.2.4 a copy of any draft report published under section 65F (administrator’s draft report) of the 2006 Act.

37.2.5 a copy of any statement provided under section 65F (administrator’s draft report) of the 2006 Act.

37.2.6 a copy of any notice published under section 65F (administrator’s draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor’s decision), 65KB (Secretary of State’s response to Monitor’s decision), 65KC (action following Secretary of State’s rejection of final report) or 65KD (Secretary of State’s response to re-submitted final report) of the 2006 Act.

37.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

37.2.8 a copy of any final report published under section 65I (administrator’s final report).

37.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State’s rejection of final report) of the 2006 Act.

37.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

37.3 Any person who requests a copy of, or extract from, any of the above documents is to be provided with a copy.

37.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

38. Auditor

38.1 The Trust shall have an auditor.

38.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

39. Audit committee

39.1 The Trust shall establish a committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

40. Accounts

40.1 The Trust must keep proper accounts and proper records in relation to the accounts.

40.2 In preparing its annual accounts, the corporation must comply with any directions given by the regulator with the approval of the Treasury as to—
(a) the methods and principles according to which the accounts must be prepared,
(b) the information to be given in the accounts.

40.3 The accounts are to be audited by the Trust’s auditor.

40.4 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

41. Annual report, forward plans and non-NHS work

41.1 The Trust shall prepare an Annual Report and send it to Monitor NHS Improvement.

41.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor NHS Improvement.

41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

41.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

41.5 Each forward plan must include information about –

41.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

41.5.1.1 the income it expects to receive from doing so.

41.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 41.5.1, the Council of Governors must –

41.6.1.1 determine whether it is satisfied that the carrying on of the activity will not, to any significant extent, interfere with the fulfillment by the Trust of its principal purpose or the performance of its other functions, and

41.6.1.2 notify the directors of the Trust of its determination.

41.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the Trust voting approve its implementation.

42. Presentation of the annual accounts and reports to the governors and members

42.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

42.1.1 the annual accounts

42.1.2 any report of the auditor on them

42.1.3 the annual report.

42.2 The documents shall also be presented to the members of the Trust at the Annual Members’ Meeting by at least one member of the Board of Directors in attendance.

42.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 42.1 with the Annual Members’
Meeting.

43. Instruments
   43.1 The Trust shall have a seal.
   43.2 The seal shall not be affixed except under the authority of the Board of Directors.

44. Amendment of the Constitution
   44.1 The Trust may make amendments of its Constitution only if –
       44.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments, and
       44.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

   44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

   44.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –
       44.3.1 At least one member of the Council of Governors must attend the next Annual Members’ Meeting and present the amendment, and
       44.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

   If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

   44.4 Amendments by the Trust of its Constitution are to be notified to Monitor NHS Improvement. For the avoidance of doubt, Monitor NHS Improvement’s functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45. Mergers etc. and significant transactions
   45.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the council of governors.

   45.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting, approve entering into the transaction.

   45.3 “Significant transaction” means:

       45.3.1 the acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 20% of the value of the Trust's gross assets before the acquisition; or
45.3.2 the disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 20% of the value of the Trust's gross assets before the disposition; or

45.3.3 a transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more than 20% of the value of the Trust's gross assets before the transaction.

45.4 For the purpose of this paragraph 45:

45.4.1 "gross assets" means the total of fixed assets and current assets;

45.4.2 in assessing the value of any contingent liability for the purposes of sub-paragraph 45.3.3, the Directors:

45.4.2.1 must have regard to all circumstances that the Directors know, or ought to know, affect, or may affect, the value of the contingent liability; and

45.4.2.2 may rely on estimates of the contingent liability that are reasonable in the circumstances; and

45.4.2.3 may take account of the likelihood of the contingency occurring.

45.5 Where the Trust has a single requirement for goods, services or works, and a number of transactions are to be entered into to fulfil that requirement, the value of the transaction for the purpose of paragraph 45.3 is the aggregate of the value of each of those transactions.
Table 1

<table>
<thead>
<tr>
<th>Name of Constituency</th>
<th>Area (Wards)</th>
<th>Minimum Number of Members</th>
<th>Number of Governors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham South Area A</td>
<td>Boston Castle, Rotherham East, Sitwell</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Rotherham North Area B</td>
<td>Keppel, Rotherham West, Wingfield</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Wentworth South Area C</td>
<td>Rawmarsh, Silverwood, Valley</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Wentworth North Area D</td>
<td>Hoober, Swinton, Wath</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Rother Valley West Area E</td>
<td>Brinsworth &amp; Catcliffe, Holderness, Rother Vale</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Wentworth Valley Area F</td>
<td>Hellaby, Maltby, Wickersley</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Rother Valley South Area G</td>
<td>Anston &amp; Woodsetts, Dinnington, Wales</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>All England Area H</td>
<td>The rest of England excluding areas A-G</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>

The Public Constituencies of the Trust are therefore constituted in accordance with Table 1 above.
ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraph 8.0)

1.0 The staff constituency is to be divided into five classes of individuals as follows:
   (a) the “Staff” Class
   (b) the “Medical, and Dental Practitioners Staff” Class
   (c) the “Nurses and Midwives Staff” Class
   (d) the “Other Health Professionals Staff” Class
   (e) the “Support Staff” Class
   (f) the “Other Staff” Class.

2.0 The members of the “Medical, Dental Practitioners Staff” class are individuals who are:
   (a) Members of the Staff Constituency who are fully registered persons within the meaning of the Medical Act 1983 or the Dentists Act 1984 (as the case may be) and who are otherwise fully authorised and licensed to practice in England and Wales; or
   (b) who are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on the professions of Registered Medical or Dental Practitioner; and
   (c) who are employed by the Trust in that capacity at the date of their application to become a Member and who at all times thereafter remain employed by the Trust in that capacity.

3.0 The Members of the “Nurses and Midwives Staff Class” are individuals who:
   (a) are Members of the Staff Constituency who are registered nurses or midwives and who are otherwise fully authorised and licensed to practice in England and Wales; or
   (b) are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife; and
   (c) who are employed by the Trust in that capacity at the date of their application to become a Member and who at all times thereafter remain employed by the Trust in that capacity.

4.0 The Members of the “Other Health Professionals Staff Class” are individuals who:
   (a) are Members of the Staff Constituency whose regulatory body falls within the remit of the Council for the Regulation of Health Care Professionals established by Section 25 of the National Health Service and Health Care Professions Act 2002 which do not fall within paragraphs 6.4.2 or 6.4.3 above or who are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on such professions; and
   (b) who are employed by the Trust in that capacity at the date of their application to become a Member and who at all times thereafter remain employed by the Trust in that capacity.
5. The Members of the “Support Staff Class” are individuals who:
   (a) are Members of the Staff Constituency who are employed or engaged by the Trust in the full-time support of those persons falling within paragraphs 6.4.2 or 6.4.3 above or who are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons discharging such functions; and
   (b) who are employed by the Trust in that capacity at the date of their application to become a Member and who at all times thereafter remain employed by the Trust in that capacity.

6.0 The Members of the “Other Staff Class” are individuals who:
   (a) are Members of the Staff Constituency who do not come within paragraphs 2.0, 3.0, 4.0, or 5.0 above and who are designated by the Trust from time to time as eligible to be Members of this Staff Class and who are not otherwise eligible to be Members of another Staff Class for the purposes of this paragraph; and
   (b) who are employed by the Trust in that capacity at the date of their application to become a Member and who at all times thereafter remain employed by the Trust in that capacity.

7.1 Members of the Trust who are Members of the Staff Constituency are to be individuals who are employed under a contract of employment by the Trust; and
   (a) who are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months; or
   (b) have been continuously employed by the Trust for at least 12 months;
   (c) who are qualified for membership under paragraph 8.

7.2 The minimum number of members required for each Staff Class of the Staff Constituency shall be five.

7.3 An individual who is eligible to be a Member of a Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency and may not become or continue as a Member of more than one Staff Class.

7.4 For the avoidance of doubt, those individuals who are eligible to be Members of the Staff Constituency are referred to collectively as “the Staff Constituency” in accordance with paragraph 4(3) of Schedule 7 of the 2003 Act.

7.5 An individual who is:
   (a) eligible to become a member of the Staff Constituency; and
   (b) invited by the Trust to become a member of the appropriate Staff Class of the Staff Constituency
shall become a member of the Trust as a member of the Staff Constituency (and appropriate class within the Staff Constituency) without an application being made, unless he informs the Trust that he does not wish to do so.
ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraph 12)

1.0 Composition of the Council of Governors

1.1 The Trust shall have a Council of Governors which shall consist of Public Governors, Staff Governors, a Local Authority Governor, and other Partnership Governors.

1.2 More than half the members of the Council of Governors shall be elected by Members of the Public Constituency.

1.3 The Council of Governors of the Trust shall comprise:

1.3.1 16 Public Governors elected in accordance with paragraph 2 below;
1.3.2 5 Staff Governors elected in accordance with paragraph 3 below;
1.3.3 1 Local Authority Governor appointed in accordance with paragraph 4 below; and
1.3.4 7 Partnership Governors appointed in accordance with paragraph 5 below.

2.0 Public Governors

2.1 The Public Constituencies of the Trust are as set out in Annex 1 and each such Public Constituency may elect two Governors.

2.2 Members of a Public Constituency may elect any of their number to be a Public Governor.

2.3 If contested the election must be by secret ballot.

2.4 The Election Scheme (including the specified forms of and periods for declarations to be made by candidates standing for office and members as a condition of voting and the process if the election is contested) is set out in Annex 5.

2.5 A person may not stand for election to the Council of Governors as a Public Governor unless, within the period specified in Annex 2, he has made a declaration in the form specified in Part 4 of that Annex of his qualification to vote as a Member of its Public Constituency for which the election is being held and is not prevented from being a member of the Council of Governors by paragraph 8 to Schedule 7 of the 2006 Act or paragraph 15 of the Constitution (“Disqualification”). It is an offence to knowingly or recklessly make a declaration under section 60 of the 2006 Act which is false in a material particular.

2.6 Public Governors:

(a) shall hold office for a period of three years;
(b) are eligible for re-election at the end of that period;
(c) may in exceptional circumstances serve longer than 9 years, but will be subject to annual re-election up to a total of 12 years; and
(d) shall cease to hold office if they cease to be a Member of the Public Constituency by which they were elected as a Public Governor.
3.0 Staff Governors

3.1 The Staff Class may elect five of their number to be a Staff Governor for that Staff Class.

3.2 If contested, the election must be by secret ballot.

3.3 The Election Scheme (including the specified forms of and periods for declarations to be made by candidates standing for office and by members as a condition of voting and the process if the election is uncontested) is set out in Annex 5.

3.4 Staff Governors
   (a) shall hold office for a period of three years.
   (b) are eligible for re-election at the end of that period;
   (c) may in exceptional circumstances serve longer than 9 years, but will be subject to annual re-election up to a total of 12 years; and
   (d) shall cease to hold office if they cease to be a Member of the Staff Constituency or cease to be a Member of the relevant Staff Class by which they were elected as a Staff Governor.

4.0 Local Authority Governor

4.1 The Rotherham Metropolitan Borough Council is authorised to appoint a Local Authority Governor pursuant to a process agreed between the said local authority and the Trust.

4.2 The Local Authority Governor:
   (a) shall hold office for a period of three years;
   (b) is eligible for reappointment at the end of that period;
   (c) may in exceptional circumstances serve longer than 9 years, but will be subject to annual re-appointment up to a total of 12 years; and
   (d) shall cease to hold office if the local authority which appointed him withdraws its appointment of him.

5.0 Partnership Governors

5.1 The organisations specified as Partnership Organisations that may each appoint a member to the Council of Governors are:
   (a) Rotherham Partnership
   (b) Voluntary Action Rotherham (VAR)
   (c) Sheffield University
   (d) Sheffield Hallam University
   (e) Barnsley and Rotherham Chamber of Commerce
   (f) Rotherham Ethnic Minority Alliance (REMA).

5.2 The Partnership Governors are to be appointed by the organisations listed in paragraph 5.1 above pursuant to a process agreed by the said Partnership Organisation with the Trust.

5.3 The Partnership Governors:
   (a) shall hold office for a period of three years;
   (b) are eligible for reappointment at the end of that period;
   (c) may in exceptional circumstances serve longer than 9 years, but will be subject to annual re-appointment up to a total of 12 years; and
(d) shall cease to hold office if the Partnership Organisation which appointed him withdraws its appointment of them.
PART 1: INTERPRETATION
1. Interpretation

PART 2: TIMETABLE FOR ELECTION
2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER
4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS
8. Notice of election
9. Nomination of candidates
10. Candidate’s particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS
19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll
22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll
27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33. Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes
36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

PART 6: COUNTING THE VOTES
STV41. Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
STV44. Rejected ballot papers and rejected text voting records
FPP44. Rejected ballot papers and rejected text voting records
STV45. First stage
STV46. The quota
STV47 Transfer of votes
STV48. Supplementary provisions on transfer
STV49. Exclusion of candidates
STV50. Filling of last vacancies
STV51. Order of election of candidates
FPP51. Equality of votes

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS
FPP52. Declaration of result for contested elections
STV52. Declaration of result for contested elections
53. Declaration of result for uncontested elections

PART 8: DISPOSAL OF DOCUMENTS
54. Sealing up of documents relating to the poll
55. Delivery of documents
56. Forwarding of documents received after close of the poll
57. Retention and public inspection of documents
58. Application for inspection of certain documents relating to election

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION
FPP59. Countermand or abandonment of poll on death of candidate
STV59. Countermand or abandonment of poll on death of candidate

PART 10: ELECTION EXPENSES AND PUBLICITY
Expenses
60. Election expenses
61. Expenses and payments by candidates
62. Expenses incurred by other persons

Publicity
63. Publicity about election by the corporation
64. Information about candidates for inclusion with voting information
65. Meaning of “for the purposes of an election”

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES
66. Application to question an election

PART 12: MISCELLANEOUS
67. Secrecy
68. Prohibition of disclosure of vote
69. Disqualification
70. Delay in postal service through industrial action or unforeseen event
1. **Interpretation**

1.1 In these rules, unless the context otherwise requires:

“2006 Act” means the National Health Service Act 2006;

“corporation” means the public benefit corporation subject to this Constitution;

“council of governors” means the council of governors of the corporation;

“declaration of identity” has the meaning set out in rule 21.1;

“election” means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

“e-voting” means voting using either the internet, telephone or text message;

“e-voting information” has the meaning set out in rule 24.2;

“ID declaration form” has the meaning set out in rule 21.1; “internet voting record” has the meaning set out in rule 26.4(d);

“internet voting system” means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

“lead governor” means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

“list of eligible voters” means the list referred to in rule 22.1, containing the information in rule 22.2;

“method of polling” means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

“Monitor” means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

“numerical voting code” has the meaning set out in rule 64.2(b)

“polling website” has the meaning set out in rule 26.1;

“postal voting information” has the meaning set out in rule 24.1;

“telephone short code” means a short telephone number used for the purposes of submitting a vote by text message;

“telephone voting facility” has the meaning set out in rule 26.2;
“telephone voting record” has the meaning set out in rule 26.5 (d);

“text message voting facility” has the meaning set out in rule 26.3;

“text voting record” has the meaning set out in rule 26.6 (d);

“the telephone voting system” means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

“the text message voting system” means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

“voter ID number” means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

“voting information” means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.
2. **Timetable**

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

<table>
<thead>
<tr>
<th>Proceeding</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication of notice of election</td>
<td>Not later than the fortieth day before the day of the close of the</td>
</tr>
<tr>
<td>Final day for delivery of nomination forms to returning officer</td>
<td>Not later than the twenty eighth day before the day of the close of</td>
</tr>
<tr>
<td>Publication of statement of nominated candidates</td>
<td>Not later than the twenty seventh day before the day of the close of</td>
</tr>
<tr>
<td>Final day for delivery of notices of withdrawals by candidates from election</td>
<td>Not later than twenty fifth day before the day of the close of the poll.</td>
</tr>
<tr>
<td>Notice of the poll</td>
<td>Not later than the fifteenth day before the day of the close of the</td>
</tr>
<tr>
<td>Close of the poll</td>
<td>By 5.00pm on the final day of the election.</td>
</tr>
</tbody>
</table>

3. **Computation of time**

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.
4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.
8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate’s particulars

10.1 The nomination form must state the candidate’s:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the Constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination form is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate’s particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate’s nomination form. If an e-mail address has been given in the candidate’s nomination form (in addition to the candidate’s postal address), the returning officer may send notice of the decision to that address.

15. **Publication of statement of candidates**

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate’s postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.
15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.
PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
   (i) configured in accordance with these rules; and
   (ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
   (i) configured in accordance with these rules; and
   (ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
   (i) configured in accordance with these rules; and
   (ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter’s voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:
   (i) to whom the ballot paper was addressed, and/or
   (ii) to whom the voter ID number contained within the e-voting information was allocated,
(b) that he or she has not marked or returned any other voting information in the election, and
(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

(“declaration of identity”)

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form (“ID declaration form”) or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.
21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member’s e-mail address, if this has been provided
to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. **Issue of voting information by returning officer**

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

(“postal voting information”).

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter’s voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

(“e-voting information”).

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;
for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/or e-mail address for each member, as specified in the list of eligible voters.

25. **Ballot paper envelope and covering envelope**

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The覆盖ing envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. **E-voting systems**

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

   (i) enter his or her voter ID number; and

   (ii) where the election is for a public or patient constituency, make a declaration of identity;
in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held,
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(v) instructions on how to vote and how to make a declaration of identity,
(vi) the date and time of the close of the poll, and
(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of:

(i) the voter’s voter ID number;
(ii) the voter’s declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter’s vote,

(e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held,
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) instructions on how to vote and how to make a declaration of identity,
(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
(i) the voter’s voter ID number;
(ii) the voter’s declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter’s vote

(e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:
   (i) provide his or her voter ID number; and
   (ii) where the election is for a public or patient constituency, make a declaration of identity;

   in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
(i) the voter’s voter ID number;
(ii) the voter’s declaration of identity (where required);
(ii) the candidate or candidates for whom the voter has voted; and
(iii) the date and time of the voter’s vote

(e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote
27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. **Voting by persons who require assistance**

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. **Spoilt ballot papers and spoilt text message votes**

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter’s identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (“the list of spoilt ballot papers”):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.
29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list (“the list of spoilt text message votes”):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list (“the list of lost ballot documents”):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list (“the list of tendered voting information”):

(a) the name of the voter,
(b) the unique identifier of any replacement ballot paper issued under this rule;
(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.
35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:
(a) a covering envelope, or
(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper, before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:
(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:
(a) put the ID declaration form if required in a separate packet, and
(b) put the ballot paper aside for counting after the close of the poll.
Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,
(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,
(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and
(d) place the document or documents in a separate packet.

An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
(c) place the document or documents in a separate packet.

Declaration of identity but no ballot paper (public and patient constituency)

Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form “disqualified”,
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
(c) place the ID declaration form in a separate packet.

De-duplication of votes

---

2 It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.
39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,
(d) the list of lost ballot documents,
(e) the list of eligible voters, and
(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.
PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

“ballot document” means a ballot paper, internet voting record, telephone voting record or text voting record.

“continuing candidate” means any candidate not deemed to be elected, and not excluded,

“count” means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

“deemed to be elected” means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

“mark” means a figure, an identifiable written word, or a mark such as “X”,

“non-transferable vote” means a ballot document:
(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

“preference” as used in the following contexts has the meaning assigned below:

(a) “first preference” means the figure “1” or any mark or word which clearly indicates a first (or only) preference,

(b) “next available preference” means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a “second preference” is shown by the figure “2” or any mark or word which clearly indicates a second preference, and a third preference by the figure “3” or any mark or word which clearly indicates a third preference, and so on,

“quota” means the number calculated in accordance with rule STV46,
“surplus” means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus, “stage of the count” means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

“transferable vote” means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

“transferred vote” means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

“transfer value” means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
   (i) the use of such software for the purpose of counting votes in the relevant election, and
   (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
   (iii) ballot papers that have been returned; and
   (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.
43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.
FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.
FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,
(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.8 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,
(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and
(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and
(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.
STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).
STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:
(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

   (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

   (ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).
STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and
(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub-parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:
   (i) the total value of votes, or
   (ii) the total transfer value of votes transferred to each candidate,
(b) add that total to the previous total of votes recorded for each candidate and record the new total,
(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
(d) compare:
   (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
   (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:
   (a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
   (b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.
STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.
FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.
FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:
   (i) where the election is held under a proposed Constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chairman of the NHS Trust, or
   (ii) in any other case, to the Chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –
   (i) where the election is held under a proposed Constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chairman of the NHS Trust, or
   (ii) in any other case, to the Chairman of the corporation, and
(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule STV44.1,
(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. **Declaration of result for uncontested elections**

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who he or she has declared elected to the Chairman of the corporation, and
(c) give public notice of the name of each candidate who he or she has declared elected.
54. **Sealing up of documents relating to the poll**

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. **Delivery of documents**

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. **Forwarding of documents received after close of the poll**
56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

   (i) any rejected ballot papers, including ballot papers rejected in part,
   (ii) any rejected text voting records, including text voting records rejected in part,
   (iii) any disqualified documents, or the list of disqualified documents,
   (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or
   (v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.
58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation’s consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and
(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and
(ii) that Monitor has declared that the vote was invalid.
**PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION**

**FPP59. Countermand or abandonment of poll on death of candidate**

**FPP59.1** If at a contested election, proof is given to the returning officer’s satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

**FPP59.2** Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

**FPP59.3** Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

**FPP59.4** The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

**FPP59.5** The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,
(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

**FPP59.6** The returning officer is to endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the Chairman of the corporation, and rules 57 and 58 are to apply.

STV59. **Countermand or abandonment of poll on death of candidate**

STV59.1 If, at a contested election, proof is given to the returning officer’s satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).
PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate’s election, whether on that candidate’s behalf or otherwise, or
(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions,
as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility (“numerical voting code”), and
(c) a photograph of the candidate.

65. Meaning of “for the purposes of an election”

65.1 In this Part, the phrase “for the purposes of an election” means with a view to, or otherwise in connection with, promoting or procuring a candidate’s election, including the prejudicing of another candidate’s electoral prospects; and the phrase “for the purposes of a candidate’s election” is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.
PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.
PART 12: MISCELLANEOUS

67. **Secrecy**

67.1 The following persons:

(a) the returning officer,
(b) the returning officer’s staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter,
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. **Prohibition of disclosure of vote**

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. **Disqualification**

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.
Delay in postal service through industrial action or unforeseen event

If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.
RELATIONSHIP BETWEEN THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

1. Communication and Conflict

1.1 This annex describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal communications, and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board of Directors.

1.2 Informal Communications

1.2.1 Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

1.2.2 The Chairman shall use his reasonable endeavours to encourage effective informal methods of communication including:

(a) participation of the Board of Directors in the induction, orientation and training of Governors;
(b) development of special interest relationships between Non-Executive Directors and Governors;
(c) discussions/meetings between Governors and the Chairman and/or the Chief Executive and/or Directors facilitated through the office of the Company Secretary. The Governors shall be able to request to meet individually with any member of the Board through the office of the Company Secretary;
(d) involvement in Membership recruitment and briefing at public events organised by the Trust.

1.3 Formal Communication

1.3.1 Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

1.3.2 Formal communications initiated by the Council of Governors and intended for the Board of Directors will be conducted as follows:

(a) specific requests by the Council of Governors will be made through the Chairman to the Board of Directors;
(b) any Governor has the right to raise specific issues to be put to the Board of Directors at a duly constituted meeting of the Council of Governors through the Chairman. In the event of disagreement, two thirds of the Governors present must approve the request. The Chairman will raise the matter with the Board of Directors and provide the response to the Council of Governors;
(c) joint meetings will take place as and when appropriate between the Council of Governors and the Board of Directors.
1.3.3 The Board of Directors may request the Chairman to seek the views of the Council of Governors on such matters as the Board of Directors may from time to time determine.

1.3.4 Communications initiated by the Board of Directors and intended for the Council of Governors will be conducted as follows:
   (a) request the Chairman to seek the view of the Council of Governors on the Board of Directors' proposals for the Strategic Direction/Forward Plans;
   (b) presentation and approval of annual accounts, annual report and auditor's report;
   (c) request the Chairman to seek the view of the Council of Governors on the Board of Directors' proposals for developments;
   (d) request the Chairman to seek the view of the Council of Governors on Trust Performance i.e. finance and quality metrics;
   (e) request the Chairman to seek the view of the Council of Governors for involvement in service reviews and evaluation;
   (f) request the Council of Governors to seek views of the Membership on proposed changes, plans and developments.

1.3.5 Formal communications will normally be conducted as follows:
   (a) attendance by the Board of Directors at a meeting of the Council of Governors;
   (b) formal reports or presentation by Executive Directors to a meeting of the Council of Governors;
   (c) inclusion of minutes for information on the Agenda of a meeting of the Council of Governors;
   (d) reporting the views of the Council of Governors to the Board of Directors through the Chairman, Lead Governor, Vice-Chairman or Senior Independent Director;
   (e) Governors attend meetings in public of the Board of Directors as observers.

1.3.6 Wherever possible and practical, written communications will be conducted by e-mail.

1.4 Resolving Conflict
1.4.1 The Council of Governors and the Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of view quickly, through discussion and negotiation.

1.4.2 If as the first step, the informal efforts the Chairman do not achieve resolution of a disagreement or a conflict, the Chairman will follow the process described in paragraphs below. The aim is to resolve the matter at the first available opportunity, and only to escalate to the next step if the step taken fails to achieve resolution.

1.4.3 In the event of a conflict between the Council of Governors and Board of Directors, the following action will be taken, in the sequence shown:
   (a) the Chairman will call a Resolution Meeting of the members of the Council of Governors and Board of Directors, to take place as soon as possible, but no later than twenty working days following the date of the request. The meeting must comprise of two thirds of the Membership of the Council of Governors and two thirds of the membership of the Board
of Directors, otherwise the meeting shall not be quorate and shall not proceed further. The meeting will be held in private. The Agenda and any papers for the meeting shall be issued in accordance with the Standing Orders of the Council of Governors. The aim of the meeting will be to achieve resolution of the conflict. The Chairman, in discussion with the Lead Governor, will have the right to appoint an independent facilitator to assist the process. Every effort must be made to reach agreement;

(b) if a Resolution Meeting of the members of the Council of Governors and Board of Directors fails to resolve a conflict, the matter may be referred to mediation by either party;

(c) if the Council of Governors consider that the Trust is failing or has failed to act in accordance with its Constitution or to act in accordance with the provisions made by or under Chapter 5 of the 2006 Act, then subject to paragraph 19.0 of this Constitution, they may refer the matter to the panel referred to in paragraph 19.0 of this Constitution.

1.4.4 The right to call a Resolution Meeting rests with the following, in the sequence of escalation shown:
(a) the Chairman;
(b) the Chief Executive;
(c) two thirds of the members of the Council of Governors;
(d) two thirds of the members of the Board of Directors.

DISQUALIFICATION AND REMOVAL OF GOVERNORS (Paragraph 15)

2. Disqualification and removal
A person may not become or continue as a member of the Council of Governors of the Trust if:
(a) in the case of a Staff Governor or a Public Governor, he ceases to be a Member of the constituency or class by which he was elected;

(b) subject to the provisions of paragraph 3.0 below, in the case of a Staff Governor he has been made the subject of a written disciplinary warning or has been suspended from duty for a period of suspension in excess of 28 days or where he has been absent from his post for a continuous period of not less than four months and no reasonable cause has been given for his absence.

(c) in the case of a Local Authority Governor, or Partnership Governor, the relevant appointing Authority or Partnership Organisation withdraws its appointment of him;

(d) he has been adjudged bankrupt or his estate has been sequestrated and in either case he has not been discharged;

(e) he has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

(f) he has within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on him;
(g) he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

(h) he has within the preceding five years been dismissed by reason of redundancy from the Trust;

(i) he is a person whose tenure of office as the Chairman or as a Member or Director of a health service body has been terminated on the grounds that his appointment is not in the interests of the health service, for non attendance at meetings or for non-disclosure of a pecuniary interest;

(j) he is an Executive or Non-Executive Director of the Trust, or a Governor, Non-Executive Director, Chairman, Chief Executive Officer of another NHS foundation trust;

(k) he has had his name removed from any list prepared pursuant to paragraph 10 of the National Health Service (Performers List) Regulations 2004 or section 151 of the 2006 Act (or similar provision elsewhere) and has not subsequently had his name included in such a list;

(l) he is incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs;

(m) he is registered as a sex offender pursuant to Part 1 of the Sex Offenders Act 1997;

(n) he has been identified and given notice in writing to that effect by the Chief Executive as a vexatious complainant;

(o) he has been identified as a person who has failed to comply with or otherwise contravened the Trust’s Zero-Tolerance Policy (as amended from time to time) and has been given notice to that effect by the Chief Executive;

(p) in the case of a Staff Governor, he is employed by the Trust on a temporary contract which contract is or was identified on the face of it as a temporary contract;

(q) he is a member of the Rotherham Metropolitan Borough Council Health Overview and Scrutiny Committee.

3.0 Where a Staff Governor has been made the subject of a written warning or a period of suspension in excess of 28 days or where he has been absent from his post as an employee of the Trust for a continuous period of not less than four months and no reasonable cause has been given for his absence, his term of office as Governor may be suspended by the Council of Governors (or by a Committee of the Council of Governors or by the Secretary as the Council of Governors may duly authorise) for such period of time as the Council of Governors, Committee or Secretary (as the case may be) deems fit and so as to enable, if necessary, an investigation to be carried out to determine whether or not the tenure of that Staff Governor should then be terminated. The Staff Governor in question may submit reasons to the Council of Governors, Committee or Secretary (as the case may be) as to why he should still be eligible to continue as a Staff Governor but the determination of the Council of Governors, Committee or Secretary as to whether to terminate the Governor’s term of office shall be final.
4.0 Where a Governor:
   (a) has given notice of resignation in accordance with paragraph 7.0 below or has had his term of office terminated pursuant to the terms of this Constitution in any manner whatsoever; or
   (b) is otherwise disqualified from holding office pursuant to the Constitution or the 2006 Act, that Governor shall thereupon cease to be a Governor and his name shall be forthwith removed from the Register of Governors.

5.0 Where a person has been elected or appointed to be a Governor and he becomes disqualified for appointment under paragraph 2.0, he shall notify the Chairman in writing of such disqualification as soon as possible.

6.0 If it comes to the notice of the Chairman that a Governor is so disqualified, whether at the time of his appointment or later, he shall immediately declare that the person in question is disqualified and notify him in writing to that effect.

7.0 A Governor who resigns or whose tenure of office is terminated shall not be eligible to stand for re-election for a period of three years from the date of his resignation or termination of office.

8.0 Vacancies
8.1 Where a Governor’s membership of the Council of Governors ceases for one or more of the reasons set out in paragraph 2.0, Public Governors and Staff Governors shall, either be replaced by elections or in accordance with the relevant Electoral Scheme(s) set out in Annex 5, and the Local Authority Governor and the Partnership Governors are to be replaced in accordance with the processes agreed.

8.2 Where an elected Governor ceases to hold office during his term of office the Trust shall offer the candidate who secured the second highest number of votes in the last election for the constituency (or Staff Class, as the case may be) in which the vacancy has arisen the opportunity to assume the vacant office for the unexpired balance of the retired Governor’s term of office. If that candidate does not accept to fill the vacancy, it shall then be offered to that candidate who secured the next higher of votes until the vacancy is filled.

8.3 If no candidate is available or is willing to fill a vacancy arising pursuant to paragraphs 8.1 and 8.2 above, the provisions of paragraph 9.0 Cooptee(s) shall apply.

8.4 To avoid doubt where a vacancy remains unfilled notwithstanding the application of the provisions of paragraph 9.0 (Cooptees) such office shall stand vacant until the next scheduled election (unless by so doing this causes the aggregate number of Governors who are Public Governors to be less than half the total membership of the Council of Governors (excluding Cooptees). In that event, an election will be held in accordance with the Election Scheme as soon as reasonably practicable).

9.0 Cooptees
9.1 Where any vacancy remains unfilled notwithstanding compliance with the procedures described in paragraph 8.0, the Lead Governor shall put forward to the Council of Governors individuals to be Cooptees in accordance with the process
agreed by the Secretary. Each such individual shall be a Member of the constituency to which the vacancy relates.

9.2 The Council of Governors shall select up to 3 Cooptees from those put forward and recommend them to the Council of Governors for appointment.

9.3 The Council of Governors shall make the final decision whether to appoint those recommended.

9.4 For the avoidance of doubt, Cooptees shall have no voting rights and shall act in an advisory capacity only
ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 18)

(In the process of being updated).
ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 32)

(In the process of being updated).
ANNEX 9 – FURTHER PROVISIONS – BOARD OF DIRECTORS

(Paragraph 10.4)