## Board of Directors

### Part one AGENDA (held in public)

**Date:** Friday 22 April 2016  
**Time:** 0930hrs – 1300hrs  
**Venue:** Boardroom, Executive Corridor, Level D, Rotherham Hospital

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*To ensure smooth transaction of business, the Chairman will invite questions from the public arising from the clinical presentation, and at the end of the meeting only.*

*In accordance with §152(4) of the Health and Social Care Act, 2012, a copy of this agenda has been provided to Governors prior to the Board Meeting*
MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON TUESDAY 29 MARCH 2016 IN THE BOARDROOM, LEVEL D

Present:  
Mr M Havenhand, Chairman  
Mrs L Barnett, Chief Executive  
Mrs G Atmarow, Non-Executive Director  
Mr J Barnes, Non-Executive Director  
Mrs A Legg, Non-Executive Director  
Ms T McErlain-Burns, Chief Nurse  
Mr B Mellor, Non-Executive Director  
Mr S Sheppard, Director of Finance

In attendance:  
Ms K Baguley, Advanced Nurse Practitioner (minute 78/16 only)  
Mr C Bott, Advanced Nurse Practitioner (minute 78/16 only)  
Mr J Beeston, Director of Clinical Services, Diagnostics and Support  
Mrs C Clements, incoming Executive Director of Workforce (observer)  
Mrs M Dennis, Director of Operations (minutes 86/16, 90/16(b) & 94/16)  
Ms A Milanec, Director of Corporate Affairs / Company Secretary  
Miss D Patel, Director of Clinical Services for Family Health  
Miss D Stewart, Corporate Governance Manager (minutes)

Apologies:  
Mr I Carmichael, Director of Clinical Services, Surgery  
Mr M Edgell, Non-Executive Director  
Ms L Hagger, Non-Executive Director  
Mr C Holt, Chief Operating Officer  
Dr J Miles, Director of Clinical Services for Integrated Medicine  
Dr S Nakash, Director of Clinical Services, Emergency Care  
Dr C Wareham, Medical Director

Observers:  
Members of the Council of Governors x1  
Members of the public x1  
Staff x2

077/16  
CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE

Mr Havenhand welcomed those present to the meeting with the apologies being NOTED. Mrs Dennis, who was deputising at the meeting for the Chief Operating Officer, would join the meeting in due course having first to attend to urgent operational matters.

Mrs Clements, incoming Executive Director of Workforce, was welcomed as an observer to the meeting prior to her formally commencing duties on 18th April 2016.
The Board welcomed Mr Bott and Ms Baguley to provide the clinical presentation on the role of the Advanced Nurse Practitioner (ANP).

The Board was informed that the role had originated in the United States of America, and was defined within the Trust as ‘a registered nurse who had acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice’. However, there was no national definition for the role or specified qualification requirements. Those in the post considered it to be on a par with middle grade doctors and not greatly different to the Nurse Consultant role.

ANPs within the trust were well received as part of the multi-disciplinary teams. There were further opportunities which could be explored to effectively utilise this skilled portion of the workforce as colleagues were interested in the development opportunities an ANP role could offer. Should it be possible to increase numbers, although it was acknowledged that there may be colleagues undertaking the role but under a different job title, it would bring the Trust in line with other organisations.

The Chairman thanked colleagues for their presentation which highlighted the potential opportunities to develop the current workforce and supplement areas where there may be service pressures. To this end, Mr Havenhand requested that the executive team consider the ANP role and to developing it for the future.

It was suggested that executive team review the clinical presentations from the preceding 12 months to assess any changes that had been made to services, or updates which the Board would be interested to hear, which had occurred as a result of the presentations.

The Chief Nurse provided two patient stories, one each of a positive and a negative nature.

The negative story related to the standards of compassion demonstrated by Ward B11. The ward team had taken the opportunity to hear first-hand the experiences of the patient concerned and had taken on board and addressed the comments which had been made. Modifications had resulted to the daily operation of the ward, emergency capacity and a redesign of the waiting areas had been undertaken to provide increased privacy and support for patients who may feel slightly anxious about their visit to hospital. Ms McErlain-Burns advised the Board that she was assured that the actions resulting from the complaint had been implemented as she had undertaken two unannounced visits to B11.
PROCEDURAL ITEMS

080/16 DECLARATIONS OF CONFLICTS OF INTERESTS

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

081/16 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on Tuesday 23rd February 2016 were AGREED as a correct record.

082/16 MATTERS ARISING FROM THE PREVIOUS MEETING

The following were cited as matters arising from the previous meeting which were not either covered by the agenda or action log.

i. Operational Performance Report (minute 055/16(b)

The Company Secretary informed the Board that Monitor/NHS Improvement had issued a statement confirming that the Risk Assessment Framework would remain in place, notwithstanding requirements from other regulators, or other changes in the current regulatory framework.

083/16 ACTION LOG

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

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

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

STRATEGY AND STRATEGIC PLANNING

084/16 REPORT FROM THE CHAIRMAN

The Board of Directors RECEIVED the report from the Chairman.

The report set out to provide an update in relation to the Rotherham Together Partnership, the Working Together Programme, Monitor and recent networking activities undertaken by the Chairman.

Mr Havenhand invited Mr Mellor to provide feedback on the work of the Rotherham Business Growth Board, which was part of the Rotherham Together Partnership. The Growth Board had established a number of work streams including the ‘Buy Local’ task and finish group, which was chaired by
Mr Mellor. The aim of this group and the work of the Growth Board are to support and invest in local suppliers.

In relation to the Working Together Programme (WTP), the Board APPROVED the new WTP principles as documented within the report.

The Board NOTED the Chairman’s report.

085/16  REPORT FROM THE CHIEF EXECUTIVE

The Board of Directors RECEIVED and NOTED the Chief Executive’s monthly report, which provided an overview of progress against the Trust’s strategic objectives and plans.

Although progress had been made across the majority of strategic areas, the issues where continued action was required, would be carried forward into 2016/17 plans.

It was noted that the one year operational plan was being finalised for formal sign off by the Board to enable submission to Monitor (NHS Improvement) by the deadline of 12 noon on 11 April 2016.

The Chief Executive advised the Board that the Commissioner Requested Service (CRS) classification for trusts achieving Foundation Trusts by 1 April 2015 expired on 1 April 2016. Before this date Commissioners had been legally required to review the CRS designation. Mrs Barnett confirmed that Rotherham Clinical Commissioning Group (RCCG) had only recently completed the required review. Their commissioning intentions had been set out in the RCCG Five Year Plan, with a further review to be undertaken in six months.

The recent national industrial action by junior doctors’ had been completed without incident. However, it recognised that the next round of action due to take place on 26/27 April 2016, which included the withdrawal of emergency care cover, would require additional planning, which had already begun.

The Board NOTED the report.

086/16  MONTHLY TRANSFORMATION REPORT

The Board of Directors RECEIVED and NOTED the Transformation Report from the Chief Executive which provided an overview on a number of work streams.

Mrs Barnett invited Executive colleagues to provide updates on the three specific areas of acute and community (unscheduled care) transformation, the Emergency Centre and the cost improvement programme.
In relation to acute and community transformation, the Board NOTED that work continued to be progressed in establishing the locality pilot. Rotherham Clinical Commissioning Group was content with progress and the level of engagement in relation to project. Additionally, the 2016/17 strategy for acute and community transformation, which utilised the learning from 2015/16, was being finalised and would be in the five priority areas as detailed within the report. The strategy and programme for 2016/17, which had been developed with clinical engagement, would be considered by the Trust Management Committee (Transformation).

The capital build for the Emergency Centre remained on plan, and whilst the position remained unresolved in relation to the contractual arrangements between the three parties, positive progress continued to be made. The IT project for the department continued on schedule with the focus being one of clinical engagement, and it was anticipated that the prototype would be in place by the end of April or beginning of May 2016. Workforce models and patient pathways continued to be developed and refined. The Board considered that the Emergency Centre was now at a stage where it should be promoted as an exciting development taking place at the Trust to support recruitment activities, with Mrs Barnett confirming that the communication plan was indeed being reviewed. It was noted that the Finance and Performance Committee would be reviewing the original Emergency Centre business case against current revised workforce and activity requirements to assess any implications.

The current year end forecast for the cost improvement programme was an outturn of £12.18m - with a recurrent value of £12.5m - against the target of £12.9m. Efforts would continue to bridge the outstanding gap by the financial year end. Work continued in relation to the 2016/17 target (£10.01m), drawing on the findings from the Lord Carter review. The Trust Management Committee (Transformation) and Finance and Performance Committee would be the primary committees reviewing the Carter findings.

One of the key points arising from Lord Cater was a single reporting framework to be adopted which drew together clinical quality and resources' performance data which compared it to the ‘best in class’. Whilst progress on this was being seen within the Trust through, for example, divisional reports submitted to the performance meetings, a fully integrated board to ward report had yet to be fully developed.

The Board NOTED the report.

087/16 REVIEW OF STRATEGIC OBJECTIVES AND VISION

The Chief Executive provided for the Board a presentation on the Trust’s strategic objectives, vision and values.

The presentation sought to build on the information provided at the February 2016 meeting. It included the proposed strategic objectives and their key priorities and underpinning SMART objectives in order to achieve each priority, with a number of examples being provided as part of the presentation.
During the ensuing discussions it was considered that there may be opportunities to strengthen the ambition of the objectives.

In relation to the proposed Patient Commitments, it was suggested that there should also be a commitment from patients to staff.

It was AGREED that the current mission statement be retained, but that the vision be revised to reflect progress made to date and future organisational ambitions. The proposed wording was discussed by the Board with a number of comments being made. The Executive Directors were requested to reflect and consider alternative vision statements for further discussion.

**ACTION - LB**

The Board of Directors NOTED the progress being made in the development of the strategic objectives and vision statement.

**088/16 16/17 OPERATIONAL PLAN**

The Board of Directors RECEIVED a presentation from the Chief Executive and Director of Finance outlining the current position on the development of the 2016/17 Annual Operating Plan.

Mrs Barnett outlined for the Board the expectations from NHS Improvement in relation to the Plan’s content, the priorities for quality/operational/workforce, the basis for the narrative and the key deadlines to achieve the submission by midday on 11 April.

In relation to the financial section of the plan, Mr Sheppard provided information on the 2015/16 outturn and the high level headlines in relation to 2016/17. These included:

- Aligned activity, capacity and workforce plans
- Well modelled financial projections
- Draft submission of £4.5m surplus against a NHSI (NHS Improvement) control total of £6.5m. With an assumed receipt of £6.5m Sustainability and Transformation Fund
- Capital Plan of £13m
- Cost Improvement programme target of £10m (5% of costs)

The Board NOTED the current position in finalising the annual operating plan, which would be further considered at a Board meeting scheduled for 8 April.

**089/16 CLINICAL STRATEGY REPORT**

The Board of Directors RECEIVED and NOTED the Clinical Strategy report from the Medical Director, which in his absence was presented by the Director of Clinical Services Diagnostics and Support.

The report provided an update on implementation of the Trust’s Clinical Strategy, with details of how the Clinical Transformation Group was focussing
on five priority specialities working within the context of the Working Together Acute Care Collaboration Vanguard, the five year forward review and the emerging South Yorkshire and Bassetlaw footprint. Each work stream had a timeframe of thirteen weeks to conclude their review, with the first set of outputs expected at the end of May 2016.

The Board was informed that there remained a high level of clinical engagement within the work streams, as highlighted by Miss Patel for the children’s review. Additionally a meeting had been held with Rotherham Clinical Commissioning Group and the Consultant Body to discuss the small volume procedures in the Trust.

Mrs Barnett concluded the discussion by commenting that the clinical strategy would align to the forward plan and provide a clear view on the specialities where collaboration through the Working Together Programme would be required; the strategy would always need to be a dynamic and evolving process.

The Board, in NOTING the report, recognised the invaluable leadership shown by Dr Wareham in relation to the work undertaken to date. Additionally, the Board acknowledged the input of both Dr Wareham and Mr Holt in establishing the collaborative arrangements with other trusts as a result of specific service pressures such as the recent agreement for gastroenterology.

**OPERATIONAL PERFORMANCE**

**090/16 MONTHLY INTEGRATED PERFORMANCE REPORT**

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

The Chief Executive advised the Board that there continued to be challenges in a number of areas, whilst improvements continued in others, which were demonstrated by the integrated report. The following reports provided supplementary information for the Board:

**090/16(b) OPERATIONAL PERFORMANCE REPORT**

The Board of Directors RECEIVED and NOTED the Operational Performance Report from the Chief Operating Officer, which was presented by the Director of Operations in his absence.

Mrs Dennis advised the Board that operational challenges continued in relation to the emergency department, with high attendance and resulting admissions. The current key factors were the emergency department medical workforce and nurse staffing levels across the organisation. However, it was disappointing that performance did not reflect the effort being placed on resolving the position. Subsequently, the challenges in this one area were now having an impact in such areas as the 62 day cancer performance where the January 2016 target had not been achieved and although a recovery plan
was in place, the quarter position was under pressure. Other areas seeing deterioration in performance were ambulance handovers, increased cancelled operations which required additional forward planning, and the low discharge levels due to frail and elderly patients impacting on the number of available beds needed to accommodate the high admissions, and with the winter ward still currently open.

The Board noted that systems and processes continued to be reviewed, with appropriate escalation in place. These included diverting patients to Care UK where appropriate, introduction of the Manchester Triage Tool and the need for effective arrangements to be in place with partner organisations, including care homes and the CCG. There remained a requirement for a systematic and planned approach to resolving the issues with due responsibility and accountability from colleagues.

Mrs Legg commented that performance was being challenged across a number of performance targets/indicators which could be associated with medical recruitment difficulties; however, the apparent poor management of annual leave was not supporting the position. The latter matter was an escalation from the Finance and Performance Committee, as it had been brought to their attention. It was confirmed that a new medical staff leave policy had been developed and would be managed centrally which, it was anticipated, would make a significant difference in planning across the specialities.

The Board was informed that there had been a breach of the 12hr ‘decision to admit’ trolley wait target. Whilst there had been a number of factors relating to the case and no adverse harm as a result to the patient, the breach was not acceptable and would be investigated as a Serious Incident. Apologies had been offered to the patient and family, with an immediate review identifying a number of actions to be taken.

As previously reported, following identification of a patient pathway administration issues, some 2,500 out of the 13,000 plus pathways had been validated. Current validation was being undertaken for patients waiting between 48 - 52 weeks, with 4 patients to date having been identified as breaching the 52 week target.

The Board NOTED the operational performance report, with additional consideration being given to the 4 hour access target at the Board seminar to be held on 8 April 2016.

090/16(a) QUALITY REPORT

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

Ms McErlain-Burns reported that there had been one C-difficile case since the last meeting with the organisation having 19 cases against the trajectory of 26. Whilst normally the expectation would be for a year on year lowering of
the trajectory, the Board noted that this would not be the case for 2016/17. On a more positive note, there had been no ward closures or serious operational implications resulting from Norovirus during 2015/16.

As a result of an increase in pressure ulcers and falls, there had been a reduction in the NHS Safety Thermometer for February.

With regards to feedback from service users, the number of complaints received in month had returned to normal trend patterns and for the third consecutive month, there had been a marginal improvement of response times. Another source of feedback, the Friends and Family Test, was showing improved response rates across a number of services, although as indicated by Mr Havenhand, it would be helpful to encourage more responses in order to obtain valuable feedback on services.

With regard to mortality, appended to the report was a full suite of data which had been considered by the Quality Assurance Committee and in detail by the Mortality Review Group. HSMR appeared to have plateaued at 108.1 and due to the delay in reporting, as predicted, SHMI had increased which reflected the previous six month increase in HSMR.

Mrs Atmarow, on behalf of the Quality Assurance Committee (QAC), indicated that QAC wished to escalate that whilst the mortality position had not deteriorated further, it had yet to improve. The Board was informed that a report had been requested for the next QAC meeting to provide assurance on the position as this area should be an issue of significant focus for the Board. Mrs Barnett agreed that the mortality position was higher than the organisation would wish to see and that the Board should be aware of the actions being taken to reduce HSMR and SHMI.

In relation to nurse staffing, the fill rates remained static for both Registered Nurse and Healthcare Support Workers’ shifts. However, there remained an underlying sickness absence rate, high levels of maternity leave and high use of flexible staffing, which was impacting on the service. The nursing and midwifery establishments remained under review, with the Safer Nursing Care Tool to be utilised during April. Mr Sheppard reiterated the importance of nurse staffing data from all divisions being available to support the discussions on the operational plan.

The newly established Practice Development Team started in late February 2016. Their work plan had been aligned to the Sign up to Safety Campaign, with the aim of the Team to improve standards of nursing and midwifery practice through instruction, coaching and measurement.
The key points from the report were:

- Continuing challenges in relation to bank and agency usage and the actions being taken to reduce reliance upon them
- Staff turnover had decreased in month; however work life balance remained the highest reason cited by departing colleagues. Further information was requested on the pattern and trends for colleagues leaving the organisation.

**ACTION – CC**

- Sickness absence had fallen across the Trust compared to the previous month. However, for some individual specialties it continued to rise. The target remained 3%.
- The mandatory and statutory training (MAST) levels across all specialties were detailed within the report. While challenging there remained a requirement to balance MAST obligations with service provision.
- The Health and Wellbeing team would be reviewing the flu vaccination programme in order to increase uptake in 2016/17 from the 60% seen in 2015/16.
- The NHS Staff survey results highlighted a number of successes for the organisation and also areas for improvement which would be supported through Listening into Action. The aspiration remained for the organisation to be in the upper quartile for future surveys.

**090/16(d) GOVERNANCE REPORT**

The Board of Directors RECEIVED and NOTED the Governance Report from the Director of Corporate Affairs/Company Secretary.

With regards to Information Governance (IG) Ms Milanec advised the Board that, whilst intensive efforts had been made to increase IG mandatory and statutory training compliance levels, the current position was 80% against the required 95% target required to achieve IG Toolkit level 2 compliance. To address this the timing of the 2016/17 training programme was being reconsidered to support compliance earlier in the financial year.

The Information Commissioners Office had confirmed that as a result of immediate action taken by the Trust, no regulatory action would be taken as a consequence of an information breach where a limited amount of patient identifiable data had been included on documents sent to a third party outside the Trust.

The report also highlighted, for information, investigations launched in month by Monitor against a number of Foundation Trusts. In the main, the investigations were either as a result of pressures in meeting the A&E performance targets or related to financial matters.

The Board was advised by Mr Sheppard that the Trust was one of ninety organisations who had expressed an interest in participating in the 'financial
improvement programme’ which was an initiative providing additional support from NHS Improvement. Information was awaited on the successful organisations to be included in the first cohort. Should the Trust not be successful it would utilise any learning or good practice resulting from the programme.

NHS Providers had published its survey on Board and Board Committees, which was appended to the report, which would provide a useful source of comparative data for the Trust’s own committee effectiveness reviews scheduled for the early summer.

The Board NOTED the report.

090/16(e) **FINANCE REPORT**

The Board of Directors RECEIVED and NOTED the finance report from the Director of Finance.

Mr Sheppard highlighted the following key financial matters:

- A £8,823K deficit to the end of February 2016, which was £6,059K adverse to the planned deficit
- In month the deficit had been £659K against the planned deficit of £199K which was a variance of £460K
- The year-end forecast was a £6.9m deficit which was adverse to plan by £4.9m
- Performance in February was within £8k of the forecast
- Income from clinical activities continued to be above plan for the fourth consecutive month and was being supported by the improvements to timeliness of clinical coding. The financial impact of lost income as a result of non-coded episodes equated to £1.4m and was offset by the balance sheet
- Although the position was improving there remained challenges in relation to pay costs. The position was above budget in February by £1,202k and for the year to date by £5,999k, which equated to the totality of the deficit. The Board recognised the importance moving into 2016/17 of workforce management and the establishment of appropriate controls.
- The cost improvement programme had achieved £12.18m against the target £12.9 - continued efforts would be made to close the gap

Mrs Legg, as Chair of the Finance and Performance Committee (FPC) indicated that there was a requirement for continued focus on cash and cash reserves. Additionally, the FPC would escalate to the Board the level of outstanding debts older than 60 days. The FPC had requested additional consideration of the position and would be discussing the matter further at its next meeting.

In conclusion, Mr Havenhand indicated that whilst the forecast year end position was a deficit of £6.9m, there had been a significant delivery of the
planned cost improvement programme. The main impact on 2015/16 had been agency and premium spends which would need to be addressed moving into 2016/17.

091/16  CQC ACTION PLAN REPORT

The Board of Directors RECEIVED and NOTED the report from the Chief Nurse which provided an update by exception on progress against the CQC inspection and the CQC Children and Looked After Safeguarding (CLAS) improvement action plans.

Ms McErlain–Burns reported that the pace of delivery in a number of areas had increased and cited M1 (training) as an example. However, whilst the overall training position was improving, challenges remained in some areas, such as Emergency Care due to operational pressures. To help resolve and mitigate the position there had been a change in focus in how training was being provided, such as delivery now within departments. Mrs Atmarow in the absence of the Non-executive Director Chair of the Quality Assurance Committee (QAC) commented that the report and verbal information demonstrated the required pace which had been an escalation from QAC.

There remained seven actions across five subject areas still rated as red. The report outlined the specific reasons for this and also the action to be taken to recover the position and ensure momentum. The report and appendices also provided further information in relation to progress in other areas of the action plan and CLAS.

The Board APPROVED the specific recommendation to remove action M1.9 (to realign work structures and positions in the Electronic Staff Record (ESR) to achieve accurate reporting on training compliance). The reason for the removal of this action was that it had since been identified that the action was no longer required.

The Board of Directors NOTED the report, with Mr Havenhand commenting that progress against the CQC action plan remained an important area for the Trust and it was vital to maintain pace of implementation.

RISK FRAMEWORK

092/16  SIRO/INFORMATION GOVERNANCE TOOLKIT REPORT

The Board of Directors RECEIVED the Information Governance (IG) toolkit interim report regarding the proposed self-assessment submission on 31 March 2016.

Self-assessment had been undertaken against forty five standards, each of which was sub-divided into six categories with each in turn requiring assurance. In overall terms the level of compliance stood at 72% compared with 62% for 2014/15, with improvements having been seen in a number of
areas. However, the Trust had yet to achieve the required 95% target for IG training which was a requirement for level 2 compliance.

The Board of Directors APPROVED the recommendation that the Trust submit compliance at Level 1. A detailed report on the 2015/16 position and actions to be taken to achieve level 2 compliance was scheduled for the April 2016 meeting.

093/16 2016/17 INTERNAL AUDIT PLAN

The Board of Directors RECEIVED the Internal Audit Plan for 2016/17, which had already been considered by the Trust Management Committee and Audit Committee.

It was NOTED that the Trust Management Committee had requested the provision within the plan for the testing of key processes. Mr Barnes as Chair of the Audit Committee indicated that there had been significant improved engagement between the Trust and the internal auditors which had resulted in the reduction of old and timelier implementation of new recommendations.

The Board APPROVED the 2016/17 plan subject to the inclusion of the items requested from the Trust Management Committee. It was noted that the plan would remain flexible in order to meet the requirements of the Trust.

REGULATORY AND STATUTORY REPORTING

094/16 STATEMENT OF READINESS IN THE EVENT OF A MAJOR INCIDENT

The Board of Directors RECEIVED and NOTED the report which provided the Trust’s statement of readiness in preparedness for a major incident and the ability to respond appropriately to any threat, and in particular, a Mass Casualties Incident, as required following a communication from NHS England.

NHS England had requested that trusts assess their preparedness in four given areas:
• Reviewed and tested cascade systems
• The ability for staff to gain access to sites should the transport infrastructure be disrupted
• Plans being in place to significantly increase critical care capacity and capability over a protracted period of time
• Due consideration having been given as to how to gain specialist advice in relation to management of significant number of patients with traumatic blast and ballistic injuries

Mrs Dennis confirmed that assurance could be provided in all four areas as a result of undertaking a number of specific tests and existing emergency preparedness, resilience and response assessments. Additionally, further actions were being taken to improve responsiveness and stress testing. The
outcome of the testing of the plans, which due to the sensitivity of the matter, would be reported to a future private board meeting.

**ACTION – CH**

It was clarified that the Local Health Resilience Partnership gold command would manage and co-ordinate any regional or inter-agency response in the event of any major incident, with clear protocols for the management of different injuries.

The Board APPROVED the statement of readiness in the event of a major incident.

Mrs Legg suggested that it may be appropriate to reassess the statement in light of the forthcoming junior doctors’ national industrial action when it was planned to withdraw emergency cover. Mrs Dennis confirmed that this scenario could feed into the table top exercises and stress testing of plans.

**BOARD GOVERNANCE**

095/16 **REGISTER OF INTEREST**

The Board of Directors RECEIVED and APPROVED the bi-annual review of the Register of Directors’ Interests.

096/16 **ANNUAL APPOINTMENT OF VICE CHAIR**

The Chairman recommended to the Board for continuity purposes that Mrs Legg should continue in her capacity as Vice Chair until the end of February 2017. This would be the date that her term of office as a Non-executive Director concluded.

The Board APPROVED the recommendation.

097/16 **ESCALATION FROM TRUST MANAGEMENT COMMITTEE**

There were no escalations from the Trust Management Committee.

**BOARD GOVERNANCE PLANNING**

098/16 **REVIEW OF BOARD ANNUAL PLANNER**

The Board of Directors RECEIVED and APPROVED its forward annual planner.
The next meeting of the Board of Directors would be held on Tuesday 26 April 2016.

Post meeting note – due to the planned national industrial action by junior doctors between 26 and 28 April 2016 the Board of Directors meeting was brought forward from Tuesday 26 April to Friday 22 April.

Martin Havenhand
Chairman

Date
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<th>Log No</th>
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<th>Report/Agenda title</th>
<th>Minute Ref</th>
<th>Action</th>
<th>Lead Officer(s)</th>
<th>Timescale/ Deadline</th>
<th>Comment/Feedback from Lead Officer(s) (each new entry date referenced)</th>
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<td>1</td>
<td>26-Jan-16</td>
<td>Minutes</td>
<td>005/16</td>
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<td>2</td>
<td>23-Feb-16</td>
<td>CEO Report</td>
<td>50/16</td>
<td>(CQC) Quality Improvement Plan for QAC review and BoD approval</td>
<td>ChN</td>
<td>26/04/2016-24 May 2016</td>
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<td>23-Feb-16</td>
<td>Transformation Report</td>
<td>52/16</td>
<td>Emergency Centre contractual arrangements re partners to be confirmed to Board, i.e. has the CCG agreed the proposed arrangements</td>
<td>DoF</td>
<td>22-Apr-16</td>
<td>See section 3.2 of the Transformation Report (item 139/16)</td>
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<td>IPR: Quality Report</td>
<td>55(a)/16</td>
<td>Nurse staffing establishment reviews - overall outcome required to provide clarity on the amount of any investment required.</td>
<td>ChN</td>
<td>28-Mar-16</td>
<td>Some details provided in the Quality Report, item 142.16 (a)</td>
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<td>23-Feb-16</td>
<td>IPR: Quality Report</td>
<td>55(a)/16</td>
<td>Results from colorectal review (mortality relating to CUSUM) to QAC (with escalation to Bod if required)</td>
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<td>Agenda item 82/16 on QAC agenda</td>
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<td>29-Mar-16</td>
<td>Clinical Presentation</td>
<td>78/16</td>
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<td>29-Mar-16</td>
<td>Transformation Report</td>
<td>86/16</td>
<td>Acute and Community Transformation to be the focus of the next Transformation Forum</td>
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<td>87/16</td>
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<td>22</td>
<td>29-Mar-16</td>
<td>Quality Report</td>
<td>90(a)/16</td>
<td>More detailed report on mortality required</td>
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<td>22-Apr-16</td>
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<td>Workforce Report</td>
<td>90(c)/16</td>
<td>Staff turnover / worklife balance - BoD to be provided with details relating to the reasons why colleagues left the organisation.</td>
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<td>24-May-16</td>
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<td>24</td>
<td>29-Mar-16</td>
<td>Statement of Readiness</td>
<td>94/16</td>
<td>Private BoD to be advised of outcome of the testing of the plans</td>
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Report: Report from the Chairman

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

Strategic Objective: Governance: Trusted, open governance

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

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

Summary of Key Points:

- Progress continues to be made by the Rotherham Together Partnership, with their new strategic view of collaborative working for benefit of the community of Rotherham.

- The Working Together Partnership is also seeing progress, with a system-wide conference taking place on 25 April 2016.

- Listening into Action, Pass It On event held on 8 April.

Board action required:
For noting
1.0 Introduction

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

2.0 Rotherham Together Partnership (RTP)

2.1 Our Chief Executive and I attended a workshop on 13 April, together with Chief Executives and Chairs of the RTP organisations.

2.2 The aim of the workshop was to develop a shared vision and priorities for a refreshed Community Strategy that will be owned and delivered by “the Partnership”.

2.3 As part of the process, each Partner Organisation shared their own strategic priorities for the next 3 – 5 years.

2.4 The workshop was initially looking at a vision to 2020 but we agreed that we needed a longer term vision for the period up to 2030.

2.5 The next formal RTP meeting will take place on 8 June 2016 when a draft of the future vision and priorities will be shared.

3.0 Working Together Programme (WTP)

3.1 The WTP Chair’s meeting took place on 4 April and the agenda focussed on the Sustainability and Transformation planning process, including governance arrangements. A system-wide conference is taking place on 25 April and the Chief Executive and I will be in attendance.

3.2 The next formal WTP Chair’s meeting will take place on 9 May.

4.0 Chairman activities

4.1 The annual, Non-Executive Director PDR process is almost complete. Members of the Council of Governors have also been invited to provide feedback for the Chairman and NEDs, and this has also been fed into the reviews.

4.2 I attended the Trust’s Listening into Action Pass it On event which took place on 8 April. The eight projects which were presented demonstrated significant improvement to patient experiences through engaging and involving colleagues right across the Trust.

Martin Havenhand
Chairman
Report: Report from the Chief Executive

Presented by: Louise Barnett, Chief Executive

Author(s): Louise Barnett, Chief Executive

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

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

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

Purpose of this paper:
This paper provides an overview of progress regarding key operational and strategic issues and stakeholder engagement.

Summary of Key Points:
- The 2016/17 Operational Plan was submitted on 18 April 2016, the original deadline having been extended from 11 April by NHS Improvement
- The Trust’s new Vision has been discussed and informally agreed – the Board is asked today to formally approve the Vision (section 2.2 in the report)

Board action required:
This report is for noting.

The Board is asked to formally approve the Trust’s new Vision.
1.0 Introduction

1.1 This paper provides an overview of progress regarding key operational and strategic issues and stakeholder engagement since the last report.

2.0 Strategic Issues

2.1 Progress against the 2015/16 strategic objective priorities is reported on the attached appendix. A review of our annual performance against the 2015/16 individual aims will be completed over the next few weeks and will be summarised and presented to the Trust Board in May 2016. Specific measurable aims have been agreed by the Trust Board for 2016/17, building on the progress against the five strategic objectives during 2015/16. These are in the process of being refined in detail to provide even greater clarity and to facilitate effective communication and engagement with colleagues and partners and to strengthen tracking.

2.2 The Trust Board is being asked to formally approve the new Vision for the Trust, which has been previously discussed by the Board Members. The Vision supports delivery of our Mission: “to improve the health and wellbeing of the population we serve, building a healthier future together”.

The new vision is: “to be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital”.

This also supports our five strategic objectives, and delivery of the strategic aim to be a standalone Trust, working in collaboration to deliver high quality sustainable services for the population we serve.
2.3 The 2016/17 Operational Plan was submitted to NHS Improvement on 18 April 2016. At its 8 April 2016 Board Meeting, it had been agreed to accept the proposed control total, whilst highlighting dependencies and risks in terms of delivery. Discussions continue with NHS Improvement and Rotherham CCG in terms of some detailed aspects relating to the plan. Risks include:

- Access to the Sustainability and Transformation Fund with delivery of its conditions, including delivery of each of the remedial trajectory key performance targets;
- Delivery of the £10.5M CIP for 2016/17, set at 5.5% of controllable costs;
- Delivery of the clinical activity contract including full receipt of CQUIN funding;
- The ability to manage workforce pressures in key areas within the budgeted establishments, which reflect an appropriate mix of substantive and agency staff.

2.4 The five year plan is under development in association with the development of the South Yorkshire and Bassetlaw ‘footprint’ area Sustainability and Transformation Plan due to be submitted in June 2016. The importance of plans and improvements to support Trust performance, the centrality of locality working in Rotherham and acute care collaboration will be highlighted as key to achieving financial and clinical sustainability. The transformation agenda is significant and therefore it will be important for the Trust to ensure sound governance and accountability arrangements across the operational and transformational agendas.

2.5 Contractual negotiations have continued throughout March and into April, with our main commissioner, Rotherham Clinical Commissioning Group (RCCG) with the expectation that the contract will be signed by midday on 25 April 2016.

3.0 Operational Priorities

3.1 The Trust continued to face considerable pressures in terms of delivering the four hour emergency access target in March, with several periods of performance that were poorer than in previous months. However, following a concentrated effort to galvanise colleagues’ engagement and increase focus on key actions, together with resourcing improvements and external factors, I am pleased to report that the Trust is currently achieving the performance standard. The Improvement Action Plan is currently being restructured to reflect the progress made and to increase focus on high impact actions, with a view to improving resilience of service delivery, to sustain high performance for patients going forwards. This standard remains
fragile, but the actions identified together with the acute and community transformation programme will support improved performance and mitigate risks in this area.

3.2 The junior doctor industrial action took place as planned between 0800 on 6 April 2016, through to 0800 on 8 April 2016. This went smoothly with minimal cancellations of activity affecting only a small number of patients. The Trust is now planning for the junior doctor industrial action planned for 26 and 27 April 2016. Full withdrawal of labour will take place between the hours of 8am and 5pm on Tuesday 26 and Wednesday 27 April 2016, including emergency cover, whilst other doctors and staff will continue to provide care during this time.

3.3 The CQC re-inspection is expected soon and planning continues. It is important that the Trust is able to demonstrate the good progress made in many areas following the original inspection in February 2015 and that all colleagues are supported to understand the CQC requirements and their role in achieving these expected standards of quality every day (and not simply for re-inspection). The up and coming inspection provides an opportunity to increase this focus and engagement, whilst continuing our programme of self-assessment through mock inspections. The re-inspection will be organisation-wide, across all key lines of enquiry, not just the areas of improvement identified previously.

3.4 The Trust Quality Improvement Plan for 2016/17 reflects the key quality priorities of the Trust and will be shared with colleagues across the organisation to ensure transparency and engagement across divisions and departments.

4.0 Stakeholder Engagement

4.1 The Emergency Centre Project Board continues to meet monthly, chaired by the Chief Operating Officer, Chris Holt, to oversee the development of the Emergency Centre and reports monthly to the Trust Management Committee. In addition, in March, a meeting took place on 21 March 2016 with Care UK and Rotherham CCG colleagues to discuss and agree the way forward in terms of organisational development support for the Emergency Centre project.

4.2 The Systems Resilience Group took place on 30 March 2016, attended by Maxine Dennis, Director of Operations to ensure effective partnership working to support increased resilience of services to meet the national performance standards locally.

4.3 A Consultant Forum took place on 1 April 2016 led by the Medical Director, Conrad Wareham. These forums are scheduled throughout the year to support informal discussions between the Medical workforce and the Medical Director supported by members of the Executive Team.

4.4 The Working Together Programme Executive took place on 4 April 2016, followed by the Joint Meeting of Chairs and the Programme Executive. The Sustainability and Transformation Plan (STP) Executive Steering Group also met to agree the way forward for the development of the STP for the footprint area.

4.5 The Listening into Action (LiA) Pass It On event took place on 8 April 2016. This was a really successful afternoon, when clinical and non-clinical colleagues in a wide variety of roles from across the Trust shared their LiA journey and the
outcomes of their work streams with colleagues. The Chairman and I both attended this event and were really impressed with the progress made and the demonstrable difference of the changes made for our patients and colleagues. The Trust will continue to support the LiA methodology to support our workforce to achieve our vision and strategic objectives.

4.6 The Rotherham Partnership Chief Executive Officer Group met on 11 April 2016, to consider the community strategy and vision and to prepare for the Rotherham Together Partnership Visioning event which took place on 13 April 2016, attended by the Chairman and I, together with representatives from partner organisations from across Rotherham. This was a productive session which will inform the development of the vision for Rotherham. The Trust Board will be kept appraised of progress.

4.7 The Monthly Board Seminar session took place on 15 April 2016, with the focus being agreement of the key financial elements underpinning the 2016/17 Operational Plan, feedback on the draft 2016/17 Operational Plan and finalisation of the plan subject to agreed amendments. In addition, the Trust Board considered performance against the four hour access standard and progress against the operational and transformational programmes in place to support achievement. Chris Holt, Chief Operating Officer and Dr Shaun Nakash, Clinical Director for Emergency Care led this session with board colleagues.

5.0 Conclusion

5.1 The Trust continues to deliver strong performance in many areas, whilst still facing challenges in other areas including the four hours access target and workforce/agency.

5.2 The 2016/17 plan requires significant change and improvement to support delivery of quality, workforce, financial and operational priorities. In addition, governance will need to continue to be strengthened from ward/department to board to support improved engagement, compliance and delivery. The transformational agenda is significant both internally, within the wider Rotherham health economy and across the STP footprint and vanguard. This will need to be sustained alongside the need to meet day to day operational requirements.

5.3 The Trust Board will continue to be appraised of progress. A review of 2015/16 performance against the strategic objectives will be shared in May and through the Annual Report and the detailed 2016/17 strategic objectives will be reported monthly beginning in May.

Whilst significant progress has been made this year in terms of a number of strategic objectives and quality performance measures, the Trust continues to face significant operational challenges, relating to achievement of the four hour access target and reduced agency spend.

5.4 Financial and clinical sustainability of the Trust remain paramount. Resolution is required in terms of outstanding planning elements in order to finalise the 2016/17 plan which forms the foundation of the first year of the revised five year strategy. Progressing the development and implementation of the Clinical Strategy, including the development of the Rotherham Borough locality-based transformation
programme, Acute Care Collaboration Vanguard and Working Together Programme, are necessary and important. Improving sustainability through collaboration at local and 'footprint' levels in the context of the national picture, will require our continued ability to adopt a strategic approach whilst identifying and driving pragmatic solutions to improving day to day performance as we continually strive to deliver clinically-led, high quality care and services for our patients.

Louise Barnett
Chief Executive
April 2016
Sustainability and Transformation Plan (STP)

At the March Working Together Provider Vanguard Programme Board the Chief Executives and Chairs discussed the new NHS Sustainability and Transformation Plans and in particular how the Working Together Partnership will fit within the new approach.

Earlier this year, national health and care bodies in England set out steps to help local organisations plan over the next six years to deliver a sustainable, transformed health service and to improve quality of care, wellbeing and NHS finances. The new dedicated Sustainability and Transformation Fund is worth £2.1 billion in 2016/17 and rising to £3.4 billion in 2020/21. The associated planning guidance outlines a new approach to help ensure that health and care services are planned by place rather than around individual institutions. They will help ensure that the investment secured in the Spending Review is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term. STPs are not an end in themselves, but a means to build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2020 and the concrete steps needed to get us there.

As in previous years, NHS organisations will be required to produce individual operational plans for 2016/17. In addition, every health and care system will be required, for the first time, to work together to produce a Sustainability and Transformation Plan, a separate but connected strategic plan covering the period October 2016 to March 2021.

As part of this, local leaders are required to set out clear plans to pursue the ‘triple aim’ set out in the NHS Five Year Forward View – improved health and wellbeing, transformed quality of care delivery, and sustainable finances.

The STP Plan has to cover the period October 2015 to March 2021. The main STP for the WTP geographic area will be South Yorkshire and Bassetlaw. This will be an umbrella plan which also has under it a number of other initiatives which will contribute. The Working Together Partnership Vanguard initiatives are an example of this.

As well as developing the South Yorkshire and Bassetlaw STP we will also need to consider how we link with the West Yorkshire, Derbyshire, Lincolnshire and Nottinghamshire plans too as we have clinical flows in those areas for many specialist services.

A high level plan has to be submitted by end of April 2016 with a further detailed plan by the end of June.

Key questions the submission has to answer are:
• Is there clear leadership and governance arrangements for the STP
• Have the health and wellbeing gaps for the geographic footprint been identified and quantified
• Have priorities or hypothesis been agreed to meet the challenge.

Each plan has to have a clear and achievable delivery programme. The footprint’s Health and social care organisations need to come together to develop the plan and delivery programme.

Phase 1 will be until July 2016 and Sir Andrew Cash as Chair of WTP will lead the group. Lesley Smith, Chair of The Commissioner Collaboration and Accountable Officer for Barnsley CCG, will jointly work with Andrew during this period. This collegiate approach between Commissioners and Providers was agreed when the Chief Executives of the Working Together Partnership met with the Accountable Officers of the corresponding CCGs to begin discussions about the South Yorkshire and Bassetlaw STP.

The next step will be a stakeholder meeting comprising representatives of the South Yorkshire and Bassetlaw STP footprint NHS Trusts, CCGs, Local Authorities and Universities on 25th April to begin to agree the priorities and high level plan.

**Working Together Work streams update:**

All of the work streams are progressing and of particular note this month are:

- **Information Technology work stream**
  
  NHS roam is now almost complete for all Trusts. A InfoFlex Database Specialist (contractor) has been appointed to progress a cancer tracking management system through inter-trust messaging across Trusts. This will enable patient data to be electronically transmitted to a referred Trust as soon as it is recorded on the CIMS InfoFlex Cancer Care system and provide clinicians with immediate access to patient clinician and non-clinician data under their care in other Trusts. Detailed patient data can then be shared between different organisations thereby removing the need for duplication, and potential transposing of data entry and provides an enabling technology solution in line with NHS England Digital Strategy for a paperless NHS by 2020.

- **GI bleeds.**

  Some early discussions have taken place between clinicians from the partner Trusts on potential future clinical models to ensure a sustainable out of hours bleeds service across the geography. Further data collection is being undertaken to inform the next steps.

- **Commissioners pre engagement process on stroke and childrens surgery services.**

  The Commissioners Working Together programme has begun pre-engagement work to raise awareness and seek public views on the future shape and needs of adult Stroke and Childrens surgery services. More information can be found at: [http://www.smybndccgs.nhs.uk/about-us](http://www.smybndccgs.nhs.uk/about-us).

And finally we are still awaiting an announcement of funding for the Working Together Acute Partnership Vanguard for 2016/17 which is due out end of March 2016. There will be a visit from the National team to monitor progress during the Spring.
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<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Deliver the 4 Quality Account ambitions; mortality; Harm Free Care; National waiting time targets and improved FFT scores</td>
<td>CN/MD and COO</td>
<td>AMJASOND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agree implementation plans for the Quality Account improvements; review of all unpredicted deaths; reduction in the number of patient staying &gt;14 days; improvements in Harm Free Care rates; both Sign up to Safety pledges; reduction in noise at night; improved FFT scores; increase in the number of colleagues trained in caring for patients living with dementia; achievement of complaints improvement.</td>
<td>CN</td>
<td>AMJASOND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine reports to QAC on achievement of the Quality Account improvements.</td>
<td>CN</td>
<td>AMJASOND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Publish the 14/15 Quality Account</td>
<td>CN</td>
<td>AMJASOND</td>
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<td></td>
<td></td>
<td>Produce the 15/16 Quality Account - commence consultation on priorities etc in September 2015.</td>
<td>CN</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Deliver National and Local Data Information requirements</td>
<td>COO</td>
<td>AMJASOND</td>
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<td></td>
<td></td>
<td>Deliver Monitor Compliance Framework requirements</td>
<td>ALL</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td>B2</td>
<td>Implement Improvement and Learning from CQC visits (Exec Lead - Chief Nurse)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>On receipt of the draft report, produce a refreshed action plan covering all the issues identified by the CQC</td>
<td>CN</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Prepare the Trust for the Quality Summit</td>
<td>CN</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Implement action plan</td>
<td>CN</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Weekly roadshows on the CQC findings and the principle actions being taken by the Trust (6 roadshows; the first to be held 12 - 18 hours before the formal publication and weekly thereafter for 6 weeks)</td>
<td>CN</td>
<td>AMJASOND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prepare a Media Strategy in conjunction with the Head of Communications and the CEO</td>
<td>CN</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Prepare the Trust for the reactive inspection, usually 4-6 weeks after completion of the main elements of the action plan.</td>
<td>CN</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td>B3</td>
<td>Focus on Patient Safety (Executive Lead - Medical Director)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Recognition and escalation processes of the deteriorating patient</td>
<td>MD</td>
<td>AMJASOND</td>
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<tr>
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<td>Compliance with WHO surgical checklist</td>
<td>MD</td>
<td>AMJASOND</td>
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<td></td>
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<td>RCA training and awareness of Duty of Candour</td>
<td>CHN</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Audit and standardise the management of information in clinical / consultant offices and departments (clinical / administrative systems)</td>
<td>MD</td>
<td>AMJASOND</td>
</tr>
<tr>
<td></td>
<td>B4</td>
<td>Clinically Led Estates Strategy</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Agree and finalise 15/16 strategy</td>
<td>COO</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Undertake an external review of the Estate to determine a 5-10 year Estates Strategy</td>
<td>COO</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Develop service environment for Paediatric Oral Surgery</td>
<td>COO</td>
<td>AMJASOND</td>
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<tr>
<td></td>
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<td>Improvements to Maternity Care settings</td>
<td>COO</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Reconfiguration of Surgical Assessment Unit</td>
<td>COO</td>
<td>AMJASOND</td>
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<td></td>
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<td>Develop Aseptic Suite</td>
<td>COO</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td>B5</td>
<td>Clinically Led IT Strategy</td>
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<td></td>
<td>Agree and finalise strategy</td>
<td>COO</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Implementation of current plan (2015-2016)</td>
<td>COO</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Finalise Emergency Centre IT Specification &amp; launch procurement</td>
<td>COO</td>
<td>AMJASOND</td>
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<tr>
<td></td>
<td></td>
<td>Complete Symphony (A&amp;E IT System) up-grade</td>
<td>COO</td>
<td>AMJASOND</td>
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<tr>
<td>Task</td>
<td>Responsibility</td>
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<tr>
<td>Windows up-grade (subject to timely commencement)</td>
<td>COO</td>
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<td>Director of Health Informatics appointed substantively</td>
<td>COO</td>
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<tr>
<td>Complete Emergency IT system procurement</td>
<td>COO</td>
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<tr>
<td>Meditek SAN up-grade</td>
<td>COO</td>
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<tr>
<td>Finalise replacement/re-procurement of Systm1 (community IT system)</td>
<td>COO</td>
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<tr>
<td>Launch of e-prescribing system</td>
<td>COO</td>
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<tr>
<td>Award contract for Emergency Centre IT system</td>
<td>COO</td>
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<tr>
<td>Colleagues B6 People Capability and Capacity to deliver the plan</td>
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<tr>
<td>Activity based workforce planning submission</td>
<td>DoHR</td>
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<tr>
<td>Feedback and discussion of workforce priorities with providers</td>
<td>DoHR</td>
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<tr>
<td>Deliver managed bank service (medics and nursing)</td>
<td>DoHR</td>
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<tr>
<td>Implementation plan for E-Rostering</td>
<td>DoHR</td>
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<tr>
<td>Leadership Development and Succession Planning</td>
<td></td>
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<tr>
<td>Complete up to date / live talent map for key leadership posts and people</td>
<td>DoHR</td>
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<tr>
<td>Support COO in structure and team development</td>
<td>DoHR</td>
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<tr>
<td>Leadership development programme in place</td>
<td>DoHR</td>
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<tr>
<td>B7 Engaging Colleagues</td>
<td></td>
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<tr>
<td>Deliver LIA Clinical Workstreams - Year two</td>
<td>DoHR</td>
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<tr>
<td>Review team brief arrangements to enable CEO at both briefs</td>
<td>DoHR</td>
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<tr>
<td>Produce and finalise NHS survey action plan</td>
<td>DoHR</td>
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<tr>
<td>National NHS Staff Survey to achieve an increase in the overall engagement score compared to 14/15 (3.75)</td>
<td>DoHR</td>
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<tr>
<td>Retention rates - improvement required</td>
<td>DoHR</td>
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<tr>
<td>B8 Reducing sickness absence</td>
<td></td>
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<tr>
<td>Manage absence robustly (long and short-term) to deliver a target of 4% in month</td>
<td>DoHR</td>
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<tr>
<td>10% of workforce to have Health MOT</td>
<td>DoHR</td>
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<tr>
<td>B8 Reduce agency/premium spend</td>
<td></td>
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<tr>
<td>List of all locums &amp; interims with exit date and arrangements</td>
<td>DoHR</td>
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<tr>
<td>List of all premium and variable pay spend by occupation group and area</td>
<td>DoHR</td>
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<tr>
<td>Pay and WTE run rate and forecast</td>
<td>DoF</td>
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<tr>
<td>Implement standard reporting pack for pay costs (E's and WTE)</td>
<td>DoF</td>
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<tr>
<td>Governance B9 Improve financial reporting and service line reporting</td>
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<tr>
<td>Enhance reporting to the Board and Committees</td>
<td>DoF</td>
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<tr>
<td>Implement SLR and PLICs to support SLM</td>
<td>DoF</td>
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<tr>
<td>Establish and implement financial awareness sessions to budget holders, and clinical/manager leaders</td>
<td>DoF</td>
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<tr>
<td>B10 Address Financial Enforcement Requirements</td>
<td></td>
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<tr>
<td>Assess compliance with undertakings</td>
<td>DoF</td>
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<tr>
<td>Compile evidence to support completion</td>
<td>DoF</td>
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<tr>
<td>Produce clear action plan for outstanding requirements</td>
<td>DoF</td>
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<tr>
<td>B11 Information Governance Toolkit</td>
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<tr>
<td>Information Governance Toolkit level 2</td>
<td>CS</td>
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<tr>
<td>B12 Introducing Service Line Management (Executive Lead - Medical Director)</td>
<td></td>
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<td>Task</td>
<td>Responsible Officer</td>
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<tr>
<td>Develop overall project plan and workstream implementation plan</td>
<td>MD</td>
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<tr>
<td>Implement SLM through effective clinical engagement</td>
<td>MD</td>
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<tr>
<td>Develop and implement standardised performance management framework</td>
<td>COO</td>
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<tr>
<td>Recruit a substantive Head of Performance</td>
<td>COO</td>
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<tr>
<td>Develop a suite of information to support business delivery</td>
<td>COO</td>
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<tr>
<td>Define levels responsibility and accountability</td>
<td>COO</td>
<td></td>
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<tr>
<td>Review and re-establish Business Planning Framework in preparation of 16/17 planning round</td>
<td>COO</td>
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</tbody>
</table>

**B13 Audit Recommendations**

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Officer</th>
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</thead>
<tbody>
<tr>
<td>Assess the number of outstanding Audit recommendations</td>
<td>DoF</td>
</tr>
<tr>
<td>Ensure Audit recommendations are a standing agenda item on TMC and Audit Committee</td>
<td>DoF</td>
</tr>
<tr>
<td>Produce clear action plan for implementing outstanding recommendations</td>
<td>DoF</td>
</tr>
</tbody>
</table>

**B14 Risk Management**

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Officer</th>
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</thead>
<tbody>
<tr>
<td>Produce a revised Risk Management Strategy</td>
<td>CN</td>
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</tbody>
</table>

**Finance**

**B15 Deliver the £12.9m CIP programme (Executive Lead - Director of Finance)**

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Officer</th>
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</thead>
<tbody>
<tr>
<td>Agree programme leads</td>
<td>DoF</td>
</tr>
<tr>
<td>Agree programme governance &amp; reporting arrangements</td>
<td>DoF</td>
</tr>
<tr>
<td>Deliver programme (2015-16)</td>
<td>DoF</td>
</tr>
<tr>
<td>Commence 2016/17 CIP programme and confirm indicative values for 2017/18 - 2019/20</td>
<td>DoF</td>
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</tbody>
</table>

**B16 Improve liquidity (Executive Lead - Director of Finance)**

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Officer</th>
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</thead>
<tbody>
<tr>
<td>Agree liquidity action plan</td>
<td>DoF</td>
</tr>
<tr>
<td>Implement liquidity action plan</td>
<td>DoF</td>
</tr>
<tr>
<td>Produce regular 13 week cash flow forecast</td>
<td>DoF</td>
</tr>
<tr>
<td>Produce 12 month rolling cash forecast</td>
<td>DoF</td>
</tr>
<tr>
<td>Produce 5 year cash flow forecast</td>
<td>DoF</td>
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</table>

**B16 Reduce underlying deficit (Executive Lead - Director of Finance)**

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Officer</th>
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</thead>
<tbody>
<tr>
<td>Complete and submit the one year operational plan</td>
<td>DoF</td>
</tr>
<tr>
<td>Produce a high level analysis of the 5 year financial plan</td>
<td>DoF</td>
</tr>
<tr>
<td>Detailed 5 year financial plan (monthly for 15/16 and 16/17)</td>
<td>DoF</td>
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</table>

**17 Capital Programme**

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Officer</th>
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</thead>
<tbody>
<tr>
<td>Establish Capital Monitoring &amp; Investment Committee</td>
<td>DoF</td>
</tr>
<tr>
<td>Develop, prioritise and sign off 1 year capital plan</td>
<td>DoF</td>
</tr>
<tr>
<td>Develop, prioritise and sign off 5 year capital plan</td>
<td>DoF</td>
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</tbody>
</table>

**B18 Share and deliver RCCG contractual requirements**

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Officer</th>
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</thead>
<tbody>
<tr>
<td>Agree the contract</td>
<td>DoF</td>
</tr>
<tr>
<td>Share details of the contract</td>
<td>DoF</td>
</tr>
<tr>
<td>Agree contract performance arrangements and leads</td>
<td>DoF</td>
</tr>
<tr>
<td>Commence 2016/17 contracting round in September 2015</td>
<td>DoF</td>
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**B19 Clinical Speciality Reviews**

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<tr>
<th>Task</th>
<th>Responsible Officer</th>
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<tbody>
<tr>
<td>Agreed prioritisation criteria &amp; prioritisation completed</td>
<td>MD</td>
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<tr>
<td>Phase 2 implementation plan agreed</td>
<td>MD</td>
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<tr>
<td>Paediatric Services Options appraisal</td>
<td>MD</td>
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<tr>
<td>Implementation of plan (2015-2016)</td>
<td>MD</td>
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**Partners B20 Acute and Community Transformation**

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<thead>
<tr>
<th>Action</th>
<th>Responsible</th>
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<tbody>
<tr>
<td>Finalise the 3 year transformation plan for formal approval</td>
<td>COO</td>
</tr>
<tr>
<td>Share plan and agree the leads</td>
<td>COO</td>
</tr>
<tr>
<td>Implement the plan (2015-2016)</td>
<td>COO</td>
</tr>
<tr>
<td>Launch the perfect week including Safer Care Bundle</td>
<td>COO</td>
</tr>
<tr>
<td>Close winter ward and 1 medical ward</td>
<td>COO</td>
</tr>
<tr>
<td>Launch new Division of Emergency Care</td>
<td>COO</td>
</tr>
<tr>
<td>24/7 site team fully operational</td>
<td>COO</td>
</tr>
<tr>
<td>Assessment and capacity and demand to support job planning</td>
<td>COO/MD</td>
</tr>
<tr>
<td>Revised medical job plans to support the acute take</td>
<td>COO/MD</td>
</tr>
<tr>
<td>Surgical Assessment Unit re-configuration of operational delivery model</td>
<td>COO</td>
</tr>
<tr>
<td>Recruitment to 7 physicians to deliver provide medical input to the community locality model</td>
<td>COO</td>
</tr>
<tr>
<td>Deliver quarterly contractual indicators in Community Transformation &amp; 7/7 programme</td>
<td>COO</td>
</tr>
<tr>
<td>Deliver quarterly contractual indicators in Acute Transformation &amp; 7/7 programme</td>
<td>COO</td>
</tr>
<tr>
<td>Phase 2 re-configuration of bed base</td>
<td>COO</td>
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<tr>
<td>Implement hospital at night (and day)</td>
<td>MD</td>
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**B21 Development of the Emergency Centre**

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<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Agreed project management and governance arrangements</td>
<td>COO</td>
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<tr>
<td>Appoint project manager (external appointment)</td>
<td>COO</td>
</tr>
<tr>
<td>Deliver year 1 of the Emergency Centre programme</td>
<td>COO</td>
</tr>
<tr>
<td>Commence new build of Emergency Centre</td>
<td>COO</td>
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</tbody>
</table>
Report: Monthly Transformation Report

Presented by: Louise Barnett, Chief Executive
Author(s): Chris Holt, Chief Operating Officer
Simon Sheppard, Director of Finance
Maxine Dennis, Director of Ops

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

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

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

Purpose of this paper:
To provide an update on progress regarding the key Transformation Programmes for 2015/16.

Summary of Key Points:
Over the last 12 months, progress has been made in a number of areas, and has continued in month:
- Progress continuing with locality pilot
- GP ward rounds now involve multi-agency involvement
- Emergency Centre build reached its half way milestone
- Contractual arrangements for the Emergency Centre partnership now confirmed
- Workforce plans for the Emergency Centre have progressed
- Emergency Centre Communications Strategy has been refreshed
- CIP outturn position for 2015/16 potentially at £12.6m
- PMO being restructured to support 2016/17 initiatives
- Lord Carter recommendations being mapped out to support efficiencies agenda

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

1.1 There are a number of transformational programmes which make a vital contribution to the delivery of the 2015/16 operational plan as well as providing the foundations for further transformation of services / models of care in future years to support improved sustainability of services.

1.2 This report provides a progress report against several of these transformational programmes.

2. **Acute and Community (Unscheduled Care) Transformation**

2.1 Progress is continuing on the Locality pilot. The current Health Village Locality has been chosen as the pilot site and the news has been welcomed by both nurses and GPs alike.

2.2 A job description is currently being prepared for the jointly funded post of Locality Project Lead. This post will be offered internally for staff of the Trust and the Local Council to apply for, and amounts to a 12 month secondment. Once the position has been appointed to an away day will be held for the team to contribute to the outcome measures of the pilot.

2.3 There has also been progress on one of our key enablers for the new model of care we will be piloting, namely SEPIA. A presentation was made to the [multi-agency] Interoperability Board who have agreed to dovetail the pilot related developments into their programme of activity for 16/17.

2.4 Away from the pilot the GP Ward round has now evolved into a multi-agency issue resolution group. The aim of the group is to resolve fundamental issues with the Discharge to Assess Pathway being the first as the current process is not working as seamlessly as it could. The Intermediate Care Pathway has been earmarked as the next issue for the group to address.

2.5 On the communications front, work is continuing on developing a Lite version of our animated vision and this will be available shortly. It concentrates on the key message of the new model of care, uses plain English, and has been reduced to a third of the original time. This version will be predominantly aimed at the public.

2.6 Following on the communications theme we have produced an A4 double sided handout that encapsulates the current situation in terms of what we have been doing over the past year and what we’re aiming to do in the coming year.

2.7 Finally, we are exploring a number of options where we can begin to showcase the work we have been doing and share our vision, and initial contact and agreement has been made to do this at the NHS Confederation Exhibition in June. This will help build on the ever growing interest our work is attracting nationally, with approaches being made from different Trusts. Comments have also been received following the publication of the animation online, with one well-known health leader commenting: “This is the most I have ever watched a presentation on integration of services… and find the whole approach they [TRFT] have taken to be quite novel and even entertaining. All we need is the word Rotherham taken out and then we can all use it…”
3. Emergency Centre

3.1 The capital build of the Emergency Centre is now half way through its completion as at the week commencing 18 April 2016. The actual full completion dates currently remain as planned. However, the Trust is still awaiting the final projection dates for any changes to this timescale that may arise from the internal reconfiguration work. The final proposals are currently being agreed and this includes negotiation on any impact on timescales. The outline business case is being finalised in relation to potential capital costs likely to be incurred.

3.2 The Trust is working closely and effectively with Care UK now that the contractual arrangements have been clarified and agreed. Weekly meetings have been established with the Care UK management team and there is a real commitment from both organisations to work together. As a result there has been significant progress in a number of the project groups, especially in relation to service model, workforce and the IT project groups.

3.3 The service model is now being tested on a daily basis with RAT running Monday – Friday, Manchester Triage being implemented and the Trust and Care UK teams working together on a daily basis. Plans are being developed to run the “Perfect Emergency Centre Day” on 20 May 2016 when all the elements of the new service model will run as planned in the new Emergency Centre. Both Trust and Care UK teams are involved in the planning of this day and there is significant clinical engagement in making this a successful day.

3.4 The Workforce project group held a Workforce Workshop on the morning of the 14 April 2016 to visualise and agree the workforce requirements and developments from now, through the initial opening/transition period and to the final 2020 model of care delivery. This was an interactive workshop, facilitated by the OD consultant supporting the workforce development. The output has agreed ways of working across the Trust and Care UK, consensus on the skills and competencies required and a workforce plan that all clinical teams were able to influence and agree. The full workforce model was agreed and will be shared once the information from the workshop has been formally reconciled.

3.5 The development of the IT system is moving at pace. This project group has excellent clinical engagement and is delivering ahead of plan. There was an open day planned on 26 April 2016 for all staff to be able to view the progress made. However, the date has had to be re-arranged due to the junior doctor industrial action.

3.6 The Communication Strategy has been refreshed and includes key messages that will be consistent across both the Trust and Care UK. The challenge is now to look at the wider communication both within the Trust, but also wider with partners and public.

3.7 Having reached the half way stage of the project, it is timely to review the Project Initiation Document (PID) for the overall project and the individual project groups. This will be undertaken throughout April and May 2016 by the Director of Operations and the Chief Operating Officer. It is an important element of ensuring all the governance and risk issues are sighted and being managed accordingly.
4. **Cost Improvement Programme**

4.1. As reported to the Board in previous months the Trust has a £12.9m CIP target in 2015/16. The draft year end forecast of CIP schemes shows a 2015/16 outturn of £12.6m, an increase of £0.3m from the February position (5% of turnover and 6% of controllable costs). This compares to a sector average of 3.1% of costs.

4.2. To support the 2016/17 Cost Improvement programme the Trust will restructure the Programme Management Office (PMO) and engage with the findings of the Lord Carter review. As reported last month to the Board, Lord Carter was asked in the summer of 2014 by the health secretary to assess what efficiency improvements could be generated in hospitals across England. He provided an interim report on his work in June 2015, in which he outlined that potentially £5bn of operational efficiency savings could be delivered in the acute sector by 2020 by improving workforce costs, hospital pharmacy medicines optimisation, and estates and procurement management.

4.3. Lord Carter has now published his final report “Operational productivity and performance in English NHS acute hospitals: Unwarranted variations” - was published on 5 February 2016. The report contains 15 main recommendations across the different chapters, each with numerous sub-recommendations. Under each recommendation is a breakdown of the key actions for providers to lead on, and which will be taken forward by the national bodies.

4.4. The 15 recommendations will be mapped to a number of individual workstreams with the Trust each with a management lead, under the overall direction of the Executive Lead, Director of Finance. These workstreams cover areas such as Estates, Pharmacy, Procurement, Theatres, Outpatients and Workforce.

4.5. The Director of Finance has now secured access to the test area of the national portal. This enables the Trust to have earlier sight to some of the high level KPIs. The following brief presentation identifies the key areas of focus for the Trust and the level of opportunity available.
Executive Summary:

This paper presents a summary of Health Informatics (HI) and the use of technology by the Trust; it provides an overview of current national, local and internal strategic priorities and, in order to ensure continual alignment with the Trust’s strategy, sets out a series of recommendations.

This review represents the views of the Director of Health Informatics (in post since September 2015), members of Health Informatics team (including the Chief Clinical Information Officer) and input from the Corporate Informatics Committee and its sub groups, including the Clinical Health Informatics Development group.

In summary:

1. NHS England have set out an ambition for the NHS to be paper free at the point of care by 2020, and has tasked responsibility to CCGs in building roadmaps to support this ambition that will feed into regional Sustainability and Transformation Plans.

2. Recent Digital Maturity self-assessment, places the Trust 144 out of 239 providers within England, 5th of 8 in Sheffield City Region (SCR) and 4th out of 7 in the Working Together Partnership, with particularly low scores in ‘Enabling Infrastructure’ and highest across SCR and WTP in digital capabilities.

3. The Directorate provides the full range of HI Services, including via an SLA technology services to Rotherham GPs and Rotherham CCG (£750k income); supporting 24x7 over 5000 staff, in 52 locations with operating budget £5.6m.
4. A recent OD led development workshop, shows a workforce that is proud to be part of the NHS in Rotherham, which needs to be valued, and welcomes opportunities to celebrate their successes.

5. Budgeted HI Staffing levels are a real concern in networks, PMO (architecture, implementation and benefits) and recruitment and retention of a coding workforce.

6. Governance in Health Informatics is robust, with a well-attended Clinical Development Group and Corporate Informatics Group (CIC) and formal linkages and attendance at local and regional HI committees and groups.

7. The Trust has two core Electronic Patient Records systems (MediTech and SystmOne) and a very well developed Clinical Portal (SEPIA) with some pockets of excellent practice, and combined together, they provide solid capabilities for further enhancement to meet NHS England’s strategy. However, there is a culture of some resistance to further clinical development of the MediTech platform, and there is now limited capacity within HI to support development of MediTech at pace (especially for nurses).

8. The last major investment in wifi and network infrastructure was in 2008 (the same year that the Iphone 1 was released) and is now nearing end of life. There is currently no ongoing continuous replacement and refresh programme for support technology such as networks, PCs or laptops.

9. The majority of clinical and non-clinical processes are either dependant on paper or comprise of workflows attaching Office documents into Email, with our Intranet and Internet functionality not able to support modern ways of working and collaboration. In addition, our short to medium term strategy with respect to Medical Records, requires urgent attention.

Recommendations

- The Trust Board is asked to note this report
- The Trust Board is asked to support the commissioning and production of a 5 year strategy, to focus upon:
  - Paper free by 2020
  - Enabling of LDR and STP
  - Building the capacity and capability to enable technology led change
  - Options regarding short to long term infrastructure (networks, wifi, PC/Laptops) replacement and management
  - Having a digital by default culture where workflows are supported by technology.

James Rawlinson
Director of Health Informatics
April 2016.
1. **Background and description of Rotherham Health Informatics**

1.1. Health Informatics is defined as “is the interdisciplinary study of the design, development, adoption, and application of IT-based innovations in healthcare services delivery, management, and planning.”

1.2. The Health Informatics Directorate within TRFT is split into two divisions – Information and Technology, with approx. 80wte and a yearly revenue budget of £5.6m with approximately 50% spent on pay. And the remainder is largely accounted to maintenance contracts for MediTech, SystmOne, Microsoft licenses agreements, data lines, 3rd party technical support and some departmental maintenance e.g. Infoflex, FFT. Health Informatics does not currently provide systems support for Radiology, Pathology and Pharmacy, with these directorates having their own systems support teams.

1.3. The full range of Informatics support services are provided to both the organisation and also, through a Service Level Agreement, to all GPs and the CCG in Rotherham. These services include:

- Coding of all inpatient activity – approx. 1300 per week
- Providing information to support national, local and corporate internal returns, plus ad-hoc queries
- IT Service desk, taking on average 3000 calls per month with an average first time fix rate of 65% and telephones response time of around 45 seconds.
- Providing technical support to over 3500 PCs and laptops across 52 sites.
- Third line technical support for all servers, storage systems and local, wifi and wide area data networks
- Maintaining the Trust’s 1200 mobile phone estate
- Project and programme management services for the development and implementation to changes, upgrades and new IT systems
- Software and Integration development and support
1.4. Of the 80 wte, there are particular single points of weakness in the teams such as Programme Management (1wte project manager) and technical specialists (4wte) supporting and development of all data, networks and storage systems. There are no specialist services in systems architecture or benefits management.

2. NHS Informatics Strategy including Lord Carter

2.1. The Five Year Forward View made a commitment that, by 2020, there would be “fully interoperable electronic health records so that patients’ records are paperless”. This has been distilled into the ambition that health and care professionals will operate ‘paper-free at the point of care’ by 2020.

2.2. NHS England state that it is clear that ‘digital’ has a significant role to play in sustainability and transformation, including delivering primary care at scale, securing seven day services, enabling new care models and transforming care in line with key clinical priorities. Local health and care systems are developing Sustainability and Transformation Plans (STPs) with expectations that the best plans will harness the opportunities that digital technology offers.

2.3. In September 2015, a three-step process began to enable local health and care systems to produce Local Digital Roadmaps (LDRs) by 30 June 2016, setting out how they will achieve the ambition of ‘paper-free at the point of care’ by 2020. The first step was the organisation of local commissioners, providers and social care partners into LDR footprints, with ourselves being in the Rotherham footprint. The second step was for NHS providers within LDR footprints to complete a Digital Maturity Self-assessment. Both of these steps have now been completed and each LDR footprint is asked to develop and submit its own Local Digital Roadmap by the June deadline.

2.4. Local Digital Roadmaps will be assessed in July 2016 within the broader context of the assessment of STPs. Further details on the process will be published in due course. While a signed-off STP will be a condition of accessing the Sustainability
and Transformation Fund in the future, a signed off LDR will be a condition for accessing investment for technology enabled transformation.

2.5. The Lord Carter review, published in February 2016, states that hospitals must standardise procedures, be more transparent and work more closely with neighbouring NHS trusts and that implementing the recommendations will help end variations in quality of care and finances that cost the NHS billions.

2.6. Within the review, are specific references to how technology can support efficiencies within hospitals such as ePrescribing, adoption of GS1 standard and systems to support greater tracking and utilization of assets such as equipment and staff.

3. NHS Digital Maturity Assessment

3.1. Together with all NHS providers, we have recently completed out Digital Maturity Assessment, comprising of over 84 separate assessment questions, which enables providers to compare themselves across a wide range of dimensions. Like any self-assessment exercise it is subject to local variations and interpretations, but serves as a useful reference point and allows some level of comparison towards national objectives.

3.2. We are placed 144 out of 239 providers within England, 5th of 8 in SCR and 4th out of 7 in WTP, with particularly low scores in 'Enabling Infrastructure' and highest across SCR and WTP in digital capabilities.

3.3. In the context of the WTP, we compare favourably in terms of Readiness and Capabilities, but unfavourably with Enabling Infrastructure. This supports our position of having strong governance in place and having capable clinical IT systems, but our infrastructure is ageing and we are unable to properly support mobile access to clinical systems.
3.4. The table below shows our assessment scores compared to all Acute Trusts.

<table>
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<tr>
<th>Domain</th>
<th>Acute Average Score</th>
<th>TRFT Score</th>
</tr>
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<tbody>
<tr>
<td>Strategic Alignment</td>
<td>74%</td>
<td>81%</td>
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<td>Leadership</td>
<td>76%</td>
<td>85%</td>
</tr>
<tr>
<td>Resourcing</td>
<td>65%</td>
<td>85%</td>
</tr>
<tr>
<td>Governance</td>
<td>73%</td>
<td>70%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>73%</td>
<td>75%</td>
</tr>
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<td>Records, Assessments &amp; Plans</td>
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<td>41%</td>
</tr>
<tr>
<td>Transfers Of Care</td>
<td>43%</td>
<td>58%</td>
</tr>
<tr>
<td>Orders &amp; Results Management</td>
<td>54%</td>
<td>79%</td>
</tr>
<tr>
<td>Medicines Management &amp; Optimisation</td>
<td>31%</td>
<td>14%</td>
</tr>
<tr>
<td>Decision Support</td>
<td>35%</td>
<td>48%</td>
</tr>
<tr>
<td>Remote &amp; Assistive Care</td>
<td>32%</td>
<td>33%</td>
</tr>
<tr>
<td>Asset &amp; Resource Optimisation</td>
<td>42%</td>
<td>10%</td>
</tr>
<tr>
<td>Standards</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>Enabling Infrastructure</td>
<td>67%</td>
<td>57%</td>
</tr>
</tbody>
</table>

3.5. Outline plans have been submitted to Rotherham CCG as to how investments could improve our “scores”, and we will be working closely with Rotherham CCG over the coming months in agreeing our Local Digital Roadmap.

4. Governance and clinical engagement

4.1. The Trust has a well-established robust governance structure to support Informatics decision making, headed by the Corporate Informatics Committee (chaired by the Director of Health Informatics, with Chief Operating Officer, CCIO and Deputy Head of Nursing). Sat beneath CIC is the Clinical Health Informatics Development Group, chaired by the CCIO, Mr. Richard Slater, with regular attendance from a number of clinicians from across the organisation, who assist the Health Informatics Directorate in determining development priorities and resolving Informatics systems Clinical risks and issues. Mark Ryan is trained in clinical safety of Informatics.
4.2. The above diagram shows how both CIC and CHID connect through the organisation’s Governance chain, and link with both local, regional and national groups and committees.

5. Systems

5.1. There are two main Electronic Patient Records systems in use by the organisation, with a small (compared to some other Acute providers) departmental systems. Both EPR (MediTech and SystmOne) have their contractual end dates in 2019, and the Trust should start to plan its replacement strategy no later than 2017.

5.2. The Implementation of MediTech started in 2008, with an ambitious aim for the organisation to be “paper free” by 2010. The much publicised complexities and problems of implementation are well documented, and has certainly led to some level of angst towards the system amongst groups of clinical colleagues.

5.3. Meditech is a used widely in the US and Canada, supporting a number of organisations in achieving very high levels of digital maturity that should be replicable within Rotherham. It is worth noting that no “deep” EPR implementation is without problems, and can take many years to fully reap the benefits – Cambridge Hospitals recent £200m EPIC implementation is an example, along with STH’s very recent Lorenzo implementation.

5.4. The Trust, in conjunction with leadership from CHID, has progressed transforming paper based clinical process successfully in a small number of departments over the last 12-18 months, but this has not been at scale and not easily reproducible without strong clinical leadership within departments.

5.5. The focus on MediTech “optimization” has been on Doctor processes. However nursing colleagues need to be appropriately and fully engaged in usage of the system in order to reap organisational wide benefits.
5.6. The development of SEPIA, which is able to show information from both MediTech and SystmOne, in recent months, is increasingly being seen as success, notably due to its ease of use across many types of IT platforms. Again, the Trust is in the enviable position of having a robust IT clinical portal, that many communities are only starting to implement, usually at considerable cost.

5.7. Whilst our core IT systems are certainly fit for purpose and provide a wide range of potential, we still are awash with paper across the organisation. This is causing increasing problems with access to Medical Records, where teams of staff are constantly attempting to fit an ever increasing amount of paper into a finite space. Whilst we have historically “archived” paper records not accessed since 2012, our processes dictate that archive records are fully printed out should patients return to the Trust, these are then “re-scanned” into the archive systems. Tackling historic paper records is a complex and costly issue.

6. Infrastructure

6.1. The majority of the IT infrastructure (networks, servers, storage, and wifi) was installed during MediTech implementation from 2008 onwards. Components are reaching end of life and, as such, there is an ever increasing risk to an ability to support the equipment by the manufacturer should it fail or problems arise.

6.2. A plan is in place, with costs having been finalised for 2016, to replace MediTech servers and connect to storage systems purchased 18 months ago; this must be completed no later than October 2016 when support by the manufacturer ends.

6.3. Our data and wifi network is also now nearing end of life, and whilst incidents of failure are few and far between, when they do occur the consequences can be widespread, meaning no access to any IT systems across the organisation. In addition, as our wifi network is over 8 years old, it does not support fully modern wifi network standards, meaning handheld mobile devices can struggle to reliably connect (our wifi network was installed in the same year as IPhone1 and Android phones first became commercially available).

6.4. In January 2016, we started a much needed upgrade and replacement from Windows XP to Windows 7 of over 1700 PC and laptop devices across the organisation. This has been extremely well received (especially in community) by recipients of those upgrades, significantly reducing the amount of “dead time” waiting for devices to work as expected. As PCs/Laptops and increasingly mobile devices become the only way to access clinical information, this refresh programme needs to be continuous.

7. Digital Organisation

7.1. Whilst much of the focus on national and regional digital strategies is rightly on Clinical IT systems, they play one of many parts to being an effective and efficient organisation.

7.2. Within the Trust, many of our non-clinical processes are still dependant on the processing of paper forms or where they have been “digitized” the completion of electronic word/excel documents emailed to various groups. Digital organisations
would have these processes managed through electronic workflows, where information can be pre-checked, authorized at the click of button and people are able to see at a glance status.

7.3. Intranet and Internets are vital “shop window” to every organisation, underpinning our brand and values and making information, such as policies, procedures, performance information easily and readily accessible by both our staff and patients. Our current Intranet platform is now many years old and whilst visually rich, is cumbersome to properly search, find and manage information. In addition, our Intranet also lacks the functionality to be properly displayed on smartphones (evidence suggest 70% of website access is via smartphone/tablet device and increasing), and does not contain information about our core clinical assets (our doctors and nurses) – see https://www.mystay.uhb.nhs.uk/

8. Health Informatics workforce

8.1. The Director of Health Informatics commissioned Organisational Development to conduct a series of workshops with staff within the Directorate during December – February 2016, to better understand the personality profiles of managers and gain feedback from staff to understand “what it feels like” to work within Health Informatics within the Trust.

8.2. Like most HI departments, the majority of staff are logical thinkers who gain personal value from providing solutions and support to organisations and welcome recognition for the work that they do. There was a very strong sense of commitment to the NHS across Rotherham, further demonstrated by the willingness from many members of the directorate to support the organisation with Ward Liaison services earlier this year.

8.3. Those attending the workshops, drafted the diagram overleaf showing what they feel are the strengths of Health Informatics.
8.4. A newly formed matrix group, of non-managers, has been established within Health Informatics, chaired by the Director of Health Informatics, and plans are progressing well to have our first inaugural newsletter, a yearly annual report and as suggested by the team, a Health Informatics Roadshow in the summer to show/demonstrate/celebrate some of the work we do.

8.5. A challenge with all Health Informatics departments, is recruitment and retention of suitable experienced and skilled staff, in specialist technical, information and general management disciplines. Due to recent budget cuts, there is little capacity to be able to offer opportunities for progression.

Opportunities

8.6. Whilst the majority of this report attempts to articulate the wide range of challenges facing Health Informatics within the Trust, there is equally a significant number of opportunities available to the organisation in order to meet our own and national ambitions:

- We DO have an Electronic Patient Record system(s) – many Trusts are only just embarking on this journey
- We have proven success in developing and delivery of enhancements to our clinical systems including SEPIA and HIPPO (GP view of our records). Again, an increasing number of healthcare communities have either just started this journey or formulating plans to do so.
- We also have proven success in supporting and collaborating with other organisations, sharing some of our best practice and taking the lead on initiatives such as Business Intelligence and systems Integration.
- The majority of our community clinicians have long embraced mobile access to their Electronic Patient Record.
- We have very strong, supportive and historic links with our local CCG in supporting the Informatics agenda, with monthly “Rotherham Interoperability Board”
- There are strong governance arrangements in place, with high levels (compared to others) of consistent clinical engagement led by our CCIO
- We have a committed Health Informatics workforce, with pockets of real excellence, who are passionate about the NHS in Rotherham and want see more use of the tools and systems we already have.
- The Trust has a funded Enterprise Wide Agreement with Microsoft, allowing access to some of the very latest technologies available
- Generally, our workforce, along with society as whole, is expectant of doing more with digital technology with some teams consistently wanting to further exploit these opportunities.

9. Recommendations

9.1. The Trust Board are asked to note this report

9.2. Support the commissioning and production of a detailed clinically led 5 year strategy, to focus upon:
- Paper free by 2020
• Enabling of LDR and STP
• Building the sustainable capacity and capability to enable technology led change
• Options available regarding short to long term infrastructure (networks, wifi, PC/Laptops) replacement and management
• Developing a digital by default culture where workflows are supported by technology.
• Address how we can use digital technology to better engage and support our workforce, patients and members of the community.

James Rawlinson
Director of Health Informatics
April 2016
Report: Annual Strategic Review - Estates

Presented by: Chris Holt, Chief Operating Officer
Author(s): John Cartwright, Director of Estates and Facilities

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

Regulatory relevance:
Monitor: Licence Condition FT4 (plus any additional)
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
BAF: ID
Corporate Risk Register: ID

Purpose of this paper:
To inform Trust Board of the work undertaken during 2015/16 and proposed work schedule for 2016/17 in relation to capital works associated with developing the estate.

Summary of Key Points:
The key points arising from the report are:
- A significant amount of work has been undertaken during 2015/16 relating to improving the patient environment, infrastructure replacements, service developments, addressing statutory and condition backlog maintenance items, improving energy efficiency, and maintaining business continuity.
- 2016/17 programme will focus on the continued delivery of the Emergency Centre and completion of the Pharmacy Aseptic Suite schemes together with seeking to address patient environment, infrastructure replacements and statutory and condition backlog items.
- In addition a number of schemes will be scoped out for future capital funding, notably relocation of Greenoaks services and future use of Ward B1.
- Other priories for 2016/17 are the development and approval of key strategic mandatory documents including a new 5 year Estates Strategy, Sustainable Development Management Plan and a revised Green Travel Plan.

Board action required: for information
Integrated Performance Report
Board Meeting: 22 April 2016

Month 12 - Period ending 31 March 2016
### Contents

Chief Executive’s Summary

PATIENTS: Excellence in Healthcare

PATIENTS: Excellence in Healthcare

COLLEAGUES: Engaged, accountable

FINANCE: Strong financial foundations

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Appendix A (62 Days Cancer Performance by Tumour Site - Month 11)

Appendix B (18 weeks specialty breakdown - Month 12) - Estimate

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<td>National Hip Fracture Database</td>
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<td>↓</td>
<td>Worse than last period</td>
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<td>3 or more consecutive failures</td>
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### Summary of Changes in Previous Period:

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## Patents: Excellence in Healthcare

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<th>YTD</th>
<th>Trend - 12 months rolling</th>
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<td>P, N, M, CCG, INT</td>
<td>Number of reported cases of MRSA bacteraemia</td>
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<tr>
<td>P, N, M, CCG, INT</td>
<td>Number of reported cases of C.diff</td>
<td>Mar-16</td>
<td>&lt;= 2 per month</td>
<td>➤</td>
<td>1</td>
<td>19</td>
<td></td>
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</tr>
<tr>
<td>CCG, INT</td>
<td>HSMR (last rolling year)</td>
<td>Jan - Dec 15</td>
<td>&lt;= 100</td>
<td>➤</td>
<td>101.8</td>
<td></td>
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<tr>
<td>CCG, INT</td>
<td>SHMI (Including out of hospital death - last rolling year)</td>
<td>Oct 14 - Sept 15</td>
<td>&lt;= 100</td>
<td>➤</td>
<td>108.7</td>
<td></td>
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<td>7</td>
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<tr>
<td>INT</td>
<td>Crude Mortality - Number of in hospital deaths</td>
<td>Mar-16</td>
<td>&lt; prev month</td>
<td>➣</td>
<td>101</td>
<td>957</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Weekend mortality (% of total in-hospital deaths occurring on weekend)</td>
<td>Mar-16</td>
<td>&lt;= 27%</td>
<td>➣</td>
<td>30.69%</td>
<td>27.49%</td>
<td></td>
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<tr>
<td>INT</td>
<td>Neonatal mortality (Labour Ward &amp; Neonatal Unit)</td>
<td>Mar-16</td>
<td>&lt;= 9</td>
<td>➤</td>
<td>0</td>
<td>1</td>
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<tr>
<td>INT</td>
<td>Number of recorded patient safety incidents per 1,000 bed days</td>
<td>Mar-16</td>
<td>&gt;= 38.7</td>
<td>➤</td>
<td>59.44</td>
<td>56.12</td>
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<td>0</td>
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<tr>
<td>INT</td>
<td>Rate of patient safety incidents resulting in severe harm/death (NRLS)</td>
<td>Mar-16</td>
<td>&lt;= 2 per month</td>
<td>➣</td>
<td>7</td>
<td>31</td>
<td></td>
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<tr>
<td>INT</td>
<td>Serious Incidents per 1,000 bed days</td>
<td>Feb-16</td>
<td>&lt;= 0.6</td>
<td>➤</td>
<td>awaiting data</td>
<td>0.30</td>
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<tr>
<td>INT</td>
<td>Never events</td>
<td>Mar-16</td>
<td>= 0</td>
<td>➤</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
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<tr>
<td>INT</td>
<td>Medication Errors (Crude rate per 1000 bed days)</td>
<td>Mar-16</td>
<td>&lt;= 8.18</td>
<td>➤</td>
<td>6.45</td>
<td>8.36</td>
<td></td>
<td>0</td>
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</tr>
<tr>
<td>INT</td>
<td>%age Average Fill Rate - Nursing Shifts to Plan (Nurses, Midwives &amp; HCA’s)</td>
<td>Mar-16</td>
<td>&gt;= 98%</td>
<td>➣</td>
<td>96.33%</td>
<td>98.26%</td>
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<tr>
<td>INT</td>
<td>Local ‘Never’ event: a) x 1 RN on shift</td>
<td>Mar-16</td>
<td>= 0</td>
<td>➣</td>
<td>8</td>
<td>31</td>
<td></td>
<td>5</td>
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<tr>
<td>INT</td>
<td>Local ‘Never’ event: c) Inappropriate discharges after 21:00 hrs</td>
<td>Mar-16</td>
<td>= 0</td>
<td>➤</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
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<tr>
<td>INT</td>
<td>Local ‘Never’ event: d) mixed gender breaches</td>
<td>Mar-16</td>
<td>= 0</td>
<td>➤</td>
<td>0</td>
<td>8</td>
<td></td>
<td>0</td>
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<tr>
<td>INT</td>
<td>Number of Grade 3&amp;4, hospital acquired PU</td>
<td>Mar-16</td>
<td>= 0</td>
<td>➣</td>
<td>3</td>
<td>15</td>
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<tr>
<td>INT</td>
<td>Number of Grade 3&amp;4, community acquired PU</td>
<td>Mar-16</td>
<td>= 0</td>
<td>➣</td>
<td>7</td>
<td>54</td>
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<td>8</td>
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<tr>
<td>INT</td>
<td>NHS Safety Thermometer (%age Harm Free Care)</td>
<td>Mar-16</td>
<td>&gt;= 96%</td>
<td>➤</td>
<td>94.87%</td>
<td>94.29%</td>
<td></td>
<td>17</td>
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<td>Indicators</td>
<td>Reporting Month</td>
<td>Target</td>
<td>Change from Prev Period</td>
<td>Actual</td>
<td>YTD</td>
<td>Trend</td>
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<td>Quality Assurance</td>
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<tr>
<td>N, CCG, INT</td>
<td>Percentage of all adult inpatients who have had a VTE risk assessment on admission to hospital.</td>
<td>Feb-16</td>
<td>&gt;= 95%</td>
<td>↑</td>
<td>96.00%</td>
<td>97.07%</td>
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</tr>
<tr>
<td>N, CCG, INT</td>
<td>Incidence of hospital-related venous thromboembolism (VTE)</td>
<td>Feb-16</td>
<td>= 0</td>
<td>↑</td>
<td>0</td>
<td>0</td>
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<tr>
<td>INT</td>
<td>Complaints</td>
<td>Mar-16</td>
<td>&lt;= 50 per month</td>
<td>↓</td>
<td>32</td>
<td>347</td>
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</tr>
<tr>
<td>INT</td>
<td>Patients with dementia having Assessment/Investigation</td>
<td>Feb-16</td>
<td>&gt;= 90%</td>
<td>↑</td>
<td>94.90%</td>
<td>92.27%</td>
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<tr>
<td>INT</td>
<td>F&amp;F Positive Score - Inpatients &amp; Day Cases (% of patients extremely likely or likely to recommend the Trust to their family and friends)</td>
<td>Mar-16</td>
<td>&gt;= 95%</td>
<td>↑</td>
<td>98%</td>
<td>97.15%</td>
<td></td>
<td>0</td>
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</tr>
<tr>
<td>INT</td>
<td>F&amp;F Positive Score - A&amp;E (% of patients extremely likely or likely to recommend the Trust to their family and friends)</td>
<td>Mar-16</td>
<td>&gt;= 85%</td>
<td>↓</td>
<td>94%</td>
<td>90.69%</td>
<td></td>
<td>0</td>
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</tr>
<tr>
<td>INT</td>
<td>F&amp;F Positive Score - Maternity (% of patients extremely likely or likely to recommend the Trust to their family and friends)</td>
<td>Mar-16</td>
<td>&gt;= 95%</td>
<td>↑</td>
<td>99%</td>
<td>98.82%</td>
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</tr>
<tr>
<td>N, CCG, INT</td>
<td>% women who have seen a midwife by 12 weeks and 6 days of pregnancy</td>
<td>Mar-16</td>
<td>&gt;= 90%</td>
<td>↓</td>
<td>85.99%</td>
<td>89.32%</td>
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</tr>
<tr>
<td>CCG</td>
<td>Proportion of patients aged over 18 with chronic condition ACS conditions admitted to hospital as an emergency.</td>
<td>Feb-16</td>
<td>&lt;=218 per month</td>
<td>↑</td>
<td>155</td>
<td>1784</td>
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</tr>
<tr>
<td>CCG</td>
<td>Emergency admissions for acute conditions not requiring hospital admission</td>
<td>Feb-16</td>
<td>&lt;= 223 per month</td>
<td>↑</td>
<td>221</td>
<td>2967</td>
<td></td>
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</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Breastfeeding initiation within 48 hrs of delivery - the percentage of all deliveries</td>
<td>Mar-16</td>
<td>&gt;=66%</td>
<td>↓</td>
<td>59.91%</td>
<td>60.47%</td>
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<tr>
<td>N, M, CCG, INT</td>
<td>Prevalence of breastfeeding at 6-8 weeks - The percentage of infants being breastfed at 6-8 weeks</td>
<td>Feb-16</td>
<td>&gt;=33.5%</td>
<td>↓</td>
<td>24.00%</td>
<td>21.00%</td>
<td></td>
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</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Maternal smoking at delivery - % of mothers smoking at delivery</td>
<td>Mar-16</td>
<td>&lt;=19.3%</td>
<td>↓</td>
<td>21.15%</td>
<td>18.15%</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>N, M, CCG, INT</td>
<td>Chlamydia Detection Rate - rate per 100,000 eligible population of 15 – 24 year olds</td>
<td>Mar-16</td>
<td>2400 - 3000</td>
<td>↑</td>
<td>2171</td>
<td>2479</td>
<td></td>
<td>11</td>
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</tr>
<tr>
<td>N, CCG, INT</td>
<td>Chlamydia Detection Rate- Coverage - Percentage of population aged 15-24.</td>
<td>Mar-16</td>
<td>&gt;=70%</td>
<td>↑</td>
<td>75.33%</td>
<td>73.44%</td>
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</tr>
<tr>
<td>INT</td>
<td>Initial Health Assessment within 20 days - Looked After Children</td>
<td>Feb-16</td>
<td>95%</td>
<td>↓</td>
<td>76.40%</td>
<td>TBC</td>
<td></td>
<td>8</td>
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</tr>
<tr>
<td>INT</td>
<td>Total number of CAMHs admissions</td>
<td>Mar-16</td>
<td>N/A</td>
<td>↓</td>
<td>2</td>
<td>21</td>
<td></td>
<td>0</td>
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</tr>
<tr>
<td>INT</td>
<td>% of CAMHs admissions assessed, and care plan in place within 24 hours of admission</td>
<td>Mar-16</td>
<td>100%</td>
<td>↑</td>
<td>100.00%</td>
<td>100.00%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Health visitor numbers</td>
<td>Mar-16</td>
<td>54</td>
<td>↓</td>
<td>64.13</td>
<td>64.13</td>
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</table>
## Indicators

<table>
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<tr>
<th>Reported to</th>
<th>Indicators</th>
<th>Reporting Month</th>
<th>Target</th>
<th>Change from Prev Period</th>
<th>Actual</th>
<th>YTD</th>
<th>Trend</th>
<th>Consecutive Failures</th>
<th>Quality Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>N, M, CCG, INT</td>
<td>% of A&amp;E attendances seen within maximum waiting time of 4 hours from arrival to admission / transfer/ discharge</td>
<td>Mar-16</td>
<td>&gt;= 95%</td>
<td>↓</td>
<td>77.41%</td>
<td>91.85%</td>
<td></td>
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<td>9</td>
</tr>
<tr>
<td>INT</td>
<td>Number of pts spending 12 hours or more on a trolley in A/E</td>
<td>Mar-16</td>
<td>0</td>
<td>↓</td>
<td>1</td>
<td>1</td>
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<tr>
<td>INT</td>
<td>The number of handover delays longer than 30 minutes</td>
<td>Mar-16</td>
<td>0</td>
<td>↓</td>
<td>58</td>
<td>231</td>
<td></td>
<td></td>
<td>6</td>
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<tr>
<td>INT</td>
<td>The number of handover delays longer than 60 minutes</td>
<td>Mar-16</td>
<td>0</td>
<td>↓</td>
<td>12</td>
<td>28</td>
<td></td>
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</tr>
<tr>
<td>INT</td>
<td>Total time in A&amp;E Department - 95th Percentile (Admitted and Non-Admitted combined) Threshold &lt; 4hrs</td>
<td>Jan-16</td>
<td>&lt; 4hrs</td>
<td>↑</td>
<td>5 hrs 57 mins</td>
<td>4hrs 58 mins</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>INT</td>
<td>Total time in A&amp;E Department (Admitted Patiens) - 95th Percentile - Threshold &lt; 4hrs</td>
<td>Jan-16</td>
<td>&lt; 4hrs</td>
<td>↑</td>
<td>6 hrs 27 mins</td>
<td>6hrs 47 mins</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>INT</td>
<td>Total time in A&amp;E Department (Admitted Patients) - Single Longest Time in A&amp;E - Threshold &lt; 6hrs</td>
<td>Jan-16</td>
<td>&lt; 6hrs</td>
<td>↓</td>
<td>18 hrs 41 mins</td>
<td>14hrs 47 mins</td>
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<tr>
<td>INT</td>
<td>Total time in A&amp;E Department (Non-Admitted) - 95th Percentile - Threshold &lt; 4hrs</td>
<td>Jan-16</td>
<td>&lt; 4hrs</td>
<td>↑</td>
<td>4 hrs 49 mins</td>
<td>4hrs 22 mins</td>
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<tr>
<td>INT</td>
<td>Total time in A&amp;E Department (Non-Admitted) - Single Longest Time in A&amp;E - Threshold &lt; 6hrs</td>
<td>Jan-16</td>
<td>&lt; 6hrs</td>
<td>↓</td>
<td>14hrs 25 mins</td>
<td>10hrs 57 mins</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>INT</td>
<td>Time to Initial Assessment - 95th Percentile - Threshold &lt; 15 mins</td>
<td>Jan-16</td>
<td>&lt; 15 mins</td>
<td>↑</td>
<td>1 hr 1 min</td>
<td>58 mins</td>
<td></td>
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<td>9</td>
</tr>
<tr>
<td>INT</td>
<td>Time to Treatment - Median Time in A&amp;E - Threshold &lt; 60 mins</td>
<td>Jan-16</td>
<td>&lt; 60 mins</td>
<td>↓</td>
<td>1 hr 38 mins</td>
<td>1hr 23 mins</td>
<td></td>
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<td>9</td>
</tr>
<tr>
<td>INT</td>
<td>A&amp;E Clinical Quality - Unplanned Re-attendance Rate (within 7 days of original attendance) - Threshold &lt; 5%</td>
<td>Jan-16</td>
<td>&lt; 5%</td>
<td>↓</td>
<td>3.16%</td>
<td>2.96%</td>
<td></td>
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</tr>
<tr>
<td>INT</td>
<td>A&amp;E Clinical Quality - Left without being seen Rate - % of patients who leave A&amp;E without being seen Threshold &lt;5%</td>
<td>Jan-16</td>
<td>&lt; 5%</td>
<td>↑</td>
<td>6.68%</td>
<td>4.96%</td>
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<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 2 weeks: Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer</td>
<td>Feb-16</td>
<td>&gt;= 93%</td>
<td>↑</td>
<td>97.38%</td>
<td>95.14%</td>
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<td>N, M, CCG, INT</td>
<td>Cancer 2 weeks: Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected</td>
<td>Feb-16</td>
<td>&gt;= 93%</td>
<td>↓</td>
<td>94.3%</td>
<td>96.87%</td>
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<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 31 day: Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis</td>
<td>Feb-16</td>
<td>&gt;= 96%</td>
<td>↓</td>
<td>95.2%</td>
<td>98.61%</td>
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<td>N, M, CCG, INT</td>
<td>Cancer 31 day: Percentage of patients receiving subsequent treatment for cancer within 31-days from the decision to treat date - where that treatment is Surgery</td>
<td>Feb-16</td>
<td>&gt;= 94%</td>
<td>↑</td>
<td>100%</td>
<td>99%</td>
<td></td>
<td></td>
<td>0</td>
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<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 31 day: Percentage of patients receiving subsequent treatment for cancer within 31-days from the decision to treat date - where that treatment is an Anti-Cancer Drug Regime</td>
<td>Feb-16</td>
<td>&gt;= 98%</td>
<td>↓</td>
<td>100%</td>
<td>100%</td>
<td></td>
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<tr>
<td>N, M, CCG, INT</td>
<td>Cancer 62 days: Percentage of patients receiving first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer</td>
<td>Feb-16</td>
<td>&gt;= 85%</td>
<td>↓</td>
<td>83%</td>
<td>88.00%</td>
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<td>N, M, CCG, INT</td>
<td>Cancer 62 days: Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service</td>
<td>Feb-16</td>
<td>&gt;= 90%</td>
<td>↓</td>
<td>86%</td>
<td>96.90%</td>
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<td>Reported to:</td>
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<tr>
<td>N, M, CCG, INT</td>
<td>% of Admitted patients waiting less than 18 weeks from point of referral to treatment</td>
<td>Mar-16</td>
<td>&gt;= 90%</td>
<td>↓</td>
<td>86.0%</td>
<td>91.80%</td>
<td></td>
<td>2</td>
<td></td>
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<tr>
<td>N, M, CCG, INT</td>
<td>% of Non Admitted patients waiting less than 18 weeks from point of referral to treatment</td>
<td>Mar-16</td>
<td>&gt;= 95%</td>
<td>↓</td>
<td>96.0%</td>
<td>97.70%</td>
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<tr>
<td>N, M, CCG, INT</td>
<td>% of patients waiting less than 18 weeks from point of referral to treatment on incomplete pathways</td>
<td>Mar-16</td>
<td>&gt;= 92%</td>
<td>↓</td>
<td>94.0%</td>
<td>96.00%</td>
<td></td>
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<tr>
<td>N, M, CCG, INT</td>
<td>Number of patients waiting more than 52 weeks on a RTT pathway</td>
<td>Mar-16</td>
<td>= 0</td>
<td></td>
<td>0</td>
<td>1</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N, CCG, INT</td>
<td>% of patients waiting 6 weeks or over for any of the 15 Key diagnostic tests</td>
<td>Mar-16</td>
<td>&lt;= 1%</td>
<td>↓</td>
<td>0.75%</td>
<td>0.4%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of patients presenting with stroke with AF anti-coagulated on discharge</td>
<td>Mar-16</td>
<td>&gt;= 60%</td>
<td>↓</td>
<td>100%</td>
<td>92.5%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival</td>
<td>Mar-16</td>
<td>&gt;= 90%</td>
<td>↓</td>
<td>50%</td>
<td>63.2%</td>
<td></td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>N, CCG, INT</td>
<td>Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit</td>
<td>Mar-16</td>
<td>&gt;= 80%</td>
<td>↓</td>
<td>76%</td>
<td>85.2%</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of stroke patients scanned within one hour of hospital arrival</td>
<td>Mar-16</td>
<td>&gt;= 50%</td>
<td>↓</td>
<td>59%</td>
<td>49.3%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of stroke patients scanned within 24 hrs of hospital arrival</td>
<td>Mar-16</td>
<td>100.0%</td>
<td>↓</td>
<td>100%</td>
<td>98.6%</td>
<td></td>
<td>0</td>
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</tr>
<tr>
<td>N, CCG, INT</td>
<td>Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (Trans Ischaemic Attack - mini stroke)</td>
<td>Mar-16</td>
<td>&gt;= 60%</td>
<td>↓</td>
<td>91%</td>
<td>90.1%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>% of patients who have a stroke who receive a follow up assessment between 4-8 months after initial admission</td>
<td>Mar-16</td>
<td>&gt;= 95%</td>
<td>↓</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>% of patients who have had a stroke who are discharged from hospital with a joint health and social care plan</td>
<td>Mar-16</td>
<td>&gt;= 85%</td>
<td>↓</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke</td>
<td>Mar-16</td>
<td>&gt;= 40%</td>
<td>↓</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>% of patients who receive thrombolysis following an acute stroke</td>
<td>Mar-16</td>
<td>&gt;= 11%</td>
<td>↓</td>
<td>7%</td>
<td>5.8%</td>
<td></td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Presence of a stroke skilled ESD team</td>
<td>Mar-16</td>
<td>100%</td>
<td>↓</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CCG, INT</td>
<td>Proportion of patients supported by a stroke skilled ESD team</td>
<td>Mar-16</td>
<td>&gt;= 40%</td>
<td>↓</td>
<td>0%</td>
<td>5.1%</td>
<td></td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>M, CCG</td>
<td>Community Care - data completeness: referral to treatment information completeness</td>
<td>Mar-16</td>
<td>&gt;= 50%</td>
<td>↓</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>M, CCG</td>
<td>Community Care - data completeness: referral information completeness</td>
<td>Mar-16</td>
<td>&gt;= 50%</td>
<td>↓</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>M, CCG</td>
<td>Community Care - data completeness: activity information completeness</td>
<td>Mar-16</td>
<td>&gt;= 50%</td>
<td>↓</td>
<td>100%</td>
<td>100%</td>
<td></td>
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</tbody>
</table>
## Reported to: Indicators

### Reporting Month | Target | Change from Prev Period | Actual | YTD | Trend | Consecutive Failures | Quality Assurance
---|---|---|---|---|---|---|---
**INT** | The number of New outpatient attendances in the period - attended | Mar-16 | >= 6828 per month | ↓ | 5674 | 70889 | 12 | 
**INT** | Out patient New to Follow up ratio | Mar-16 | <= 3.1 | ↓ | 2.3 | 2.3 | 0 | 
**INT** | Out patient DNA rates | Mar-16 | <= 7.7% | ↓ | 8.8% | 9.9% | 17 | 
**INT** | The number of unplanned (emergency) Admissions into the Trust | Mar-16 | <= 2123 per month | ↓ | 2717 | 31513 | 12 | 
**INT** | The number of Planned Admissions into the Trust | Mar-16 | >= 6553 per month | ↑ | 2942 | 0 | 
**CCG, INT** | Percentage of patients being admitted as an emergency within 28 days of discharge following an emergency admission | Mar-16 | < 12.5% | ↑ | 14.7% | 13.6% | 2 | 
**CCG, INT** | Percentage of patients being admitted as an emergency within 28days of discharge following a planned admission | Mar-16 | < 6% | ↑ | 5.25% | 5.2% | 0 | 
**INT** | Average Length of Stay - Elective | Mar-16 | <= 3.05 | ↑ | 2.84 | 3.10 | 0 | 
**INT** | Average Length of Stay - Non-Elective | Mar-16 | <= 5 | ↑ | 4.74 | 5.60 | 0 | 
**N, INT** | % of available beds occupied at midnight on a Thursday | Mar-16 | <=85% | ↑ | 90.1% | 84.2% | 4 | 
**INT** | Theatre Session Utilisation (DS) | Mar-16 | >=85% | ↑ | 76% | 81% | 9 | 
**INT** | Theatre Session Utilisation (MT) | Mar-16 | >=91% | ↓ | 85% | 91% | 2 | 
**INT** | Number of Cancelled Patient Appointments | Mar-16 | < Prev Month | ↓ | 4968 | 54499 | 2 | 
**CCG, INT** | % of patients cancelled on day of operation for non medical reasons | Mar-16 | <= 0.8% | ↑ | 0.34% | 0.83% | 0 | 
**CCG, INT** | Urgent operations cancelled for a second time | Mar-16 | 0 | 0 | 0 | 0 | 
**N, CCG, INT** | Percentage of patients whose transfer of care from hospital was delayed. | Mar-16 | <= 3.5% | ↑ | 2.76% | 3.35% | 0 | 
**INT** | # NOF - Time to surgery within 36hrs (refer to national definition) - taken from the National Hip Database - not including full BPT criteria | Mar-16 | TBC | ↓ | 80.00% | 82.61% | 0 | 
**INT** | # NOF - Time to surgery within 48hrs | Mar-16 | 100% | ↓ | 93.33% | 88.54% | 11 | 
**INT** | Community Service Area TOTAL | Feb-16 | 452,386 | ↑ | 56,346 | 676,511 | 0 | 
**INT** | - Planned Care | Feb-16 | 244,046 | ↓ | 14,119 | 225,771 | 0 | 
**INT** | - Urgent Care, IC & LTC | Feb-16 | 254,222 | ↑ | 26,977 | 285,928 | 0 | 
**INT** | - Children's Services | Feb-16 | 34,129 | 2,450 | 25,875 | 4 | 
**INT** | - Other Services | Feb-16 | 117,461 | ↑ | 12,800 | 138,937 | 0 |
## COLLEAGUES: Engaged, accountable

<table>
<thead>
<tr>
<th>Reported to:</th>
<th>Indicators</th>
<th>Reporting Month</th>
<th>Target</th>
<th>Change from Prev Period</th>
<th>Actual</th>
<th>YTD</th>
<th>Trend</th>
<th>Consecutive Failures</th>
<th>Quality Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>INT</td>
<td>Variable Pay: Bank costs as % of Pay Bill</td>
<td>Mar-16</td>
<td>5%</td>
<td></td>
<td>not yet available</td>
<td>13.85%</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>INT</td>
<td>Variable Pay: Consultants Job Plans excluding Associate Specialists etc</td>
<td>Mar-16</td>
<td>=&gt; 90%</td>
<td></td>
<td>65.00%</td>
<td>65%</td>
<td></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>INT</td>
<td>MAST: Mandatory &amp; Statutory Training - overall compliance</td>
<td>Mar-16</td>
<td>=&gt; 80%</td>
<td></td>
<td>72%</td>
<td>72%</td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>INT</td>
<td>Employee Relations: Total active employee relations cases at month end</td>
<td>Mar-16</td>
<td>N/A</td>
<td></td>
<td>99</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>Employee Engagement: Staff Survey - engagement score</td>
<td>Mar-16</td>
<td>&lt;= 3.75</td>
<td></td>
<td>3.65%</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>Employee Engagement: - survey feedback sessions</td>
<td>Mar-16</td>
<td>=&gt; 4 per month</td>
<td></td>
<td>8</td>
<td>100</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>Employee Engagement: PDR's</td>
<td>Mar-16</td>
<td>=&gt; 90%</td>
<td></td>
<td>74.2%</td>
<td>74.22%</td>
<td></td>
<td></td>
<td>17</td>
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<tr>
<td>INT</td>
<td>Recruitment and Retention: Total staff in post - headcount</td>
<td>Mar-16</td>
<td>N/A</td>
<td></td>
<td>4223</td>
<td>4226</td>
<td></td>
<td></td>
<td>17</td>
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<tr>
<td>INT</td>
<td>Recruitment and Retention: Total staff in post - FTE</td>
<td>Mar-16</td>
<td>N/A</td>
<td></td>
<td>3552</td>
<td>3541</td>
<td></td>
<td></td>
<td>17</td>
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<tr>
<td>INT</td>
<td>Recruitment and Retention: Starters in month - headcount</td>
<td>Mar-16</td>
<td>N/A</td>
<td></td>
<td>43</td>
<td>677</td>
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<tr>
<td>INT</td>
<td>Recruitment and Retention: Starters in month - FTE</td>
<td>Mar-16</td>
<td>N/A</td>
<td></td>
<td>38.59</td>
<td>593.00</td>
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<tr>
<td>INT</td>
<td>Recruitment and Retention: Leavers in month - headcount</td>
<td>Mar-16</td>
<td>N/A</td>
<td></td>
<td>49</td>
<td>564</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>INT</td>
<td>Recruitment and Retention: Leavers in month - FTE</td>
<td>Mar-16</td>
<td>N/A</td>
<td></td>
<td>38.90</td>
<td>470.00</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>INT</td>
<td>Recruitment and Retention: Exit Interviews - issued to leavers</td>
<td>Mar-16</td>
<td>100%</td>
<td></td>
<td>100.0%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>INT</td>
<td>Recruitment and Retention: Exit Interviews - Returned</td>
<td>Mar-16</td>
<td>50%</td>
<td></td>
<td>30.0%</td>
<td>29.00%</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>INT</td>
<td>Recruitment and Retention: Rolling Turnover Rate in month - FTE</td>
<td>Mar-16</td>
<td>&lt;= 10%</td>
<td></td>
<td>10.6%</td>
<td>10.50%</td>
<td></td>
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<td>17</td>
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<tr>
<td>INT</td>
<td>Recruitment and Retention: Average time from Successful Candidate to Hire (weeks)</td>
<td>Mar-16</td>
<td>&lt;= 8</td>
<td></td>
<td>8</td>
<td>9</td>
<td></td>
<td></td>
<td>0</td>
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<tr>
<td>INT</td>
<td>Health and Wellbeing: Sickness absence rate in month %</td>
<td>Mar-16</td>
<td>&lt;= 4%</td>
<td></td>
<td>4.25%</td>
<td>4.53%</td>
<td></td>
<td></td>
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<tr>
<td>INT</td>
<td>Health and Wellbeing: Rolling sickness absence rate %</td>
<td>Mar-16</td>
<td>&lt;= 4%</td>
<td></td>
<td>4.4%</td>
<td>4.55%</td>
<td></td>
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<td>17</td>
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<tr>
<td>INT</td>
<td>Health and Wellbeing: Completed return to work %</td>
<td>Mar-16</td>
<td>100%</td>
<td></td>
<td>55.2%</td>
<td>47.09%</td>
<td></td>
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<td>17</td>
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<td>Indicators</td>
<td>Reporting Month</td>
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<td>Change from Prev Period</td>
<td>Actual</td>
<td>YTD</td>
<td>Trend</td>
<td>Consecutive Failures</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>------------</td>
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<td>-----------------</td>
</tr>
<tr>
<td>INT</td>
<td>Health and Wellbeing: Sickness Estimated Costs in month</td>
<td>Mar-16</td>
<td>N/A</td>
<td>↑</td>
<td>£417,972</td>
<td>N/A</td>
<td></td>
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</tr>
<tr>
<td>INT</td>
<td>Health and Wellbeing: Sickness Attendance - Short Term % (&lt;21 days) FTE</td>
<td>Mar-16</td>
<td>&lt;= 1%</td>
<td>↑</td>
<td>1.24%</td>
<td>1.18%</td>
<td></td>
<td></td>
<td>17</td>
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<tr>
<td>INT</td>
<td>Health and Wellbeing: Sickness Attendance - Long Term % (&gt;21 days) FTE</td>
<td>Mar-16</td>
<td>&lt;= 3%</td>
<td>↑</td>
<td>3.01%</td>
<td>3.35%</td>
<td></td>
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<td>5</td>
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<tr>
<td>INT</td>
<td>Health and Wellbeing: Total number of referrals to Health &amp; Wellbeing</td>
<td>Mar-16</td>
<td>N/A</td>
<td>↓</td>
<td>153</td>
<td>2027</td>
<td></td>
<td></td>
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<tr>
<td>INT</td>
<td>Health and Wellbeing: Internal referrals</td>
<td>Mar-16</td>
<td>N/A</td>
<td>↑</td>
<td>118</td>
<td>1511</td>
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<tr>
<td>INT</td>
<td>Health and Wellbeing: External referrals</td>
<td>Mar-16</td>
<td>N/A</td>
<td>↓</td>
<td>35</td>
<td>516</td>
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<td></td>
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<tr>
<td>INT</td>
<td>Health and Wellbeing: External income</td>
<td>Mar-16</td>
<td>N/A</td>
<td>↑</td>
<td>£6,881</td>
<td>£46,946</td>
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## FINANCE: Strong financial foundations

<table>
<thead>
<tr>
<th>Reported to:</th>
<th>Indicators</th>
<th>Reporting Month</th>
<th>Plan £000</th>
<th>Actual £000</th>
<th>Variance £000</th>
<th>Quality Assurance</th>
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<tbody>
<tr>
<td>INT</td>
<td>Income &amp; Expenditure</td>
<td>Mar-16</td>
<td>(1,924)</td>
<td>(8,625)</td>
<td>(6,701)</td>
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<tr>
<td>INT</td>
<td>Cash Flow</td>
<td>Mar-16</td>
<td>3,212</td>
<td>3,612</td>
<td>400</td>
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<tr>
<td>INT</td>
<td>Continuity of Service Risk Rating (COSR)</td>
<td>Mar-16</td>
<td>2</td>
<td>1</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Capital Programme</td>
<td>Mar-16</td>
<td>14,113</td>
<td>13,491</td>
<td>(622)</td>
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<tr>
<td>INT</td>
<td>Elective Activity Income</td>
<td>Mar-16</td>
<td>16,930</td>
<td>15,548</td>
<td>(1,382)</td>
<td></td>
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<tr>
<td>INT</td>
<td>Day Case Activity Income</td>
<td>Mar-16</td>
<td>21,669</td>
<td>21,593</td>
<td>(76)</td>
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<tr>
<td>INT</td>
<td>A&amp;E Activity Income</td>
<td>Mar-16</td>
<td>8,530</td>
<td>8,491</td>
<td>(39)</td>
<td></td>
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<tr>
<td>INT</td>
<td>Non Elective Activity Income</td>
<td>Mar-16</td>
<td>46,694</td>
<td>49,127</td>
<td>2,433</td>
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<tr>
<td>INT</td>
<td>New Outpatients Income</td>
<td>Mar-16</td>
<td>13,026</td>
<td>12,658</td>
<td>(368)</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Follow Up Outpatients Income</td>
<td>Mar-16</td>
<td>22,474</td>
<td>23,352</td>
<td>878</td>
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<tr>
<td>INT</td>
<td>Other Clinical Income</td>
<td>Mar-16</td>
<td>91,023</td>
<td>90,811</td>
<td>(212)</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Education &amp; Training income</td>
<td>Mar-16</td>
<td>6,578</td>
<td>6,910</td>
<td>332</td>
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<tr>
<td>INT</td>
<td>Other non clinical income</td>
<td>Mar-16</td>
<td>11,779</td>
<td>12,500</td>
<td>721</td>
<td></td>
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<tr>
<td>INT</td>
<td>Pay Costs</td>
<td>Mar-16</td>
<td>158,375</td>
<td>165,001</td>
<td>(6,626)</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Non Pay Costs</td>
<td>Mar-16</td>
<td>70,886</td>
<td>75,805</td>
<td>(4,919)</td>
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<tr>
<td>Monitor</td>
<td>Nursing Total Pay spend</td>
<td>Mar-16</td>
<td>54,817</td>
<td>52,708</td>
<td>2,109</td>
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<tr>
<td>Monitor</td>
<td>Nursing Agency Spend</td>
<td>Mar-16</td>
<td>346</td>
<td>3,625</td>
<td>(3,279)</td>
<td></td>
</tr>
<tr>
<td>Monitor</td>
<td>Percentage</td>
<td>Mar-16</td>
<td>7.7%</td>
<td>6.9%</td>
<td>0.77%</td>
<td></td>
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</table>
## FINANCE: Strong financial foundations

<table>
<thead>
<tr>
<th>Reported to:</th>
<th>Indicators</th>
<th>Reporting Month</th>
<th>Plan £000</th>
<th>Actual £000</th>
<th>Variance £000</th>
<th>Quality Assurance</th>
</tr>
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<tbody>
<tr>
<td>INT</td>
<td>Elective Activity</td>
<td>Mar-16</td>
<td>5,983</td>
<td>5,369</td>
<td>(614)</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Day Case Activity</td>
<td>Mar-16</td>
<td>35,453</td>
<td>35,011</td>
<td>(442)</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>A&amp;E Activity</td>
<td>Mar-16</td>
<td>78,167</td>
<td>77,147</td>
<td>(1,020)</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Non Elective Activity</td>
<td>Mar-16</td>
<td>25,481</td>
<td>26,470</td>
<td>989</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>New Outpatients</td>
<td>Mar-16</td>
<td>93,485</td>
<td>90,695</td>
<td>(2,790)</td>
<td></td>
</tr>
<tr>
<td>INT</td>
<td>Follow Up Outpatients</td>
<td>Mar-16</td>
<td>203,274</td>
<td>205,383</td>
<td>2,109</td>
<td></td>
</tr>
</tbody>
</table>

### Key

- Variance: Worse than plan
- Variance: In line with plan / better than plan

---

63
### APPENDIX A - Breakdown of 62 day Performance by Tumour Site - Month 11

<table>
<thead>
<tr>
<th>Tumour Site</th>
<th>62 Day from 2ww (*)</th>
<th>62 day CUG</th>
<th>62 Day Screening</th>
<th>31 Day 1st Treatment</th>
<th>31 Day Subsequent</th>
<th>2WW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Median Wait Days (Treating Hospital)</td>
<td>%</td>
<td>Median Wait Days (Treating Hospital)</td>
<td>%</td>
<td>Median Wait Days (RFR)</td>
</tr>
<tr>
<td>Acute Leukaemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain/CNS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>100.0</td>
<td>31 (RFR) 31 (RHQ)</td>
<td>100.0</td>
<td>0 (RFR)</td>
<td>100.0</td>
<td>9 (RFR)</td>
</tr>
<tr>
<td>Childrens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>100.0</td>
<td>40 (RFR) 51 (RHQ)</td>
<td>100.0</td>
<td>28 (RFR) 31 (RHQ)</td>
<td>100.0</td>
<td>20 (RFR)</td>
</tr>
<tr>
<td>Haematological</td>
<td>100.0</td>
<td>28 (RFR)</td>
<td>100.0</td>
<td>0</td>
<td>100.0</td>
<td>1</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>0.0</td>
<td>87 (RHQ)</td>
<td>100.0</td>
<td>38 (RHQ)</td>
<td>100.0</td>
<td>29</td>
</tr>
<tr>
<td>Lower GI</td>
<td>56.2</td>
<td>57 (RFR) 50 (RHQ)</td>
<td>87.5</td>
<td>21 (RFR) 71 (RFR)</td>
<td>50.0</td>
<td>1</td>
</tr>
<tr>
<td>Lung</td>
<td>100.0</td>
<td>28 (RHQ)</td>
<td>88.9</td>
<td>2 (RFR) 39 (RHQ)</td>
<td>100.0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>100.0</td>
<td>44 (RFR)</td>
<td>100.0</td>
<td>0</td>
<td>100.0</td>
<td>13</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>100.0</td>
<td>46 (RHQ)</td>
<td>100.0</td>
<td>0</td>
<td>100.0</td>
<td>13</td>
</tr>
<tr>
<td>Skin</td>
<td>100.0</td>
<td>38 (RFR) 56 (RHQ)</td>
<td>100.0</td>
<td>33 (RFR) 56 (RHQ)</td>
<td>90.0</td>
<td>19</td>
</tr>
<tr>
<td>Testicular</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper GI</td>
<td>100.0</td>
<td>29 (RHQ)</td>
<td>100.0</td>
<td>31 (RFR)</td>
<td>100.0</td>
<td>0</td>
</tr>
<tr>
<td>Urological</td>
<td>87.5</td>
<td>45 (RFR) 103 (RHQ)</td>
<td>75.0</td>
<td>52 (RFR) 65 (RHQ)</td>
<td>80.0</td>
<td>9</td>
</tr>
<tr>
<td>All</td>
<td>83.0%</td>
<td></td>
<td>89.5%</td>
<td></td>
<td>85.7%</td>
<td></td>
</tr>
</tbody>
</table>

RFR = Rotherham FT
RHQ = Sheffield Teaching Hospitals FT
RR8 = Leeds Teaching Hospitals NHS Trust

(*) Performance includes reallocations
## APPENDIX B - ESTIMATE - March 2016 18 Week RTT Return Data

### Rotherham CCG Admitted

<table>
<thead>
<tr>
<th>Specialty</th>
<th>&lt;18Wks</th>
<th>18Wks+</th>
<th>% &lt;18Wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>165</td>
<td>18</td>
<td>90%</td>
</tr>
<tr>
<td>Urology</td>
<td>55</td>
<td>10</td>
<td>94%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>165</td>
<td>32</td>
<td>83%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>40</td>
<td>5</td>
<td>88%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>161</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>General Medicine</td>
<td>2</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>12</td>
<td>7</td>
<td>83%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>7</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>34</td>
<td>4</td>
<td>99%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>4</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td>10</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>155</td>
<td>30</td>
<td>83%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>816</td>
<td>106</td>
<td>88%</td>
</tr>
</tbody>
</table>

### Rotherham CCG Non Admitted

<table>
<thead>
<tr>
<th>Specialty</th>
<th>&lt;18Wks</th>
<th>18Wks+</th>
<th>% &lt;18Wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>341</td>
<td>17</td>
<td>95%</td>
</tr>
<tr>
<td>Urology</td>
<td>157</td>
<td>3</td>
<td>98%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>419</td>
<td>9</td>
<td>97%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>729</td>
<td>10</td>
<td>98%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>432</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>General Medicine</td>
<td>53</td>
<td>24</td>
<td>88%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>50</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>66</td>
<td>20</td>
<td>76%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>319</td>
<td>18</td>
<td>94%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>78</td>
<td>2</td>
<td>97%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td>119</td>
<td>5</td>
<td>95%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>65</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>323</td>
<td>5</td>
<td>98%</td>
</tr>
<tr>
<td>Other</td>
<td>243</td>
<td>2</td>
<td>99%</td>
</tr>
<tr>
<td>Total</td>
<td>3394</td>
<td>127</td>
<td>96%</td>
</tr>
</tbody>
</table>

### Trust Total Admitted

<table>
<thead>
<tr>
<th>Specialty</th>
<th>&lt;18Wks</th>
<th>18Wks+</th>
<th>% &lt;18Wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>175</td>
<td>21</td>
<td>89%</td>
</tr>
<tr>
<td>Urology</td>
<td>63</td>
<td>13</td>
<td>82%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>194</td>
<td>33</td>
<td>85%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>46</td>
<td>7</td>
<td>86%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>172</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>129</td>
<td>39</td>
<td>76%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>General Medicine</td>
<td>2</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>13</td>
<td>9</td>
<td>59%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>7</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>37</td>
<td>4</td>
<td>90%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>5</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td>12</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>173</td>
<td>32</td>
<td>84%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>1</td>
<td>90%</td>
</tr>
<tr>
<td>Total</td>
<td>1037</td>
<td>159</td>
<td>86%</td>
</tr>
</tbody>
</table>

### Trust Total Non Admitted

<table>
<thead>
<tr>
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<th>% &lt;18Wks</th>
</tr>
</thead>
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</tr>
<tr>
<td>Urology</td>
<td>180</td>
<td>3</td>
<td>98%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>468</td>
<td>11</td>
<td>97%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
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<tr>
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<td>486</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>174</td>
<td>12</td>
<td>93%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
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<td>0</td>
<td></td>
</tr>
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<td>General Medicine</td>
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<td>54</td>
<td>14</td>
<td>79%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>69</td>
<td>21</td>
<td>76%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>386</td>
<td>24</td>
<td>94%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>108</td>
<td>2</td>
<td>98%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td>132</td>
<td>5</td>
<td>96%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>68</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>361</td>
<td>5</td>
<td>98%</td>
</tr>
<tr>
<td>Other</td>
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<td>98%</td>
</tr>
<tr>
<td>Total</td>
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<td>96%</td>
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</table>

### Trust Total Incomplete

<table>
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<th>% &lt;18Wks</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1381</td>
<td>110</td>
<td>92%</td>
</tr>
<tr>
<td>Urology</td>
<td>888</td>
<td>20</td>
<td>97%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>1488</td>
<td>81</td>
<td>94%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>1344</td>
<td>72</td>
<td>94%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>813</td>
<td>3</td>
<td>99%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>1051</td>
<td>71</td>
<td>93%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>General Medicine</td>
<td>232</td>
<td>24</td>
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</tr>
<tr>
<td>Gastroenterology</td>
<td>592</td>
<td>69</td>
<td>99%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>562</td>
<td>38</td>
<td>93%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>853</td>
<td>31</td>
<td>96%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>440</td>
<td>23</td>
<td>95%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td>291</td>
<td>12</td>
<td>96%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>186</td>
<td>8</td>
<td>95%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>981</td>
<td>38</td>
<td>96%</td>
</tr>
<tr>
<td>Other</td>
<td>379</td>
<td>7</td>
<td>98%</td>
</tr>
<tr>
<td>Total</td>
<td>11481</td>
<td>607</td>
<td>94%</td>
</tr>
</tbody>
</table>

### TARGETS

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

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

Author(s): As above

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

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

Risk Reference:
- BAF: B1, B2, B3, B6
- Corporate Risk Register: 3870, 3936, 4080, 4174

Purpose of this paper:
To summarise a set of quality indicators and to provide assurance to the Board of Directors.

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

- The Trust performed well against the C-difficile target in 2016/17 and is revising the prevention strategy based on learning from the past year.
- The Harm Free Care rate has improved in month, recovering from the reduction in February 2016.
- The Chief Nurse, Director of Finance and Acting Director of Workforce have met with the ‘bed holding’ Clinical Divisions to review the nursing and midwifery staffing establishments. The most significant changes to establishment arise from the new models of care and expansion of the Acute Medical unit.
- The HSMR has improved. The SHMI will be refreshed next month.

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

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

1.2 A range of quality indicators are included in this report. Over time they may change as the narrative changes to reflect the content of the Integrated Performance Report.

2. **Healthcare Associated Infections**

2.1 The Board should note that the Trust ended the year having reported only 19 cases of hospital acquired C-difficile against a target of no more than 26. Of those 19 cases, seven were caused by lapse in the quality of care. The C-difficile prevention strategy is being revised.

2.2 Information received from the Public Health England, Fingertip Antimicrobial Resistance Indicators, published in March 2016, for the period 2013-14 positions the Trust, when compared to an England benchmark below 25th percentile for the daily doses of broad-spectrum antibiotics and less than 50th percentile for highly broad spectrum antibiotics (mainly Meropenem). These are favourable results.

2.3 On 15 March 2016 NHS England published the Clostridium difficile infection objectives for NHS organisations in 2016/17 and guidance on sanction implementation. The CDI objectives for acute organisations (including The Rotherham NHS Foundation Trust) are the same as last year, i.e. 26 case. For 2016/17 the contractual sanction that can be applied to each case in excess of the objective is £10,000.

2.4 There have been no ward closures or serious operational impacts resulting from Norovirus, or any other infection in the past month.

3. **Harm Free Care**

3.1 The NHS Safety Thermometer result for March was 94.87%, an increase of 1.6%, following the 1.7% reduction last month. No new actions are required.

4. **Complaints**

4.1 The Board will receive the Annual Complaints and Concerns Report in May 2016. By way of headlines there was a 1.6% increase in the combined number of complaints and concerns in 2015/16 (1046 compared to 1030 in the previous year); formal complaints against the Trust decreased by 12%¹ and informal concerns increased by 10%.

4.2 In March, performance against response targets deteriorated. The single cause of this deterioration was front line operational pressure. The Patient Experience and Complaints Manager is leading recovery of that position and maintaining a dialogue with those patients and families whose response is delayed.

¹ To be expanded in the annual report
5. **Friends and Family Test (FFT)**

5.1 The lowest positive response score in March 2016 was 94% in Emergency Care. Five areas of the Trust achieved 100% positive response scores. These were; antenatal community maternity services; postnatal community maternity services; community nursing services; community in-patient services and rehabilitation and therapy services.

5.2 Two months ago the Board was advised of the fall in positive response scores within the School Nursing team. In February the score had improved to 95% and last month this improved to 99%.

6. **Serious Incidents and Never Events**

6.1 Six serious incidents were declared in March. All six incidents were different. They involved a breach of the emergency care standards for trolley waits; response to a patient whose condition was deteriorating; referral to tertiary services; suspected transfusion associated circulatory overload; referral to treatment pathways and a retrospective report regarding patient triage.

6.1 All of these incidents are subject to investigation.

7. **Mortality**

7.1 This is the latest mortality update with statistics provided by Dr Foster following submission of the trust HES data.

7.2 This report is written to provide assurance to the board and our stakeholders that mortality is an essential priority for the trust and remains an essential objective for clinicians within the trust. The statistics are provided by Dr Foster and we continue to have close relationships with the link person to ascertain the minutiae of the data to enable those monitoring the progress to be alerted quickly and to take action. The crude mortality statistics are taken directly from PAS system for admissions and discharges and described as a percentage of these.

7.3 The trust current process for mortality reviews consists of initial quick review to determine any serious failings within 1 week of death. This process will need a review as reliance on too few clinicians becomes resource intensive. The aim would be to have a core multidisciplinary team making initial decisions regarding care and identifying obvious areas of improvement so that lessons can be quickly learned and disseminated. This process was in place but has proved difficult to maintain.

7.4 These deaths are then reviewed in depth within the divisions and discussed at governance. Action plans and learning are taken through. Any death that is collectively considered to be avoidable meaning a PRISM 6 or if there are any organisational or clinical failed standards then those cases are escalated to the mortality and quality alerts committee where the case will be discussed and the action plan will return when the divisions and the governance have made progress.

7.5 NHS England are keen to ensure standardised mortality process and review and the process went to tender and The Improvement Academy of which the trust is a member won and therefore the review process of reporting PRISM and NCEPOD scoring will become the national process.
7.6 The trust is currently still developing the electronic version of the mortality reviews to enable easier reporting of the outcome of the reviews. Security issues have thwarted the process but once functioning should save both time, resource and ease of reporting the outcome of mortality reviews.

7.7 The mortality and quality alerts’ meeting was held on the 9th March. Of note the future of this standalone meeting will be changed and will be incorporated into a clinical governance session which will allow better representation from divisional leads. This will be chaired by the Medical Director in line with NHS England recommendations.

7.8 The meeting highlighted the statistics and generated discussions regarding the importance of vigilance in monitoring the alerts to ensure that the trust is aware of issues prior to the triggering of significance. It is of note that following an intensive pneumonia review and implementation of the recommendations that pneumonia now no longer triggers as a concern in HSMR reporting.

7.9 Following publication of the colorectal alert a review was undertaken to determine the root cause and any underlying themes for improvement. This was reported into the mortality and quality alerts committee and found no avoidable deaths. The action plan will be taken back through the governance measures within surgery and will be monitored by the mortality group. This will in turn be easier as the committee will be amalgamated within the clinical governance trust committee.

7.10 The review of congestive heart failure remains outstanding.

7.11 It is clear that the learning from the mortality reviews is important to ensure that practice is improved and recommendations are implemented. This will ensure that if a condition alerts that it soon becomes statistically insignificant due to changes made as was the case in pneumonia. The learning is taken through the governance meetings and the action plans are monitored in this setting. It will become more visible when the electronic mortality database is launched.

7.12 The statistics are included at the end of the paper but in summary:

7.13 HSMR has for the first time in 9 months has fallen to below statistical significance which is reassuring. This is still subject to change as there are still a number of uncoded episodes although the number of uncoded admissions and deaths has also fallen following discussion and action taken within the coding department. This is also reassuring but requires further improvement to ensure that the HSMR continues to be an accurate reflection of the trust position.

7.14 The HSMR at 101.8 is the lowest it has been during 2015. The trust no longer features in the HSMR all outlier trusts following the reduction in significance of HSMR.

7.15 The reported SHMI is the same figure as previously reported as this has not been updated as HSCIC publish SHMI on a quarterly basis.

7.16 The reported crude mortality is in percentage to discharges is of a similar order of magnitude to the crude rate for admissions. The number of deaths increased in
January but this spike is of a lesser peak than this time last year and this reporting month of February it has fallen to 1.46%.

7.17 Crude rate for the weekend mortality has equally fallen and in view of this where mortality was overall statistically significant this is no longer the case. There is no day of significance and in actual fact Saturday and Sunday mortality is even less of a significant issue with the lower confidence interval reduced further away from 100 than reported in the March report. Admission on a Friday remains the better.

7.18 Congestive heart failure non-hypertensive remains unreported as the review has not been completed. This has been escalated to the director of clinical services and will now need to be reviewed by an external group to determine what actions need to be taken to ensure best practice is conducted within the trust.

7.19 Fracture of neck of femur features in the latest report. It remains not of significance but will be closely monitored through the committee. The mortality and quality alerts group will remain vigilant on these diagnoses to avoid them becoming statistically significant.

7.20 Intestinal obstruction without hernia no longer features and only featured in the March report.

7.21 Zero days' length of stay is still statistically significant but the picture is still improving from last month's report and the month before. The palliative care team are working collaboratively with community colleagues in reviewing the case notes for such patients and recommendations will be progressed through the mortality and quality alerts group. There is work ongoing with the community colleagues in recognising that patients could be potentially treated in alternative settings if they have been identified as being at the end of their life and not requiring acute medical care.

7.22 The Associate Medical Director: Standards of Medical Care is conducting a seven day working review in accordance with the NHS England directive to determine the trust position and will report to Quality Assurance Committee once the national data has been published. This is a prospective review of 280 cases of emergency admissions into the trust between the week beginning 30th March and patients will be followed up for 5 days to determine the level of consultant review in both the acute setting and the general ward that they may be transferred to.

8. **Nurse Staffing**

8.1 A detailed report was presented to the Quality Assurance Committee on 14 April 2016. The headlines for March 2016 were that Registered Nurse shift fill rates (daytime) decreased to 90.6% compared to 94.2% in February and 96.8% on nights compared to 98%. At the same time Healthcare Support Worker (HCSW) fill rates increased on days to 103.5% from a position of 101.7% in February and reduced to 99.7% from 102% on nights.

8.2 Eight in-patient areas had Registered Nurse shift fill rates (days) below 90%. These were; Ward A1, A2, A4, A5, AMU, B4, Stroke Unit, and Keppel. Seven areas had a day time shift fill rate less than 85% and these were A1 at 78%, A2 at 81.5%, A4 at 78.1%, A5 at 76.3%, AMU at 82%, B4 at 81.4% and the Stroke Unit at 76.1%.
8.3 Two areas had Registered Nurse shift fill rates (nights) below 90% and they were Keppel Ward and the Children’s Ward.

8.4 There were eight ‘internal never event’ shifts in March, across the Divisions, one in Medicine, six in Surgery and one in Family Health.

8.5 There were 29 shifts in the month with over 50% of RNs on duty being within the 12 month preceptorship period. As with all the other indicators this is reviewed daily by the senior nursing team. This indicator was added by the Chief Nurse eight months ago as a proxy for the measurement of experience / competence.

8.6 There has been a small increase in the use of agency nurses and a reduction in the use of flexible staffing (internal bank) in March. The overall use of flexible staffing and agency nurses has reduced in this period. The Trust has certainly noticed a marked difference in the availability of agency nurses following the introduction of the adjusted agency cap rates on 01 April 2016.

8.7 There was an increase in the number of shifts with more than 50% of RNs being flex (bank) or agency, the majority of these shifts were in the Division of Medicine.

8.8 In response to agency price caps and experience week commencing 04 April when the Trust operated in incident management mode due to a surge in the total number of in-patients a ‘nurse bank’ team has been established to proactively contact all colleagues registered on the flexible staffing bank to offer vacant shifts, and week commencing 18 April the executive team will consider other ways of incentivising nurses and midwives to join the flexible staffing bank.

8.9 In the community there was a deficit of 8.5% of nursing against plan representing deterioration on the previous month.

8.10 Following the establishment reviews by all ‘bed holding’ clinical divisions the Chief Nurse, Director of Finance and Acting Director of Workforce met with each divisional leadership team on 13 April to review the outputs and sign off the establishment plans. The headlines for the Division of Planned Care and Surgery are:

- No changes to Ward B4 however it was agreed to fund the two unfunded positions. These were required following the last establishment review but had not yet been funded. Costs were being incurred on the basis of the ward staffing to the agreed staffing levels.
- B5 / SAU - The requirement to staff the second consulting room was discussed. It was agreed to uplift the establishment by one Healthcare Support Worker (HCSW) which will be funded by the changes to the Fitzwilliam ward adjustments.
- Similarly for Sitwell and increase of 1.9 wte HCSW was agreed on the basis of eliminating agency use.
- A reduction of 1.0 wte band 5 staff nurse (vacancy) on Fitzwilliam due to a reduction in beds following the move from B3.
- A freeze on recruitment to Keppel Ward which is over-established.
- In summary, no new changes to budget. Possible non-recurrent cost improvements were identified. the next establishment panel will also consider critical care, theatres and the relevant out-patients.
8.11 The headlines for the Division of Integrated Medicine are:

- No change to the community unit establishments
- No immediate changes to the neuro-rehabilitation establishment however the service model is being reviewed. Recent recruitment success was noted.
- No proposed changes to Breathing Space at this time albeit there does need to be a more detailed review of skill mix and the nursing model. It was agreed that the Chief Nurse and Head of Nursing would commission an external review.
- Ward A1 will receive an increase of one Healthcare Support Worker (HCSW)
- Ward A2 will reduce the band 5 RN establishment due to the reduction in beds. This reduction of 4.14 whole-time equivalents will be accommodated through vacancies.
- The specialities on Ward A4 have recently changed. As with A1 there will be an increase in HCSW
- No change on Ward A5. The ward is piloting a 10am to 6pm HCSW shift.
- No change to Ward A7. The Safer Nursing Care Tool (SNCT) results were reviewed.
- Changes to the Stroke Unit establishment have recently been described in the business case to achieve national accreditation standards.
- No changes to CCU at this stage but the next review will focus on evaluating skill mix.
- In summary the changes are effectively cost neutral. The reduction in band 5 staff nurses (£145K) and the increase in HCSWs (£143K) increase cost by £2k.

8.12 The headlines for the Division of Emergency Care are:

- The Trust will fill the band 8a lead Advanced Nurse Practitioner (ANP) / Educator in the next three weeks.
- The focus needs to be on getting to a point of having a band 7 co-ordinator on every shift (24/7) and a children’s trained nurse on every shift (24/7). There are currently 3 Children’s trained nurses in post and offers have been made to two more.
- With vacancies at band 7, band 6, band 5, band 3 and band 2 it was agreed that the priority is recruitment (and retention of existing colleagues). The appointment of the band 8a lead Advanced Nurse Practitioner / Educator is seen as a key appointment in the short-term.
- To achieve an RN in each bay plus a coordinator on AMU with a 70:30 skill mix, plus ANPs the Acute Medical Unit establishment needs to increase from 56.72 wte which was based on 29 beds, to 70.23 wte; an increase of 13.51wte. This increase was supported by the Chief Nurse and Director of Finance subject to the General Manager and Head of Nursing providing a trajectory for increasing recruitment and reducing agency. The unit is currently attempting to staff to the revised establishment through flexible staffing therefore the Trust is incurring the cost.

8.13 The headlines for the Division of Family Health² are:

- Following a review of pathways for the management of patients presenting for acute assessment on Ward B11, there are no proposed changes to the establishment.
- No changes to the genito-urinary medicine and contraception and sexual health service nurse staffing establishments but colleagues will do a final check on the impact of a reduction in the value of the public health budget.

² NB. There remains an action to review the midwifery establishments against the NICE guidance. This was not completed ahead of the panel meeting.
• Delivery Suite and Wharncliffe; no changes. The midwife to birth ratio is noted to be 1:25 on the Yorkshire and Humber maternity dashboard and 1:28, by slightly different measures, when Birthrate+ was last used. Both ratio are acceptable. It was agreed that the division will commission another review using Birthrate+ in 2016.
• No changes to community midwifery.
• No changes to Greenoaks. The ongoing service review was noted.
• Children’s Ward has a funded establishment of 25.34 and an unfunded establishment of 3.0 wte agreed post inspection by the Care Quality Commission (CQC). It was agreed to increase the establishment by 3.0wte to 28.34 fully funded. PANDA recommends a further increase of 1.8wte. The Chief Nurse has already commissioned an analysis of March activity compared to actual staff on duty and PANDA. This analysis is expected to be complete by the end of the month to inform the submission of the Children’s Ward report to Board at the end of May 2016. Therefore the final decision on any further adjustment to establishment will be taken after that analysis.
• The Special Care Baby Unit has an establishment of 27.89wte. It was noted that activity has increased but within that ITU activity has decreased. The unit has recruited to vacancies. It was agreed that the General Manager and Head of Nursing / Midwifery will check the data against the existing derogation of BAPM standards (British Association of Perinatal Medicine) and advise the Chief Nurse of any concerns.
• School Nursing and Health Visiting – no changes. The service will be tendered during the year.
• Specialist Midwife. No change. Now funded ay 0.8wte.
• In summary, the only change is to the Children’s Ward establishment – 3.0wte band 5.

8.14 The SNCT data collection period commenced on Monday 4 April 2016 and will end on Sunday 1 May. To increase confidence in the whole process of deployment and response, data is being validated twice a week by Matrons and Ward A7 data is validated three times a week by the Assistant Chief Nurse (Workforce).

9. Conclusion

9.1 The Trust performed well against the C-difficile target in 2016/17 and is revising the prevention strategy based on learning from the past year.

9.2 The Harm Free Care rate has improved in month, recovering from the reduction in February 2016.

9.3 The Chief Nurse, Director of Finance and Acting Director of Workforce have met with the ‘bed holding’ Clinical Divisions to review the nursing and midwifery staffing establishments. The most significant changes to establishment arise from the new models of care and expansion of the Acute Medical unit.

9.4 The HSMR has improved. The SHMI will be refreshed next month.

Tracey McErlain-Burns        Dr Conrad Wareham
Chief Nurse                  Medical Director
March 2016
Introduction
Carrie
Can you please coordinate with Lisa and see if you can develop an expanded mortality dataset for me to take to the Board (last Tuesday of the month) on a recurring basis for the next year. I would like the report to include:

Section A (Hospital wide)
1. HSMR
2. SHMI
3. CUSUM
4. a) Crude mortality (in month) number
   b) Crude mortality (in month) as a proportion of all discharges

Section B (by SRG)
5. Worst 10 SRGs HSMR
6. Best 10 SRGs HSMR
7. All Outliers (lower confidence limit > 1.0)
   a) HSMR
   b) SHMI
   c) CUSUM

Section C (by area)
8. Worst 5 Units HSMR
9. Best 5 Units HSMR
10. All Outliers (lower confidence limit > 1.0)
    a) HSMR
    b) SHMI
    c) CUSUM

Section D (weekends)
11. Deaths happening on Saturdays and Sundays
    a) Crude mortality (in month) number
    b) Crude mortality (in month) as a proportion of all discharges
12. HSMR (hospital wide) for patients who were admitted on each day of the week

Section E (extremes of stay)
13. Deaths within 24 hours of admission
    a) HSMR
    b) Crude mortality number
14. Deaths within 48 hours of admission
    a) HSMR
    b) Crude mortality number
15. Deaths after 21 days from admission
    a) HSMR
    b) Crude mortality number

Definitions:
HSMR & SHMI – are these 12 month rolling figures, as opposed to the HSMR for the relevant month? Yes just the crude mortality as in month figures

- A definition for SRG, under section B please? These are the diagnoses (eg pneumonia)
- Section C ‘best and worst units’ – are we defining those in terms of HSMR/SHMI values? Yes
- Section E – the HES data is not timestamped, however for the 24 & 48 hours we could look at 0,1 & 2 days LoS – or take timestamped from PAS if available, however we wouldn’t then have HSMR values. Please could you confirm your preference? The former would be my preference.
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<tr>
<td>Section B - Alerting HSMR &amp; SHMI Groups</td>
<td>Pg</td>
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<td>Section C - Best &amp; Worst Performers</td>
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<td>Section D - Weekend Mortality</td>
<td>Pg</td>
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<td>Section E - Extremes of Stay</td>
<td>Pg</td>
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</table>

## Executive Summary
Section A (Hospital wide)

1. HSMR
2. SHMI
3. CUSUM

4. a) Crude mortality (in month) number
   b) Crude mortality (in month) as a proportion of all discharges

**Note:**

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<th>Provider</th>
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<th>Deaths</th>
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CUSUM: TRUST-WIDE (Jan 15 - Dec 15)

Diagnosis alerts remain the same compared to the last report. There are fewer procedure alerts; 6 alerts had triggered last month, with an additional alert within ‘rest of arteries and veins’ group. In addition, the alert in ‘Drainage through perineal region’ replaces ‘diagnostic endoscopy on lower GI tract’, seen in the last report.

To replicate, click here

Last Month:

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### Section B (SMQ)

5. 

5.1. (b) Low 10 SHMs, HSMR

5.2. Other (included in box 5)

### (c) CUSUM

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<th>Superspells</th>
<th>Obs</th>
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<th>Rate %</th>
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### (c) CUSUM for significantly HIGH HSMR-diagnosis groups

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### Last month (2015-2019)

#### Last month: Data on adverse events between the reports

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Spells</th>
<th>Superspells</th>
<th>Obs</th>
<th>Exp</th>
<th>Rate %</th>
<th>CI SHMI</th>
<th>SHMI *</th>
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</thead>
<tbody>
<tr>
<td>Dehydration, severe</td>
<td>139</td>
<td>153</td>
<td>26</td>
<td>11.57</td>
<td>3.57</td>
<td>1.99</td>
<td>42.09</td>
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<td>2.57</td>
<td>1.04</td>
<td>1.26</td>
<td>29.70</td>
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## Last month: N/A - no significantly high HSMR & CUSUM alerts this month
### Section 2 (Day ward)

#### All Higher HSMRs - Observed vs Expected Spells Superspells

<table>
<thead>
<tr>
<th>Trust</th>
<th>Spells</th>
<th>Deaths</th>
<th>Expected</th>
<th>Exp. Rate</th>
<th>Low</th>
<th>High</th>
<th>Exp. Rate</th>
<th>Low</th>
<th>High</th>
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<tbody>
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</table>

#### All Lower HSMRs - Observed vs Expected Spells Superspells

<table>
<thead>
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<th>Spells</th>
<th>Deaths</th>
<th>Expected</th>
<th>Exp. Rate</th>
<th>Low</th>
<th>High</th>
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</table>

#### All Other Trusts - Observed vs Expected Spells Superspells

<table>
<thead>
<tr>
<th>Trust</th>
<th>Spells</th>
<th>Deaths</th>
<th>Expected</th>
<th>Exp. Rate</th>
<th>Low</th>
<th>High</th>
<th>Exp. Rate</th>
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<th>High</th>
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</thead>
<tbody>
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<td>44537</td>
<td>1711</td>
<td>2206.58</td>
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</tbody>
</table>

#### All Other Trusts - Outliers Spells Superspells

<table>
<thead>
<tr>
<th>Trust</th>
<th>Spells</th>
<th>Deaths</th>
<th>Expected</th>
<th>Exp. Rate</th>
<th>Low</th>
<th>High</th>
<th>Exp. Rate</th>
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<th>High</th>
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<tr>
<td>Calderdale</td>
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Note: All data is based on the latest available information as of the report date. For detailed analysis, please refer to the specific source or official document.
11. Deaths following admissions on Saturdays and Sundays
   a) Crude mortality (in month) number
   b) Crude mortality (in month) as a proportion of all discharges

12. HSMR (hospital wide) for patients who were admitted on each day of the week

### WEEKEND MORTALITY - ALL DIAGNOSES

<table>
<thead>
<tr>
<th>Type</th>
<th>SATURDAY</th>
<th>SUNDAY</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Admissions</td>
<td>4,337</td>
<td>4,282</td>
<td>8,619</td>
</tr>
<tr>
<td>Deaths</td>
<td>141</td>
<td>158</td>
<td>399</td>
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</tbody>
</table>

Crude rate 3.25% 3.69% 3.47%

*Deaths may have occurred on any day of the week*

### HSMR Basket of 56 Diagnosis Groups

<table>
<thead>
<tr>
<th>Day of Admission</th>
<th>Spells</th>
<th>Superspells</th>
<th>Observed</th>
<th>Expected</th>
<th>Obs. - Exp.</th>
<th>Rate (%)</th>
<th>Exp. (%)</th>
<th>RR</th>
<th>Low</th>
<th>High</th>
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<tr>
<td>ALL</td>
<td>20184</td>
<td>19637</td>
<td>881</td>
<td>865.93</td>
<td>15.65</td>
<td>4.49</td>
<td>4.41</td>
<td>101.81</td>
<td>95.20</td>
<td>108.76</td>
</tr>
<tr>
<td>Thursday</td>
<td>3612</td>
<td>3547</td>
<td>135</td>
<td>136.85</td>
<td>-1.85</td>
<td>3.81</td>
<td>3.86</td>
<td>98.65</td>
<td>82.71</td>
<td>116.77</td>
</tr>
<tr>
<td>Friday</td>
<td>3218</td>
<td>3131</td>
<td>109</td>
<td>123.81</td>
<td>-14.83</td>
<td>3.46</td>
<td>3.95</td>
<td>88.02</td>
<td>72.27</td>
<td>106.18</td>
</tr>
<tr>
<td>Saturday</td>
<td>1533</td>
<td>1474</td>
<td>119</td>
<td>105.00</td>
<td>14.02</td>
<td>8.07</td>
<td>7.12</td>
<td>115.33</td>
<td>93.85</td>
<td>135.62</td>
</tr>
<tr>
<td>Sunday</td>
<td>1507</td>
<td>1463</td>
<td>126</td>
<td>110.35</td>
<td>15.60</td>
<td>8.61</td>
<td>7.04</td>
<td>114.18</td>
<td>95.11</td>
<td>135.95</td>
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</tbody>
</table>

### Last Month:

#### WEEKEND MORTALITY - ALL DIAGNOSES

<table>
<thead>
<tr>
<th>Type</th>
<th>SATURDAY</th>
<th>SUNDAY</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
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<td>4,367</td>
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<tr>
<td>Deaths</td>
<td>196</td>
<td>174</td>
<td>370</td>
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</table>

Crude rate 3.46% 3.92% 3.66%

*Deaths may have occurred on any day of the week*
Section E (extremes of stay)

13. Deaths within 24 hours of admission
   a) HSMR
   b) Crude mortality number

14. Deaths within 48 hours of admission
   a) HSMR
   b) Crude mortality number

15. Deaths after 21 days from admission
   a) HSMR
   b) Crude mortality number

---

HSMR: basket of 56 diagnosis groups

### Mortality by length of stay (Jan 15 - Dec 15)

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Spells</th>
<th>Superspells</th>
<th>Observed</th>
<th>Expected</th>
<th>Obs. - Exp.</th>
<th>Rate (%)</th>
<th>Exp. (%)</th>
<th>RR Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Days</td>
<td>1594</td>
<td>1545</td>
<td>68</td>
<td>44.98</td>
<td>23.02</td>
<td>4.40</td>
<td>2.91</td>
<td>151.17</td>
<td>117.40 191.67</td>
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<tr>
<td>1 Day</td>
<td>982.7</td>
<td>914.1</td>
<td>101</td>
<td>94.57</td>
<td>5.52</td>
<td>6.86</td>
<td>5.24</td>
<td>104.31</td>
<td>85.99 134.98</td>
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<tr>
<td>2 Days</td>
<td>1646</td>
<td>1574</td>
<td>50</td>
<td>74.00</td>
<td>5.95</td>
<td>5.08</td>
<td>4.70</td>
<td>100.31</td>
<td>81.64 134.45</td>
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<tr>
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<td>905</td>
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<td>134.52</td>
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<td>0.15</td>
<td>0.15</td>
<td>102.15</td>
<td>86.18 121.25</td>
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### SMR: All Diagnoses

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<th>Spells</th>
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<th>Observed</th>
<th>Expected</th>
<th>Obs. - Exp.</th>
<th>Rate (%)</th>
<th>Exp. (%)</th>
<th>RR Low</th>
<th>High</th>
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</thead>
<tbody>
<tr>
<td>0 Days</td>
<td>10226</td>
<td>10176</td>
<td>93</td>
<td>63.75</td>
<td>39.30</td>
<td>91.00%</td>
<td>63.00%</td>
<td>147.87</td>
<td>117.73 178.70</td>
</tr>
<tr>
<td>1 Day</td>
<td>11539</td>
<td>11469</td>
<td>128</td>
<td>123.28</td>
<td>4.72</td>
<td>11.60%</td>
<td>10.00%</td>
<td>103.83</td>
<td>86.62 123.45</td>
</tr>
<tr>
<td>2 Days</td>
<td>5322</td>
<td>5198</td>
<td>99</td>
<td>93.14</td>
<td>1.06</td>
<td>190.80%</td>
<td>179.00%</td>
<td>106.29</td>
<td>86.99 129.41</td>
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<tr>
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<td>114</td>
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<td>6.25%</td>
<td>10.65%</td>
<td>58.67</td>
<td>23.51 130.93</td>
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Last month:

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<th>Superspells</th>
<th>Observed</th>
<th>Expected</th>
<th>Obs. - Exp.</th>
<th>Rate (%)</th>
<th>Exp. (%)</th>
<th>RR Low</th>
<th>High</th>
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</thead>
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<td>1501</td>
<td>74</td>
<td>46.00</td>
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<td>123.90 188.10</td>
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<tr>
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<td>316</td>
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<td>89.61 124.32</td>
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<table>
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<th>Spells</th>
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<th>Expected</th>
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<td>114</td>
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<td>11.93</td>
<td>-4.93</td>
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<td>10.65%</td>
<td>58.67</td>
<td>23.51 130.93</td>
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<tr>
<td>Ward/Department</td>
<td>Beds</td>
<td>Total Un-Qualified/Qualified Band 2-7</td>
<td>Un-Qualified / Qualified Band 2-7</td>
<td>Skill Mix Budgeted Band 2-6 %</td>
<td>SNCT Review</td>
<td>Proposal</td>
<td>Skill Mix Budgeted Band 2-6 %</td>
<td>Optimal Staffing levels - Days</td>
<td>Optimal Staffing levels - Nights</td>
</tr>
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<tr>
<td></td>
<td></td>
<td>Budgeted FTE</td>
<td>Actual FTE</td>
<td>Band</td>
<td>Funded Establishment</td>
<td>Budgeted Registered Band 5 to 6</td>
<td>Budgeted Non-Registered Band 2 to 4</td>
<td>HCSW Qualified Band 5-6</td>
<td>Budgeted Registered Band 5 to 6</td>
</tr>
<tr>
<td>Breathing Space- 20 Beds</td>
<td>20</td>
<td>23.24</td>
<td>21.80</td>
<td>2</td>
<td>5.60</td>
<td>52.02%</td>
<td>47.98%</td>
<td>23.58</td>
<td>10.00</td>
</tr>
<tr>
<td>Community Hospital</td>
<td>22</td>
<td>32.50</td>
<td>34.59</td>
<td>2</td>
<td>13.50</td>
<td>52.46%</td>
<td>47.54%</td>
<td>31.81</td>
<td>14.50</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>8</td>
<td>19.92</td>
<td>20.00</td>
<td>2</td>
<td>2.26</td>
<td>88.65%</td>
<td>11.35%</td>
<td>0.00</td>
<td>2.26</td>
</tr>
<tr>
<td>A2 (previously Fitzwilliam)</td>
<td>23</td>
<td>35.11</td>
<td>31.77</td>
<td>2</td>
<td>10.06</td>
<td>64.64%</td>
<td>35.36%</td>
<td>0.00</td>
<td>12.06</td>
</tr>
<tr>
<td>Ward A1-Cardio Respiratory</td>
<td>26</td>
<td>34.94</td>
<td>40.17</td>
<td>2</td>
<td>10.88</td>
<td>67.94%</td>
<td>32.06%</td>
<td>44.26</td>
<td>12.58</td>
</tr>
<tr>
<td>Ward A7-Clinical Haematology &amp; Specialist Medicine</td>
<td>12</td>
<td>28.22</td>
<td>24.90</td>
<td>2</td>
<td>8.00</td>
<td>70.61%</td>
<td>29.39%</td>
<td>14.48</td>
<td>8.00</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td>3</td>
<td>0.00</td>
<td></td>
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</tr>
<tr>
<td>Ward/Department</td>
<td>Beds</td>
<td>Total Un-Qualified/Qualified Band 2 - 7</td>
<td>Un-Qualified / Qualified by Band 2 - 7</td>
<td>Skill Mix Budgeted Band 2-6 %</td>
<td>SNCT Review</td>
<td>Proposal</td>
<td>Skill Mix Budgeted Band 2-6 %</td>
<td>Optimal Staffing levels - Days</td>
<td>Optimal Staffing levels - Nights</td>
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</tr>
<tr>
<td>Ward A5-Endocrinology &amp; Diabetes</td>
<td>33</td>
<td>37.56 38.10</td>
<td>5 21.36 6 2.00</td>
<td>63.89% 36.11%</td>
<td>41.68 14.90 23.36</td>
<td>61.06% 38.94%</td>
<td>5 3 3 3</td>
<td>1:6.6 1:6.6 1:11</td>
<td></td>
</tr>
<tr>
<td>AMU</td>
<td>34</td>
<td>56.72 49.54</td>
<td>2 14.68 3 0.00 5 23.26 6 8.73</td>
<td>69.08% 30.92%</td>
<td>14.68 45.49</td>
<td>75.60% 24.40%</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward A4-Gastroenterology</td>
<td>34</td>
<td>38.81 36.74</td>
<td>2 14.00 3 0.00 5 21.81 6 2.00</td>
<td>62.97% 37.03%</td>
<td>63.34 15.96 23.81</td>
<td>59.87% 40.13%</td>
<td>5 3 3 3</td>
<td>1:6.8 1:6.8 1:11.3</td>
<td></td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>27</td>
<td>45.99 40.72</td>
<td>2 15.45 3 0.00 5 20.14 6 9.40 7 1.00</td>
<td>65.66% 34.34%</td>
<td>40.80 15.45 29.54</td>
<td>65.66% 34.34%</td>
<td>5 1 E 3 L 2 3</td>
<td>1:5.4 1:5.4 1:13.5</td>
<td></td>
</tr>
<tr>
<td>Medicine Totals</td>
<td>205</td>
<td>353.01 338.33</td>
<td>259.95 120.39 229.29</td>
<td>22.35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward B4 - Surgery</td>
<td>33</td>
<td>34.90 35.82</td>
<td>2 12.59 3 0.00</td>
<td>65.93% 34.07%</td>
<td>43.83 11.55 22.35</td>
<td>65.93% 34.07%</td>
<td>6 3 3 2</td>
<td>1:5.5 1:5.5 1:11</td>
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<tr>
<td>Ward/Department</td>
<td>Beds</td>
<td>Total Un-Qualified/Qualified Band 2-7</td>
<td>Un-Qualified / Qualified by Band 2-7</td>
<td>Skill Mix Budgeted Band 2-6 %</td>
<td>SNCT Proposal</td>
<td>Skill Mix Budgeted Band 2-6 %</td>
<td>Optimal Staffing levels - Days</td>
<td>Optimal Staffing levels - Nights</td>
<td>Ratio</td>
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<td>Budgeted FTE</td>
<td>Actual FTE</td>
<td>Band</td>
<td>Funded Establishment</td>
<td>Budgeted Registered Band 5 to 6</td>
<td>Budgeted Non-Registered Band 2 to 4</td>
<td>HCSW</td>
<td>Registered Band 5-6</td>
</tr>
<tr>
<td>Ward B5 - Surgery</td>
<td>33</td>
<td>41.02</td>
<td>37.21</td>
<td>5</td>
<td>25.43</td>
<td>68.54%</td>
<td>31.46%</td>
<td>37.32</td>
<td>13.59</td>
</tr>
<tr>
<td>Keppel Orthopaedics Elective Ward</td>
<td>33</td>
<td>28.18</td>
<td>30.29</td>
<td>2</td>
<td>9.72</td>
<td>64.24%</td>
<td>35.76%</td>
<td>25.75</td>
<td>9.76</td>
</tr>
<tr>
<td>Fitzwilliam (Previously Ward B3) - Orthopaedics</td>
<td>27</td>
<td>35.51</td>
<td>33.53</td>
<td>2</td>
<td>11.76</td>
<td>65.92%</td>
<td>34.08%</td>
<td>35.26</td>
<td>11.76</td>
</tr>
<tr>
<td>Sitwell - Urology</td>
<td>14</td>
<td>18.97</td>
<td>19.60</td>
<td>2</td>
<td>5.88</td>
<td>67.28%</td>
<td>32.72%</td>
<td>16.44</td>
<td>6.88</td>
</tr>
<tr>
<td>Surgery Totals</td>
<td>140</td>
<td>158.58</td>
<td>156.45</td>
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<tr>
<td>Ward/Department</td>
<td>Beds</td>
<td>Total Un-Qualified/Qualified</td>
<td>Un-Qualified / Qualified by Band 2-7</td>
<td>Skill Mix Budgeted Band 2-6 %</td>
<td>SNCT Review</td>
<td>Proposal</td>
<td>Skill Mix Budgeted Band 2-6 %</td>
<td>Optimal Staffing levels - Days</td>
<td>Optimal Staffing levels - Nights</td>
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<tr>
<td><strong>Childrens Wards</strong></td>
<td>22</td>
<td>36.80</td>
<td>37.39</td>
<td>67.99%</td>
<td>32.01%</td>
<td>10.74</td>
<td>28.25</td>
<td>72.45%</td>
<td>27.55%</td>
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<tr>
<td><strong>Ward B11 - Gynaecology</strong></td>
<td>14</td>
<td>18.86</td>
<td>19.01</td>
<td>64.78%</td>
<td>35.22%</td>
<td>13.69</td>
<td>6.29</td>
<td>11.57</td>
<td>64.78%</td>
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<tr>
<td><strong>Wharncliffe Ward - Obstetrics</strong></td>
<td>35</td>
<td>87.65</td>
<td>81.65</td>
<td>73.24%</td>
<td>26.76%</td>
<td>20.54</td>
<td>67.11</td>
<td>76.57%</td>
<td>23.43%</td>
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<tr>
<td><strong>Family Health Totals</strong></td>
<td>71</td>
<td>143.31</td>
<td>138.05</td>
<td></td>
<td></td>
<td>13.69</td>
<td>37.57</td>
<td>106.93</td>
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<tr>
<td></td>
<td>416</td>
<td>654.90</td>
<td>632.83</td>
<td></td>
<td></td>
<td>432.24</td>
<td>211.50</td>
<td>436.90</td>
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</tr>
</tbody>
</table>
Report: Operational Performance Update

Presented by: Chris Holt, Chief Operating Officer
Author(s): Chris Holt, Chief Operating Officer

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

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

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

Purpose of this paper:
This paper provides an overview of performance against the key operational indicators, summarising headline issues around performance and actions being taken to address.

Summary of Key Points:
- Performance against the 4hr emergency access standard continues, with March’16 being the most challenging period on record for the Trust
- Particular challenges remain around staffing levels across a number of key areas, and in particular ED consultants, which severely impacts on the ability to run the systems and processes in the consistent way that is required
- 62 day cancer performance for Feb’16 has also not achieved, as anticipated. However, early indications are that the recovery plan that was put in place in order to secure the Q4 position should be successful
- The Incomplete standard for the 18week RTT pathways continues to deliver and show strong performance relative to the national picture
- The Trust has also continued to deliver performance against the 6 week wait diagnostics standard, as well as return to positive performance against the ‘cancelled operations on the day’ standard
- Work also continues around the validation process linked to the potential 52 week wait breaches outlined last month, with a total of 5 x 52 week waits identified to date

Board action required:
For noting
1.0 Introduction

1.1 This paper provides an overview of performance against the key operational indicators, summarising headline issues around performance and actions being taken to address.

2.0 4hr emergency access target

2.1 Performance against the 4hr emergency access target proved to be a significant challenge for the Trust during March, with the lowest performance since the standard was introduced, at 77.14%. This led to a Q4 performance of 83.78% and an overall 2015/16 performance level for 2015/16 of 90.59%.

2.2 The principal reasons for such a deteriorating position in March (beyond the national challenges) were the ongoing medical workforce numbers and increased internal pressure on inpatient beds. Within the Emergency Department, the management of a number of long-term gaps led to a continued reliance on just 3 substantive consultants from an establishment of 10 and a subsequent increased need for locum consultants at a very difficult time of the year for emergency demand. This was coupled with ongoing workforce challenges within some of the medical specialties with again a reliance on locums in a number of specialties, which in turn led to daily pressures to ensure timely review and discharge of patients.

2.3 Whereas performance in March 2015 also saw a fall from the previous month, this year the fall was much greater. Our overall position relative to 14/15 has therefore continued to worsen.

2.4 When looking across the month, the number of ‘red’ days i.e. when performance was <95%, again reflects the pressures through the month, with only one day delivering over 95%. Achievement in the standard for this day followed a week of intense focus in order to prepare the Trust for the 4 day Easter bank holiday weekend through the enactment of a combination of actions. Whilst putting the Trust in a stronger position for the weekend, it also culminated in much improved flow. This also led to there being 40+ empty beds going in to the weekend. Unfortunately, due once again to some of the staffing challenges, this improved performance was unable to be maintained.
Overview of March’16 breach days

<p>| | | | | | |</p>
<table>
<thead>
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<tbody>
<tr>
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<td>20</td>
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<td></td>
<td></td>
<td></td>
<td>21</td>
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</tr>
</tbody>
</table>

- daily performance >95%
- daily performance <95%

2.5 As per last month, there were increasing ambulance handover delays through the month, and there remains work to be done in ensuring early escalation both internally and from YAS (Yorkshire Ambulance Service) as there was no early warning on the day and the bulk of the over 1hr delays occurred on a single day.

2.6 Analysis on TRFT performance relative to local Trusts as well as the national picture shows that national performance continued to be a challenge, with February once again the worst performing month on record with only 2 Trusts achieving 95%. However, as national performance continues to be released 6 weeks in delay it is anticipated that TRFT relative performance in March will fall.

**National performance against 4hr emergency access (to Feb’16)**

<table>
<thead>
<tr>
<th>Period</th>
<th>TRFT Performance</th>
<th>TRFT Rank (of 140)</th>
<th>England Avg (Type 1)</th>
<th>No. of Trusts &gt;95% (Type 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>93.3%</td>
<td>53</td>
<td>89.8%</td>
<td>31</td>
</tr>
<tr>
<td>May</td>
<td>97.3%</td>
<td>9</td>
<td>91.5%</td>
<td>45</td>
</tr>
<tr>
<td>June</td>
<td>97.1%</td>
<td>16</td>
<td>91.5%</td>
<td>53</td>
</tr>
<tr>
<td>Q1</td>
<td>95.7%</td>
<td>23</td>
<td>91.1%</td>
<td>44</td>
</tr>
<tr>
<td>July</td>
<td>93.7%</td>
<td>73</td>
<td>92.5%</td>
<td>55</td>
</tr>
<tr>
<td>August</td>
<td>88.6%</td>
<td>113</td>
<td>91.5%</td>
<td>44</td>
</tr>
<tr>
<td>September</td>
<td>93.9%</td>
<td>46</td>
<td>90.1%</td>
<td>34</td>
</tr>
<tr>
<td>Q2</td>
<td>92.1%</td>
<td>79</td>
<td>91.4%</td>
<td>43</td>
</tr>
<tr>
<td>October</td>
<td>92.5%</td>
<td>44</td>
<td>88.6%</td>
<td>21</td>
</tr>
<tr>
<td>November</td>
<td>93.7%</td>
<td>29</td>
<td>87.1%</td>
<td>14</td>
</tr>
<tr>
<td>December</td>
<td>85.5%</td>
<td>82</td>
<td>86.6%</td>
<td>14</td>
</tr>
<tr>
<td>Q3</td>
<td>90.5%</td>
<td>58</td>
<td>87.4%</td>
<td>12</td>
</tr>
<tr>
<td>January</td>
<td>88.5%</td>
<td>42</td>
<td>83.0%</td>
<td>7</td>
</tr>
<tr>
<td>February</td>
<td>85.8%</td>
<td>49</td>
<td>81.6%</td>
<td>2</td>
</tr>
</tbody>
</table>

2.7 Analysis across local Trusts shows that this performance is being managed to a mixed degree within South Yorkshire.

**Local performance against 4hr emergency access (to Feb’16)**

<table>
<thead>
<tr>
<th>Trusts</th>
<th>Q1 15/16</th>
<th>Q2 15/16</th>
<th>Q3 15/16</th>
<th>Feb’16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doncaster &amp; B</td>
<td>93.9%</td>
<td>52</td>
<td>94.1%</td>
<td>57</td>
</tr>
<tr>
<td>Chesterfield</td>
<td>95.3%</td>
<td>36</td>
<td>95.7%</td>
<td>21</td>
</tr>
<tr>
<td>Barnsley</td>
<td>94.8%</td>
<td>45</td>
<td>94.2%</td>
<td>55</td>
</tr>
<tr>
<td>TRFT</td>
<td>95.7%</td>
<td>23</td>
<td>91.1%</td>
<td>79</td>
</tr>
<tr>
<td>Sheffield TH*</td>
<td>93.8%</td>
<td>55</td>
<td>92.8%</td>
<td>71</td>
</tr>
</tbody>
</table>

*STH have not been able to report 4hr performance due to IT issues
2.8 The overall national picture was that there were 1,871,729 ED attendances in February 2016, 13.1% more than in February 2015, although February 2016 contained one extra day. Attendances over the latest twelve months are higher than levels in the preceding twelve month period (an increase of 1.6%). Overall, 81.6% of Type 1 patients were admitted, transferred or discharged from A&E within four hours of arrival, below the 95% standard, and 87.8% when including Type 1, 2 and 3. This is the lowest performance since monthly data became available in August 2010.

2.9 Additional information around TRFT performance relative to the national picture can also be drawn against standards beyond the 95% 4-hour indicator, and a sample of these are shown in the table below:

**Local performance against 4hr emergency access (to Feb’16)**

<table>
<thead>
<tr>
<th>Month</th>
<th>No. of A&amp;E Attends</th>
<th>No. of Emergency Admissions</th>
<th>Conversion Rate (TRFT)</th>
<th>Conv. Rate (Eng Avg)</th>
<th>Patients waiting &gt;4hrs following a DTA*</th>
<th>DTA &gt;4hrs (Eng Avg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct’15</td>
<td>6,352</td>
<td>1,353</td>
<td>21%</td>
<td>27%</td>
<td>3.2%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Nov’15</td>
<td>6,324</td>
<td>1,237</td>
<td>20%</td>
<td>28%</td>
<td>1.5%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Dec’15</td>
<td>6,488</td>
<td>1,424</td>
<td>22%</td>
<td>29%</td>
<td>8.1%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Jan’16</td>
<td>6,477</td>
<td>1,414</td>
<td>22%</td>
<td>28%</td>
<td>7.5%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Feb’16</td>
<td>6,209</td>
<td>1,318</td>
<td>21%</td>
<td>27%</td>
<td>10.6%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

*DTA is Decision to Admit

2.10 Whereas the information could be interpreted in a number of ways, it does reflect a relatively low conversion rate from ED attendances to admissions for TRFT, which despite the reliance on locums indicates good decision making at the ‘front door’ when compared against a much higher national rate. Furthermore, once a decision to admit (DTA) has been taken there are relatively fewer patients waiting within ED for longer than 4 hours, when compared to national averages. The impact of such outcomes is crowding within the ED department for patients waiting to be admitted, and whilst this remains a real challenge for us, it again needs to be understood within the national context.

3.0 Cancer

3.1 Cancer performance in Feb’16 has not delivered compliance with the Cancer 62 day (Urgent GP Referral) 85% standard. It was declared last month that performance for the whole of Q4 was going to be a challenge as a result of performance in Jan and Feb, but early indications are that there has been a magnificent response internally through March that should be enough to secure Q4 performance overall.

3.2 National reported performance in January saw the 85% standard for 62 Day cancer waiting time fail again, at 81%. Overall, TRFT was ranked 86th of 158 providers reporting cancer performance, which was a fall on last month (49th).
TRFT Cancer Performance Q1 to Feb’16 15/16

<table>
<thead>
<tr>
<th>Target</th>
<th>Operational Standard</th>
<th>Q1 2015/16</th>
<th>Q2 2015/16</th>
<th>Q3 2015/16</th>
<th>Jan 2015/16</th>
<th>Feb 2015/16</th>
<th>National (Feb 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2ww</td>
<td>93%</td>
<td>94.6%</td>
<td>94.8%</td>
<td>94.9%</td>
<td>96.2%</td>
<td>97.4%</td>
<td>95.4%</td>
</tr>
<tr>
<td>31 Day First Definitive Treatment</td>
<td>96%</td>
<td>98.6%</td>
<td>98.8%</td>
<td>99.1%</td>
<td>100.0%</td>
<td>95.2%</td>
<td>97.7%</td>
</tr>
<tr>
<td>62 Day from 2ww</td>
<td>85%</td>
<td>88.7%</td>
<td>85.1%</td>
<td>91.2%</td>
<td>84.3%</td>
<td>83.0%</td>
<td>81.0%</td>
</tr>
<tr>
<td>Breast Symptoms 2ww</td>
<td>93%</td>
<td>97.3%</td>
<td>96.5%</td>
<td>98.4%</td>
<td>94.6%</td>
<td>94.3%</td>
<td>94.5%</td>
</tr>
<tr>
<td>31 day Subsequent Treatment Surgery</td>
<td>94%</td>
<td>100.0%</td>
<td>95.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>95.7%</td>
<td>95.7%</td>
</tr>
<tr>
<td>31 day Subsequent Treatment Drug</td>
<td>98%</td>
<td>100.0%</td>
<td>99.6%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.6%</td>
<td>99.6%</td>
</tr>
<tr>
<td>62 Day Screening</td>
<td>90%</td>
<td>100.0%</td>
<td>95.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>86.0%</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

4.0 18 week RTT

4.1 The Trust performance against the main 18 week RTT indicators continues in a similar trend as to previous months. The main outcome indicator (Incompletes standard) is above the 92% target. Nationally, 92.1% of patients on the waiting list at the end of February 2016 had been waiting less than 18 weeks, thus meeting the 92% standard.

TRFT 18 week RTT Performance Apr’15 to Mar’16

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr</td>
<td>May</td>
<td>June</td>
<td>Jul</td>
</tr>
<tr>
<td>Admitted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clock Stops</td>
<td>1,802</td>
<td>1,601</td>
<td>1,509</td>
<td>1,730</td>
</tr>
<tr>
<td>Performance (Target = 90%)</td>
<td>93.8%</td>
<td>95.6%</td>
<td>94.5%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Non-Admitted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clock Stops</td>
<td>4,149</td>
<td>3,890</td>
<td>5,296</td>
<td>5,087</td>
</tr>
<tr>
<td>Performance (Target = 95%)</td>
<td>99.4%</td>
<td>99.0%</td>
<td>98.9%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Incompletes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total PTL</td>
<td>9,798</td>
<td>11,072</td>
<td>11,576</td>
<td>10,141</td>
</tr>
<tr>
<td>Performance (Target = 92%)</td>
<td>96.8%</td>
<td>97.3%</td>
<td>97.2%</td>
<td>96.4%</td>
</tr>
</tbody>
</table>

4.2 Once again we failed the admitted performance target and by a more significant margin than last month (40 breaches) and the primary reason remains the pressure on inpatient beds. This indicator is no longer a nationally mandated indicator; however we continue to aim for compliance internally.

5.0 6 week wait diagnostic tests

5.1 Following a failure against this standard in January 2016 which was largely a result of the challenges within Gastroenterology, performance against the standard has returned within target levels for the last two months. Performance however has increased from previous low levels, and again this is linked to diagnostic tests in Endoscopy (Gastroscopy, Colonoscopy and Flexi Sigmoidoscopy). The arrangement with Doncaster, whereby gastroenterology consultant support will be provided, will allow for this position to be improved more in line with performance seen over the previous 12 months.
5.2 The national performance reported that 1.3% of patients waiting at the end of the month had been waiting six weeks or longer from referral for one of the 15 key diagnostic tests, higher than the standard of 1%, although the lowest figure since November 2014. The 1% operational standard was last met nationally in November 2013.

6.0 Cancelled Operations on the day (for non-clinical reasons)

6.1 Following 4 months of non-performance, March saw a return to compliance at 0.34% against the 0.8% standard. Whilst this was at a difficult time for admitted pathways, it reflects the improved forward planning in scheduling electives.

<table>
<thead>
<tr>
<th>% of operations cancelled on the day for non-clinical reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014/15</strong></td>
</tr>
<tr>
<td>Activity</td>
</tr>
<tr>
<td>Cancelled Ops</td>
</tr>
<tr>
<td>%</td>
</tr>
<tr>
<td>Target &lt; 0.8%</td>
</tr>
</tbody>
</table>

| **2015/16**        | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Activity          | 3131 | 2873 | 3319.00 | 3262 | 2794 | 3114 | 3125 | 3247 | 2857 | 2839 | 3038 | 2976 |
| Cancelled Ops     | 24   | 19   | 19   | 44   | 12   | 17   | 25   | 33   | 27   | 45   | 29   | 10   |
| %                | 0.77% | 0.66% | 0.57% | 1.35% | 0.43% | 0.55% | 0.80% | 1.02% | 0.95% | 1.59% | 0.95% | 0.34% |
| Target < 0.8%    | 0.80% | 0.80% | 0.80% | 0.80% | 0.80% | 0.80% | 0.80% | 0.80% | 0.80% | 0.80% | 0.80% | 0.80% |

7.0 52 week waits

7.1 As presented in last month’s report, a further issue around potential 52 week waits has been identified. Whilst the issue that led to the potential delays has now been identified and is being addressed, circa 13,500 pathways require validating.

7.2 A trajectory has been set and agreed with the divisions to see all validation completed by the beginning of May’16, and progress against this plan is provided below. Whilst not on track with the original plan assurances have been given from
the teams that the current trajectory (red line) will be maintained and hence see completion by the target date.

**Pathway Validation: Plan trajectory v Actual**

![Pathway Validation Chart]

7.3 There have also been a total of 5 breaches of the 52 week wait standard identified. All of these have been closed out immediately, as the principal reason for breach is no evidence of communication of final diagnostic results all of which were positive in their outcome and hence no patient harm caused. Nationally, 683 patients were waiting more than 52 weeks at the end of February 2016.

**8.0 Conclusion**

8.1 The Trust continues to experience difficulties in achieving the 4hr emergency access target, which is also reflective of a very difficult national context, and these challenges continue into the achievement of other key outcome standards. In terms of the overall compliance against the main national indicators our performance relative to the national picture is as presented in the table below, and demonstrates that whilst there is significant work to do, there are areas that we continue to deliver against, and remain committed to doing so, whilst also recovering the position in those where we are non-compliant.

**TRFT performance v National picture**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>TRFT Performance</th>
<th>National Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4hr emergency access</td>
<td>Mar’16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 62 day waits</td>
<td>Feb’16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 wk RTT Incompletes</td>
<td>Mar’16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 week wait diagnostics</td>
<td>Mar’16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Report: Workforce Report

Presented by: Cheryl Clements – Director of Workforce
Author(s): Paul Ferrie – Deputy Director of HR

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

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

Risk Reference:
BAF: B6, B7 & B8
Corporate Risk Register: 3060, 3287, 990, 4218, 4176

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

Summary of Key Points:
- Another reduction in monthly sickness rate (March – 4.25%); as twelve month annual rate falls to 4.44%.
- Recruitment and retention of registered nurses remains problematic
- Continuing improvement in MAST compliance, though backlog with Information Governance in last two months
- Ethnic minority groups take opportunity to progress careers within Trust

Board action required:
For noting
1.0 Bank & Agency Usage

1.1 Agency cost for March 2016 were £1,338K (previous month £1,370K) while the cost of bank staff was £386K (previous month £367K). Agency costs remain a concern.

1.2 The reduction in agency costs in Surgery is due to a reconciliation issue caused by the fact that prior to August, figures had to be estimated and have since been re-adjusted now that accurate information is available. Finance cannot change previous month’s data.

1.3 Elsewhere, there have been rises in agency costs in Corporate Services, Emergency Care and Family Health. In Medicine, the trend is for a fall in agency costs matched by a gradual rise in bank costs.

2.0 Workforce Development

2.1 The main recruitment challenge remains the ability to attract and retain registered nurses. Registered nursing shortages particularly in Integrated Medicine (c60 FTE below establishment)

2.2 Despite extensive recruitment, including from overseas, we are around 15FTE short of the overall target for registered nurses at 31st March 2016; based on last year’s planning submission. The Recruitment & Retention focus group will be reviewing the 2016/17 nurse workforce requirements with Divisions and Head of Nursing/Clinical Professions.

2.3 We will also need to consider whether budget establishments as held in ESR should form the basis of our projections for year 1 of any new plan. The Chief Nurse, Director of Finance and Deputy Director of HR held a review panel with all Divisions to review and sign off their ward based establishments following the recent Safer Nursing Care Tool exercise.

2.4 This year’s deadline for submission of workforce projections to Yorks. & Humber HEE will be the end of June 2016. It is essential, both in terms of informing national and regional education and training plans and ensuring this Trust’s workforce demands are met, that TRFT obtain the contributions of senior staff at departmental and divisional level and consolidate them all into the final submission.

2.5 The same group (identified in 2.4) must take the opportunity to review the progress of the workforce plan at regular intervals (at least quarterly) and that practical actions are being taken to ensure the plan is either carried out as indicated or whether it needs to be amended at any point.

3.0 Turnover

3.1 The Trust’s rolling turnover remains around 10.60% for the last 12 months, during the month the number of starter and leavers remained approximately neutral (38.59wte starters v 38.90 wte leavers).

3.2 The number of leavers in the qualified nursing group slightly outstripped the starters in the past month, indicative of general retention problems in this group.
4.0 Recruitment

4.1 A number of recruitment campaigns are being managed by the team in addition to the normal activity:

- Apprentice Healthcare – start date at the beginning of May
- HCSW campaign – start date 20th June
- Radiologists
- Physiotherapists
- Midwifes
- Emergency Centre

4.2 From the overseas recruitment campaigns the Trust currently have the following Nurses employed at the Trust. The retention rate for our overseas nurse workforce is highlighted below and demonstrates the Trust’s good track record in assimilating the nurses into TRFT.

<table>
<thead>
<tr>
<th>Croatia</th>
<th>Spain</th>
<th>Romania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake Sep 2015</td>
<td>Intake Feb-May</td>
<td>Intakes March 2015- March 2016</td>
</tr>
<tr>
<td>17 recruits</td>
<td>2015</td>
<td>67 recruits</td>
</tr>
<tr>
<td>16 still here (94%)</td>
<td>16 recruits</td>
<td>60 still here (89.5%)</td>
</tr>
<tr>
<td></td>
<td>12 still here (75%)</td>
<td>3 band 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 band 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 band 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30 band 5</td>
</tr>
</tbody>
</table>

5.0 Sickness Absence

5.1 Overall 2015/16 sickness rate for the whole Trust stands at 4.44%, with the monthly sickness rate for March 2016 at 4.25% (down from 4.91% in February). Divisional sickness generally shows a fall as well in the last month, with the exception of Integrated Medicine (5.30%) and Emergency Care (5.22%).

5.2 TRFT sickness remained at average levels compared to other local organisations as assessed by I-view in November 2015.

5.3 The HR Advisors are involved with WHWB looking at Stress Assessments and Wellbeing strategy as stress related illness accounts for 23-26% of all absence reasons each month.

5.4 Throughout the last financial year 2015/16, each comparative month had an improved sick absence performance.

5.5 Table - Monthly Comparison of Sickness Absence
6.0 **Mandatory and Statutory Training**

6.1 Dementia is ahead of the three year trajectory (plan to train 80% by the 31st March 2018).

6.2 Prevent target is to train 100% staff by 31/03/17 (target 66.6% by 31/3/16) so ahead in Clinical Support Services and Family Health.

6.3 EC remains a concern as still behind on Conflict Resolution, E&D, Fire, IG and Prevent. The Division attended the SWC and are developing a plan to enable staff to attend training.

6.4 Two e-learning planned drop in sessions were arranged in the Community teams via the Community matron and Locality leads.

6.5 The new Silver Adults e-learning package has been very well received with over 335 completions in 4 weeks.

6.6 E learning drop in sessions continue to be well attended at Woodside and the Trust will continue to run.

6.7 **Current MAST Compliance**

<table>
<thead>
<tr>
<th>Division</th>
<th>Conflict Resolution</th>
<th>Dementia Awareness</th>
<th>Equality and Diversity</th>
<th>Fire Safety</th>
<th>Information Governance</th>
<th>PREVENT</th>
<th>Resuscitation</th>
<th>Adult Safeguarding (level 2 and above)</th>
<th>Child Safeguarding (level 2 and above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Services</td>
<td>82.57%</td>
<td>82.42%</td>
<td>85.22%</td>
<td>79.78%</td>
<td>87.45%</td>
<td>65.13%</td>
<td>59.21%</td>
<td>49.16%</td>
<td>59.76%</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>90.59%</td>
<td>78.16%</td>
<td>87.80%</td>
<td>81.51%</td>
<td>86.30%</td>
<td>84.90%</td>
<td>84.55%</td>
<td>76.24%</td>
<td>76.01%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>53.85%</td>
<td>48.08%</td>
<td>74.52%</td>
<td>50.48%</td>
<td>56.25%</td>
<td>41.83%</td>
<td>66.03%</td>
<td>31.50%</td>
<td>57.14%</td>
</tr>
<tr>
<td>Family Health</td>
<td>89.86%</td>
<td>65.04%</td>
<td>75.68%</td>
<td>60.86%</td>
<td>73.53%</td>
<td>72.81%</td>
<td>58.23%</td>
<td>46.05%</td>
<td>78.35%</td>
</tr>
<tr>
<td>Medicine</td>
<td>74.71%</td>
<td>61.91%</td>
<td>65.27%</td>
<td>69.05%</td>
<td>67.05%</td>
<td>57.71%</td>
<td>70.53%</td>
<td>44.28%</td>
<td>50.84%</td>
</tr>
<tr>
<td>Surgery</td>
<td>74.68%</td>
<td>67.92%</td>
<td>80.26%</td>
<td>74.79%</td>
<td>71.14%</td>
<td>63.20%</td>
<td>78.48%</td>
<td>56.17%</td>
<td>64.93%</td>
</tr>
<tr>
<td>Total</td>
<td>79.13%</td>
<td>69.61%</td>
<td>78.31%</td>
<td>72.72%</td>
<td>75.61%</td>
<td>66.97%</td>
<td>71.07%</td>
<td>51.48%</td>
<td>64.56%</td>
</tr>
</tbody>
</table>

7.0 **Diversity**

7.1 Staff from black and Asian ethnic backgrounds are particularly well represented at band 5 level in the organisation in proportion to their numbers in the organisation.
51% of all Asian staff and 46% of all staff from a black background are at that level compared to 18.5% of all white British staff.

7.2 By contrast, almost 35.7% of white British staff are on bands 2 to 3 compared to 13% of Asian and 7.7% of all black staff.

7.3 The White Other group consists largely of recent nursing recruits from Europe at band 5, though some are currently awaiting pin numbers and are on band 3.

7.4 This suggests ethnic minority groups have taken the opportunity to progress their careers in this organisation, although staff of Pakistani origin are still under-represented in the workforce compared to the local population.

7.5 Broad ethnicity by Agenda for Change pay band March 2016

<table>
<thead>
<tr>
<th>Pay Band</th>
<th>Asian</th>
<th>Black</th>
<th>Chinese</th>
<th>Mixed</th>
<th>Other/Not Known</th>
<th>White - Other</th>
<th>White British</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>5</td>
<td>7.14%</td>
<td>4</td>
<td>10.26%</td>
<td>0.00%</td>
<td>1.50%</td>
<td>2.41%</td>
<td>191</td>
</tr>
<tr>
<td>Band 2</td>
<td>8</td>
<td>9.52%</td>
<td>3</td>
<td>17.60%</td>
<td>25.00%</td>
<td>11.76%</td>
<td>6.25%</td>
<td>211</td>
</tr>
<tr>
<td>Band 3</td>
<td>3</td>
<td>3.57%</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>3.76%</td>
<td>4.31%</td>
<td>519</td>
</tr>
<tr>
<td>Band 4</td>
<td>5</td>
<td>5.05%</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>331</td>
</tr>
<tr>
<td>Band 5</td>
<td>43</td>
<td>51.13%</td>
<td>16</td>
<td>18.15%</td>
<td>0.00%</td>
<td>5.36%</td>
<td>14.95%</td>
<td>287</td>
</tr>
<tr>
<td>Band 6</td>
<td>10</td>
<td>11.90%</td>
<td>7</td>
<td>17.35%</td>
<td>50.00%</td>
<td>11.76%</td>
<td>6.25%</td>
<td>177</td>
</tr>
<tr>
<td>Band 7</td>
<td>4</td>
<td>4.76%</td>
<td>6</td>
<td>15.30%</td>
<td>0.00%</td>
<td>3.76%</td>
<td>4.31%</td>
<td>504</td>
</tr>
<tr>
<td>Band 8a</td>
<td>3</td>
<td>3.57%</td>
<td>1</td>
<td>2.56%</td>
<td>17.60%</td>
<td>5.36%</td>
<td>1.08%</td>
<td>145</td>
</tr>
<tr>
<td>Band 8b</td>
<td>1</td>
<td>1.19%</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>48</td>
</tr>
<tr>
<td>Band 8c</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>4</td>
</tr>
<tr>
<td>Band 8d</td>
<td>1</td>
<td>1.19%</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>4</td>
</tr>
<tr>
<td>Band 9</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>84</td>
<td>100.00%</td>
<td>39</td>
<td>100.00%</td>
<td>48.00%</td>
<td>17.00%</td>
<td>12.00%</td>
<td>3716</td>
</tr>
</tbody>
</table>

8.0 Occupational Health and Wellbeing

8.1 There has been an increase in counselling referrals, counselling appointments and physio referrals this month. (See table below)

8.2 H&W&B reintroduced MOTs last month which has shown an increase in activity from Feb to March.

8.3 Highest level of income generated in March 2016 at £6,881.

8.4 Occupational Health & Wellbeing activity to March 2016
<table>
<thead>
<tr>
<th>Week/Year</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-16</th>
<th>Feb-16</th>
<th>Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Invoiced</td>
<td>£2,550.00</td>
<td>£4,034.00</td>
<td>£4,052.00</td>
<td>£4,080.00</td>
<td>£2,099.00</td>
<td>£3,191.00</td>
<td>£5,125.00</td>
<td>£3,045.00</td>
<td>£2,056.00</td>
<td>£4,101.00</td>
<td>£4,017.00</td>
<td>£8,881.00</td>
</tr>
<tr>
<td>TRFT Mgr Refs</td>
<td>106</td>
<td>82</td>
<td>116</td>
<td>61</td>
<td>68</td>
<td>73</td>
<td>73</td>
<td>67</td>
<td>54</td>
<td>72</td>
<td>82</td>
<td>12</td>
</tr>
<tr>
<td>Referred by Mgr</td>
<td>105</td>
<td>81</td>
<td>116</td>
<td>61</td>
<td>68</td>
<td>73</td>
<td>73</td>
<td>67</td>
<td>53</td>
<td>71</td>
<td>82</td>
<td>12</td>
</tr>
<tr>
<td>Referred by Self</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Waiting Time</td>
<td>2 Wks</td>
<td>2 Wks</td>
<td>1.5 Wks</td>
<td>4 Wks</td>
<td>4 Wks</td>
<td>3 Wks</td>
<td>4 Wks</td>
<td>1 to 2 Wks</td>
<td>2 to 3 Wks</td>
<td>3 Wks</td>
<td>2 Wks</td>
<td>2 Wks</td>
</tr>
<tr>
<td>TRFT Physio Referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
<td>37</td>
<td>18</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>TRFT Counselling Refs</td>
<td>34</td>
<td>20</td>
<td>23</td>
<td>25</td>
<td>12</td>
<td>34</td>
<td>19</td>
<td>32</td>
<td>22</td>
<td>22</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Counselling Sessions</td>
<td>79</td>
<td>74</td>
<td>85</td>
<td>99</td>
<td>55</td>
<td>97</td>
<td>73</td>
<td>116</td>
<td>64</td>
<td>77</td>
<td>60</td>
<td>90</td>
</tr>
<tr>
<td>Waiting time for Counselling session</td>
<td>3-4 Wks</td>
<td>3-4 Wks</td>
<td>5 Wks</td>
<td>3 Wks</td>
<td>4-6 Wks</td>
<td>4-6 Wks</td>
<td>2-3 Wks</td>
<td>1 Wks</td>
<td>2 Wks</td>
<td>1-2 Wks</td>
<td>2 Wks</td>
<td>2 Wks</td>
</tr>
<tr>
<td>Waiting time Counselling 20 min assess</td>
<td>1 Wk</td>
<td>1 Wk</td>
<td>1 Wk</td>
<td>2 Wks</td>
<td>2 Wks</td>
<td>4 Wks</td>
<td>2-3 Wks</td>
<td>1-2 Wks</td>
<td>1 Wk</td>
<td>2 Wks</td>
<td>1 Wk</td>
<td>2 Wks</td>
</tr>
<tr>
<td>External Manager Referrals</td>
<td>36</td>
<td>35</td>
<td>40</td>
<td>54</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOTs carried out</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>33</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>MOTs DNA/Late Cancelled</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Paul Ferrie  
Deputy Director of HR  
April 2016
**Report:** Governance Report

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

**Author(s):** As above

**Strategic Objective:** Governance: Trusted, open governance

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

**Risk Reference:**
- BAF: B10, B12, B13
- Corporate Risk Register: 3509, 3908

### Purpose of this paper:

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

### Summary of Key Points:

- Progress has been made with the annual internal audit plan, with most work having now been completed, or is in the process of finalising
- After much anticipation, NHSI now in existence
- Annual Plan submission deadlines pushed back
- IG Toolkit submission complete

### Board action required:

For noting.
1. Introduction

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

2. Internal Audit

2.1 Progress against the current year internal audit work plan has changed since last month as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Final Report Issued</td>
<td>32%</td>
<td>30.8%</td>
<td>38.5%</td>
<td>42.3%</td>
<td>48%</td>
<td>100%</td>
</tr>
<tr>
<td>Draft Report Issued</td>
<td>4%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>3.8%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>Planned work</td>
<td>40%</td>
<td>42.3%</td>
<td>42.3%</td>
<td>19.2%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>Work in progress</td>
<td>24%</td>
<td>19.2%</td>
<td>11.5%</td>
<td>34.6%</td>
<td>28%</td>
<td>0%</td>
</tr>
</tbody>
</table>

2.2 At the time of writing, the Internal Auditor's portal is reporting that all outstanding work for 2015/16 has been completed.

As reported to the Audit Committee, there has been some positive movement relating to the number of open (or awaiting audit approval) recommendations to date, with four outstanding recommendations of more than 12 months old, and seven of more than six months old. These relate to old legacy audits, and are again being considered.

2.3 Total numbers of outstanding 2015/16 recommendations (including those recently issued) are shown in the table immediately below and include recommendations from audits recently finalised.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority 1 recommendations</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Priority 2 recommendations</td>
<td>35</td>
<td>35</td>
<td>18</td>
<td>28</td>
<td>30</td>
<td>18</td>
</tr>
<tr>
<td>Priority 3 recommendations</td>
<td>25</td>
<td>25</td>
<td>18</td>
<td>22</td>
<td>20</td>
<td>19</td>
</tr>
</tbody>
</table>

2.4 The three outstanding priority 1 recommendations relate to:
Data Quality – Mortality Reporting (x1)
Clinical Administration Systems (x1)
Human Resources Agency Staffing (x1; down from x2 last month)

2.5 At the time of writing, four reports have been finalised since the last report to Board:
Review of Change Control (reasonable assurance), Board Assurance Framework (reasonable assurance), IG Toolkit (limited assurance) and CQC Compliance Review (advisory only).
3. **Information Governance**

3.1 A full report on information governance matters and the end of year IG Toolkit submission is provided elsewhere on the agenda in the SIRO / IG Toolkit annual report.

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

4. **NHS Improvement**

4.1 This new organisation (formally Monitor and the Trust Development Authority) came into existence on 1 April 2016.

4.2 NHSI has announced that it is working with the Kings Fund to help NHS Providers develop cultures that are continuously improving. The programme is taking place in three phases over the next two years that include diagnosis, design and implementation. Three pilot Trusts are taking part – Central Manchester University Hospital NHS FT, Northumbria Healthcare NHS FT and East London NHS FT.

4.3 A national whistleblowing policy has now been established which aims to support staff who have concerns that they may wish to raise. The incoming Director of Workforce will be reviewing the national document, a copy of which can be found [here](#), to ensure that the Trust’s own documentation meets requirements.

4.4 The Trust’s annual operating plan was due to be submitted on 11 April 2016. However, shortly before the proposed deadline, NHSI advised that the submission deadline had been moved to 18 April 2016. The Plan was submitted on deadline date.

4.5 The deadline for agreement of the Annual Contract was 31 March 2016. Any Trust that has not signed off their Contract by 25 April 2016 will need to enter arbitration.

5. **Miscellaneous matters**

5.1 A period of purdah for the local and EU elections began on 15 April 2016 and will end on 24 June 2016.

6. **Conclusion**

6.1 It is evident that regulators are responding to the challenges in the sector and it is critical that the Trust’s governance processes are robust and resilient to respond, in a timely manner, to the changes that are being made in the regulatory environment.
The following provides details of some of the work undertaken by the Information Governance department and myself for the period 1 March 2016 – 31 March 2016. I will update this on a monthly basis for information.

<table>
<thead>
<tr>
<th>Category</th>
<th>1 to 31\textsuperscript{st} March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOI requests received by the Trust</td>
<td>48</td>
</tr>
<tr>
<td>FOI requests answered by the Trust</td>
<td>33</td>
</tr>
<tr>
<td>FOI reviews (requested by submitter) requested</td>
<td>0</td>
</tr>
<tr>
<td>FOI reviews (requested by submitter) answered</td>
<td>0</td>
</tr>
<tr>
<td>IG breaches reported through Datix</td>
<td>18</td>
</tr>
<tr>
<td>IG breaches reported through Datix requiring investigation</td>
<td>7</td>
</tr>
<tr>
<td>IG Datix investigations completed</td>
<td>2</td>
</tr>
<tr>
<td>IG Datix incidents requiring further action after investigation</td>
<td>5</td>
</tr>
<tr>
<td>IG breaches reported through SIRI</td>
<td>0</td>
</tr>
<tr>
<td>Enquiries received from ICO</td>
<td>0</td>
</tr>
<tr>
<td>Decision notices received from the ICO in favour of the Trust</td>
<td>0</td>
</tr>
<tr>
<td>Of those above, number that have gone on to Tribunal (decision due approx., end of December)</td>
<td>0</td>
</tr>
<tr>
<td>Number of colleagues NOT compliant with IG MAST</td>
<td>1283</td>
</tr>
<tr>
<td>Additional, non-statutory IG training sessions taken place</td>
<td>3</td>
</tr>
<tr>
<td>Number of colleagues attending the above</td>
<td>69</td>
</tr>
<tr>
<td>Number of colleagues attending corporate induction and receiving IG training</td>
<td>44</td>
</tr>
</tbody>
</table>
Overview:

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

- Delivery against the planned deficit;
- Delivery against the capital programme.
- The financial sustainability risk rating.

Conclusions:

- Prior to audit a £8,625K deficit to the end of March 2016, which is £6,701K adverse to the planned deficit.
- Financial sustainability risk rating of 1 against the plan of 2.
- An underspend at the year-end on the capital programme of £0.6m, £13.5m spend against a capital plan of £14.1m.
- Year-end cash balance of £3.7m
- CIP delivery of £12.6m, £0.3m below the annual target of £12.9m.
1. Introduction and Context

1.1 This paper provides Finance & Performance Committee with an update on performance against the Trust’s key financial duties, namely:

- Delivery against the planned deficit;
- Delivery against the capital programme;
- The financial sustainability risk rating.

2. Key Financial Duties

2.1 The following table summarises the financial position:

<table>
<thead>
<tr>
<th>Financial Duty</th>
<th>March Plan £m</th>
<th>March Actual £m</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering the Planned Deficit</td>
<td>(1.924)</td>
<td>(8.625)</td>
<td>R</td>
</tr>
<tr>
<td>Achieving the Capital Plan (Original)</td>
<td>14.113</td>
<td>13.491</td>
<td>A</td>
</tr>
<tr>
<td>Achieving the Capital Plan (Revised)</td>
<td>14.113</td>
<td>13.491</td>
<td>A</td>
</tr>
</tbody>
</table>

- Prior to the year-end audit, a £8,625K deficit to the end of March 2016, which is £6,701K adverse to the planned deficit.
- Financial sustainability risk rating of 1 against the plan of 2.
- An underspend at the year-end on the capital programme of £0.6m, £13.5m spend against a capital plan of £14.1m.
- Year-end cash balance of £3.7m
- CIP delivery of £12.6m, £0.3m below the annual target of £12.9m.
3. Financial Position (Month 12 – March 2016)

3.1 The month 12 results may be summarised as follows and as detailed in the Appendices:

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Actual</th>
<th>Better (Worse) than Plan</th>
<th>Description</th>
<th>Plan</th>
<th>Actual</th>
<th>Better (Worse) than Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17,745</td>
<td>18,676</td>
<td>930</td>
<td>Clinical</td>
<td>220,346</td>
<td>221,580</td>
<td>1,234</td>
</tr>
<tr>
<td>665</td>
<td>706</td>
<td>41</td>
<td>Research &amp; Development &amp; Education</td>
<td>6,578</td>
<td>6,910</td>
<td>332</td>
</tr>
<tr>
<td>888</td>
<td>1,546</td>
<td>658</td>
<td>Other</td>
<td>11,434</td>
<td>12,500</td>
<td>1,066</td>
</tr>
<tr>
<td>19,298</td>
<td>20,927</td>
<td>1,629</td>
<td>TOTAL INCOME</td>
<td>238,358</td>
<td>240,989</td>
<td>2,631</td>
</tr>
<tr>
<td>Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12,475</td>
<td>12,176</td>
<td>299</td>
<td>Pay - In Post</td>
<td>154,974</td>
<td>145,280</td>
<td>9,695</td>
</tr>
<tr>
<td>15</td>
<td>386</td>
<td>(371)</td>
<td>Pay - Bank</td>
<td>164</td>
<td>4,182</td>
<td>(4,018)</td>
</tr>
<tr>
<td>660</td>
<td>1,269</td>
<td>(610)</td>
<td>Pay - Agency</td>
<td>3,195</td>
<td>15,540</td>
<td>(12,345)</td>
</tr>
<tr>
<td>3,648</td>
<td>4,449</td>
<td>(801)</td>
<td>Drugs &amp; Clinical Supplies</td>
<td>43,667</td>
<td>45,908</td>
<td>(2,241)</td>
</tr>
<tr>
<td>2,584</td>
<td>3,289</td>
<td>(705)</td>
<td>General Supplies</td>
<td>28,491</td>
<td>29,733</td>
<td>(1,242)</td>
</tr>
<tr>
<td>1,256</td>
<td>561</td>
<td>(695)</td>
<td>Other</td>
<td>1,805</td>
<td>164</td>
<td>(1,970)</td>
</tr>
<tr>
<td>18,126</td>
<td>21,009</td>
<td>(2,883)</td>
<td>TOTAL EXPENDITURE</td>
<td>228,686</td>
<td>240,806</td>
<td>(12,120)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>1,654</td>
<td>(1,479)</td>
<td></td>
<td>7,938</td>
<td>183</td>
<td>(7,755)</td>
</tr>
<tr>
<td>(815)</td>
<td>(41)</td>
<td>(773)</td>
<td>Financing Costs</td>
<td>(9,862)</td>
<td>(8,808)</td>
<td>1,055</td>
</tr>
<tr>
<td>839</td>
<td>134</td>
<td>(705)</td>
<td>SURPLUS/(DEFICIT) - Excluding Impairment</td>
<td>(1,924)</td>
<td>(8,625)</td>
<td>(6,701)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Impairment of Assets &amp; Donated Asset treatment</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>839</td>
<td>134</td>
<td>(705)</td>
<td>SURPLUS/(DEFICIT)</td>
<td>(1,924)</td>
<td>(8,625)</td>
<td>(6,701)</td>
</tr>
</tbody>
</table>

3.2 In the month of March 2016 the Trust delivered a surplus of 134k against a planned surplus of £839K; an adverse variance of £705K. Cumulatively, this results in a deficit of £8,625K; adverse to plan by £6,701K.

3.3 The attached graph shows how the Trust’s financial performance on its income and expenditure account during the 2015/16 financial year.

3.4 The key reasons for the variances are:
Income

- Patient care income is £934K better than plan in month and now £1,234K better than plan cumulatively, but was significantly below forecast in the Surgery Division (Orthopaedics and General Surgery).
- Cumulatively, elective activity continues to under-perform (-£770K) which is being offset by over-performance on non-elective activity (+£2,433K).
- Non-PbR income continues to exceed plan year to date by £1,627K although a significant proportion of this is being driven by excluded drugs which simply represents an offset to expenditure.
- Other income has improved significantly in month (+£658K) as a result of increased recharges.

Pay

- Pay costs are again significantly above budget in March 2016 (£682k) and year to date (£6,668k). This is as a consequence of two factors namely; continuing reductions in budgets as the cost improvement phasing increases together with increased levels of expenditure.
  - The Trust continues to see bank and agency costs above the levels seen 12 months ago, with the main cost pressure being shown within medical staff as opposed to nursing staff, including healthcare assistants and other support staff.
  - Bank and agency spend as shown in the following charts has increased significantly in both absolute cost terms and as a percentage of total pay since April 2014. At the beginning of the 2014/15 financial year the Trust was spending approximately £800K per month on non-substantive staffing, representing c. 6% of the total pay cost. The average for the 2015/16 financial year is c. 12%.
The above chart shows that the pay costs in year have been relatively stable on a monthly basis. The presentation on the outputs of the Carter report will provide further information as to how these costs benchmark against other providers and a selected peer group.

- The Trust has been set a target by Monitor to reduce its agency expenditure for nursing staff to 8% for the last six months of the financial year, which has been challenging as demand increases throughout the winter period and the Trust has already opened up additional bed capacity. Initiatives have been put in place to encourage greater use of bank staffing and the Trust is working with Talent, the contractor for the master vendor arrangement, for the hiring of nurse agency staffing.

Performance against Monitor’s nursing agency target for the six months ending March 2016 is 6.5%. Cumulatively for the year this ratio is 6.88%, which was ahead of the 8% target.

**Non-Pay**

- Non-pay costs are £75,805 against a budget of £70,353 resulting in a £5,452K adverse position for the year.

4. **Cost Improvement Programme**

4.1. The table below shows the year end position against the Cost Improvement Programme. This shows a delivery of almost £12.6m against a target of £12.9m, which reflects 5.3% of turnover compared to a sector average of 3.1%.

<table>
<thead>
<tr>
<th>Divisions</th>
<th>Plan £000</th>
<th>Actual £000</th>
<th>Var. £000</th>
<th>Plan £000</th>
<th>Actual £000</th>
<th>Var. £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>81</td>
<td>51</td>
<td>-30</td>
<td>679</td>
<td>525</td>
<td>-154</td>
</tr>
<tr>
<td>Medicine -Integrated Medicine</td>
<td>384</td>
<td>398</td>
<td>15</td>
<td>2,669</td>
<td>3,180</td>
<td>511</td>
</tr>
<tr>
<td>Surgery</td>
<td>798</td>
<td>473</td>
<td>-315</td>
<td>3,476</td>
<td>2,950</td>
<td>-526</td>
</tr>
<tr>
<td>Family Health</td>
<td>297</td>
<td>220</td>
<td>-77</td>
<td>1,835</td>
<td>1,313</td>
<td>-522</td>
</tr>
<tr>
<td>Diagnostics &amp; Support</td>
<td>321</td>
<td>665</td>
<td>345</td>
<td>2,233</td>
<td>1,343</td>
<td>-890</td>
</tr>
<tr>
<td>Corporate</td>
<td>258</td>
<td>415</td>
<td>157</td>
<td>2,047</td>
<td>3,261</td>
<td>1214</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>2,130</strong></td>
<td><strong>2,223</strong></td>
<td><strong>93</strong></td>
<td><strong>12,940</strong></td>
<td><strong>12,572</strong></td>
<td><strong>-368</strong></td>
</tr>
</tbody>
</table>
5. Year End Position

5.1. The year-end position, prior to audit, of a £8.6m deficit, £6.7m adverse to plan. This has deteriorated from the position reported last month for 2 main reasons;

- Deterioration in Surgical activity against forecast– the reasons behind this will be verbally updated to the Board
- Balance Sheet amendments

5.2. Whilst this position is disappointing this does reflect a number of successful actions implemented, these include;

- Significant reduction in the use of corporate interims
- Enhanced controls of discretionary spend
- Improved clinical coding in Q3 as part of the recovery plan
- CIP progress delivery of £12.6m target
- Reduced levels of health care assistant / nursing support agency spend

5.3. The key drivers for this revised position can be summarised as follows;

<table>
<thead>
<tr>
<th>Description</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/16</td>
<td></td>
</tr>
<tr>
<td>Gross variance to plan</td>
<td>(6,701)</td>
</tr>
<tr>
<td>Loss of clinical income due to non coded episodes</td>
<td>(1,400)</td>
</tr>
<tr>
<td>Cost Pressures and CIP shortfall against plan</td>
<td>(1,558)</td>
</tr>
<tr>
<td>Workforce, including premium costs of non contracted staff</td>
<td>(5,115)</td>
</tr>
<tr>
<td>Over performance on activity nett of costs</td>
<td>1,372</td>
</tr>
<tr>
<td></td>
<td>(6,701)</td>
</tr>
</tbody>
</table>

5.4. Clearly, the most significant factor impacting on the position has been the increased use and reliance on premium pay. The level of spend is not sustainable and the Trust needs to see a reduced level of expenditure to support the 2016/17 financial plan.

5.5. The reliance on premium pay (year-end of £15.6m) has been as a consequence of a number of factors, but namely;

5.5.1. Consultant and middle grades vacancies in specialities such as Emergency Care, Dermatology and Gastroenterology
5.5.2. Registered nurse vacancies across clinical areas and the requirement to use agency staff in the absence of an internal bank.
5.5.3. Additional A&C/Senior Manager support to fill key vacancies and/or deliver specific projects.

5.6. Whilst clinical coding has had its challenges in the first half of the year, the current performance is excellent, with the freeze dates hit for November, December and January activity (and a quickly reducing backlog)

6. Working Capital and Cash

6.1. The chart below shows the latest cash position against the plan; £3.6m out-turn compared to a plan of £3.2m. The Trust’s under-performance on its income and expenditure account is adversely affecting the overall level of cash balances held, which is being offset by the small under-spend on capital expenditure (see Section 7 below).
6.2. The consequences of the financial performance in 2015/16 is that a far greater amount of the loan received in 2015/16 has been used to support the 2015/16 capital plan.

7. Capital

7.1. As discussed at the July Committee, the Trust revised the profile of the capital programme after results were reported for the first quarter of the financial year. Performance for March 2016 and to the year-end against the revised plan is shown in the table below.

<table>
<thead>
<tr>
<th>In Month</th>
<th>Forecast Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td>EK</td>
<td>EK</td>
</tr>
<tr>
<td>75</td>
<td>232</td>
</tr>
<tr>
<td>1,010</td>
<td>773</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0</td>
<td>98</td>
</tr>
<tr>
<td>1,085</td>
<td>1,151</td>
</tr>
<tr>
<td>19</td>
<td>265</td>
</tr>
<tr>
<td>30</td>
<td>459</td>
</tr>
<tr>
<td>92</td>
<td>1,335</td>
</tr>
<tr>
<td>150</td>
<td>0</td>
</tr>
<tr>
<td>1,376</td>
<td>3,210</td>
</tr>
</tbody>
</table>

7.2. The year-end position shows that over 95% of the capital programme has been delivered, which reflects a positive position across the year, which has required flexibility across all programmes.

8. Next Steps and Recommendations

8.1. Board of Directors is recommended to:

- **Note** the contents of this report
Report: Care Quality Commission – Action Plan Report

Presented by: Ms Tracey L McErlain-Burns, Chief Nurse
Author(s): As above

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

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

Risk Reference:
- BAF: B1, B2, B6
- Corporate Risk Register: 3395, 4429, 4394, 3870, 4507, 990, 4176,

Purpose of this paper:
The purpose of this report is to provide detail by exception, on progress towards achieving the CQC improvement action plan.

Summary of Key Points:
The key points arising from the report are:
- The Board approved improvement action plan was scheduled to have been fully completed by 31 March 2016.
- A small number of actions are outstanding.
- The Chief Nurse will review the position in relation to the areas of risk, with the Medical Director and provide a verbal update at the Board meeting.
- The areas of greatest concern are: DNACPR, MCA due to the absence of the ward round proforma assurance tool, risk register review (especially in the division of integrated medicine), ward rounds in critical care and patient records.
- A number of mock inspections are being planned together with other activities to ensure that the Trust is ready for re-inspection.

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

1.1 The Care Quality Commission undertook two simultaneous inspections of the Trust in February 2015. As a consequence of the comprehensive inspection the Trust achieved a ‘Requires Improvement’ rating consistent with its self-assessment. Further, as a member of the Health and Social Care partnership accountable for the delivery of services to children in the Looked After and Safeguarding system the Trust is required to address a number of recommendations which when undertaken alongside actions being taken by other partners, will improve the consistency and quality of safeguarding services across the Borough.

1.2 Both inspections resulted in reports being published in July 2015 and these are accessible on the CQC and Trust websites. In addition the action plans subsequently signed off through Board and multi-agency governance arrangements\(^1\) are also available on the Trust website.

1.3 The CQC Improvement Action plan was designed to be delivered in full by 31 March 2016. Eight actions have been graded RED as at 15 April for the reasons described below.

2. **Update**

2.1 M1 – Training. All of the actions contained within M1 have been reported as taken, some only very recently and the evidence has not yet been provided in order to turn the action ‘blue’

<table>
<thead>
<tr>
<th>Training Subject</th>
<th>Jan 2015 position</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>15.3% of colleagues compliant</td>
<td>70.79%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>70.8%</td>
<td>72.38%</td>
</tr>
<tr>
<td>Safeguarding Adults L2</td>
<td>19.07%</td>
<td>52.83%</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>46.9%</td>
<td>62.65%</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>62.8%</td>
<td>74.47%</td>
</tr>
</tbody>
</table>

2.2 As with all requirements the evidence will be tested in a further round of mock inspections over the coming few weeks. These mock inspections will do two things; firstly they will seek assurance on the actions taken and secondly they will test our readiness for re-inspection. The mock inspections will be unannounced.

2.3 M2 – Mental Capacity Act. Whilst the specific actions have been progressed there are two significant risks relating to M2. Firstly there is no evidence that the ward round proforma has been adopted into practice and that significantly weakens the assurance that Mental Capacity is being considered in relation to each patient. Secondly, whilst the named nurse has worked with colleagues in the medical directors office to align MCA and DoLs awareness to DNACPR the delayed implementation of the SPICT tool also weakens the assurance of Mental capacity being considered. A verbal update will be reported at the Board following discussion with the Medical Director.

2.4 M3A – Nurse Staffing. The Board is aware of the evidence of actions through the Quality Report. There are two RED actions relating to M3A. The first arises because the Trust has not yet agreed maximum caseload sizes for community practitioners. Attempts to benchmark through local networks and NHS

\(^{1}\) Multi-agency sign off relates to the Children Looked After and Safeguarding Report.
Benchmarking have been largely unsuccessful. Therefore over the course of the four weeks professional judgement will be applied to agree maximum caseloads.

2.5 The second RED arises because the Trust did not achieve a maximum sickness absence rate of 4% by 31 March 2016 despite improvements compared to 2014/15, and specifically because some nursing teams have sickness absence rates significantly above 4%.

2.6 M3B – Medical Staffing. More recently the Quality Assurance Committee and Board have received medical staffing data and going forward this will be included in the monthly Quality Report in the same way as Nurse Staffing data is provided monthly.

2.7 Red flag shifts have been agreed but still need to be implemented in practice. Whilst the action has turned blue, this is because the red flag shifts have been agreed and the workforce coordinators are currently reporting them. To change practice, medical colleagues need to start reporting the shifts giving rise to patient and organisational risk.

2.8 Action M3B.5 is graded RED because the 2016/17 job plans were not agreed by 31 March 2016. This was an action agreed by the Board. More recently it has been agreed that job planning will be completed in quarter 1 of 2016/17.

2.9 M4 – DNACPR. This is an area of risk to the Trust. There are three RED actions. The Associate Medical Director has conducted a number of audits and provided feedback to clinicians and divisions but the deployment of the SPICT tool has stalled and as such the policy has not been further adjusted or launched at Grand Round. As with M2 this will be discussed with the Medical Director and a verbal update will be provided to the Board of Directors.

2.10 M5 – EMSA. The outstanding actions have now been completed. The standard operating procedure is complete and each in-patient area has been assessed against the guidance. In a small number of in-patient wards single gender toilet facilities can be achieved but the Trust cannot achieve single gender assisted bathrooms at this time. This position will need to be assessed annually and the opportunities to improve this position should be built into each and every in-patient refurbishment plan.

2.11 M6 – Out-patient validation. The validation trajectories have been reviewed by the Quality Assurance Committee. The evidence needs to be provided of clinicians reviewing the records of those patients who have been found to breach the contractual standards.

2.12 M7 – Children’s environments. A recent audit of the risk assessments demonstrates that they have all being reviewed.

2.13 M8 – Incident reporting. The incident improvement trajectory has been reviewed by the Quality Assurance Committee. There has been deterioration in performance in the past month after month-on-month improvement. Audits of the knowledge of lessons learnt are currently taking place by the patient safety team. The new Serious Incident management panel is in place and has been meeting weekly.

2.14 M9 – Risk registers. The corporate risk register is now embedded into the Trust Management Committee. All clinical divisions are using Datix to record their risks and the majority of corporate and executive directors have confirmed that all of their
risks are now captured on Datix. Some clinical divisions, especially the division of integrated medicine still have a large number of open risks on their register. The number of risks scoring 12 and above are discussed at each monthly performance meeting led by the Chief Operating Officer. The content of risk registers will be tested during the mock inspections. In addition the Chief Nurse is reviewing the opportunity to release patient safety resource to work with the division of integrated medicine to tidy up their risk register within 4 weeks.

2.15 M10 – MAST. There has been significant work undertaken by the Deputy Head of Nursing to facilitate community health services for adult colleagues being able to attend mandatory and statutory training. Supported by the Head of Learning and Development trainers have been going out to community teams on a regular basis and the training plan for 2016/17 is ready for approval by the Head of Nursing.

2.16 M11 – Patient records. Education, information and audit have been repeated throughout recent months. All but one action have been completed however there is a still a risk associated with this requirement because practice has either not changed in all areas, or not been consistently sustained in other areas. The single RED action relates to the fact that some divisions have recently cancelled meetings that the Director of Corporate Affairs was planning to attend. To address sustainability this is one example of actions that will be built into monthly practice audits.

2.17 M12 – Complaints. The specific actions have been taken however the evidence is that the Trust continues to under-achieve compliance with policy, specifically in relation to providing a timely response to complaints. The quality of the complaint response is improving and the majority of complaints now lead to defined actions with evidence of the action plan in the complaints investigation folder. There is improvement in the sensitivity of complaints management with an increase in the number of face-to-face meetings going along way to achieving this.

2.18 M13 – Healthcare associated infections. Action was taken very quickly to address the requirements. Those actions have been audited.

2.19 M14 – Unsafe medicine management. Immediate actions were taken and these have been further strengthened due to the recent audit findings. The relevant short-break service will be visited shortly to test the practices.

2.20 M15 – CASH and School Nursing. Pathways have been reviewed and implemented but audit evidence is lacking which is why there is a RED action. Recent meetings with School Nurses provide reassurance of the pathways being known in practice.

2.21 S1 – Emergency Department. As described in the Quality Report staffing levels across the division of emergency care have been reviewed. There are still risks in this area for two reasons; firstly vacancies and secondly the use of locum and agency colleagues. In relation to the latter long-term locums and agency colleagues are being booked and inducted. There is active recruitment to all vacancies. Since the inspection the service has moved into the former acute medical unit.

2.22 Systems for professional sign language interpretation is available have been tested and will be retested in the coming weeks.
2.23 S2 – Surgery. The 18 week referral to treatment pathway remains under review and performance is scrutinised at the monthly performance meetings. Since the inspection pathways through the trauma and orthopaedic unit and the elective orthopaedic unit have been revised and the movements that gave rise to concern during the inspection have been stopped.

2.24 Access and flow for patients attending the fracture clinic have been minimally improved on the basis of limitations caused by the building works. The division of planned care and surgery should undertake a further walk-through with a patient to review opportunities.

2.25 S3 – Critical Care. Access to evidence based guidelines and security of the unit has been achieved and tested several times.

2.26 Recent audit of ward rounds has demonstrated failure to meet the standard. The advice of the Medical Director is being sought and a verbal update will be provided at the Board.

2.27 S4 – Maternity. Guidelines for the severely ill woman have been reviewed; audit of processes involving Social Care have been carried out and actions taken. The number of delayed discharges has markedly reduced and there have been no delays in the past quarter. Access and flow through labour ward and the postnatal ward has been reviewed and new arrangements are in place for post-operative recovery.

2.28 The review of the newborn early warning system guidelines is incomplete and needs to be prioritised by the Divisional Director for completion and implementation within 4 weeks.

2.29 S5 – Children and Young People. The mechanisms for accessing internal safeguarding advice have been reviewed and safeguarding supervision has been strengthened. Leadership of the service has been improved by the appointment of a Deputy Head of Nursing who provides senior children’s nursing advice.

2.30 Transitional arrangements are being reviewed and will be strengthened following the recent development of the Children’s cross division Board which met for the first time in April.

2.31 S6 – Diagnostic and out-patients. Immediate action was taken to review sharps management. The policies were reviewed and communicated. These have been further visited in recent weeks following discovery of a different sharp-smart product in two clinical areas. In addition, the Trust has rolled out an increasing number of sharp safety devices.

2.32 S7 – several trust-wide matters. Information about how to make a complaint or raise a concern is now available, very visibly across the Trust and in different languages. A large number of colleagues have been trained to provide clinical supervision and a clinical supervisor of the day arrangement has been put in place. In addition Schwartz rounds have been held and de-briefs have been arranged following significant events.

2.33 All patients living with dementia should have a ‘this is me’ booklet and whilst the incidence of use is increasing there is more work to do. The Trust is actively engaging with the dementia cafes in Rotherham and all carers are being provided...
with the opportunity to provide feedback via the carers survey. More recently the site management office is using the forget me not flower to highlight patients with a diagnosis of dementia needing special consideration.

2.34 S8 – Community adult. Colleagues working in the adult community services frequently report much greater engagement and whilst not all of the IT connectivity problems have been fixed standard operating procedures are in place and colleagues from the Director of Health Informatics office have plans to improve IT access for all community based colleagues, not just those in adult services.

2.35 Surveys have been used to confirm that colleagues know how to report clinical incidents and access interpreter services.

2.36 S9 – End of Life Care. Colleagues working in the adult community services frequently report increased engagement not only pan-trust but also with the Hospice and hospice at home team. The individualised patient pathway has been rolled out. These arrangements will be tested in a mock inspection on 18 April led by the Assistant Chief Nurse.

2.37 S10 – Community in-patients. The extent to which patients in the Oakwood community unit can engage in activities has been transformed following the appointment of an activities co-ordinator. The range of activities is outstanding.

2.38 Delayed discharges are still a feature of the Trust as they will be in many; however the Trust has improved line of sight on each patient pathway not least because of the development of Sepia and a more proactive level of management and clinical engagement with adult social care.

2.40 S11 – Community health services for children. There are eight recommendations in S11. Access to safeguarding supervision via the safeguarding team has been strengthened. The substance misuse pathway has been reviewed. New templates for midwife to health visitor handover are now available on Systmone and being used. Audit has recently been undertaken but the evidence and results have not yet been shared with the Head of Governance.

2.41 The Early Attachment service has been reviewed and signed off through divisional governance arrangements. The service has been reviewed alongside Dr Lee from Tameside and training has been provided to colleagues based on the Solihull parenting programme.

2.42 The community health services for children team have received some investment in information technology and as referred in para 2.34 colleagues from the IT team are working with community based colleagues to improve levels of access.

2.43 S12 - Community health services for children. There are seven recommendations in S12. A review of access to CASH clinics has been undertaken and some changes have been made. Further changes will be made during the long summer holiday period.

2.44 The Trust will embark on a children and young people’s service transformation programme this year maximising the opportunity to take a consistent approach to engaging with children and young people. Template letters including how to access information in other languages have been developed but there is no audit to provide
assurance of use. This needs to be progressed by the service within the next 4 weeks.

2.45 Training for service leads on both risk management and complaints management has been provided. More recently following a mock inspection, weekly ‘fix it’ meetings are being held with School Nurses and Health Visitors to progress a range of day-to-day concerns.

2.46 Summit – School Nursing budget. The contract for services commissioned by the Local Authority Public Health Department has been reduced by 1.8%. The Trust anticipates that the 0-19 service will be put out to tender during 2016/17.

2.47 Summit – CAMHs. The paediatric liaison service is working very well. Engagement is strong and the Children’s Ward team are benefitting from a range of training.

2.48 Summit – Gastroenterology. The Trust has secured the support of Doncaster and Bassetlaw Trust for a period of six months or until such time as the Trust can recruit to a substantive consultant team.

2.49 Summit – Nurse staffing. Escalation was managed at the time. Only in April 2016 did the NMC confirm that they have commenced registration of the Croatian nurses.

2.50 Summit - In-patient paediatrics. The Trust has developed new ways of working and engaged the strategic clinical network in the evaluation. A separate report will be presented to the Board in May 2016.

2.51 Summit - MCA and DoLs. Training support was provided by RMBC. The Best Interest response is still under-developed.

2.52 Summit – Maternity. The Quality Assurance Committee has reviewed maternity outcomes and especially section rates and third degree tears. NHS England did support a request to develop a South Yorkshire Supervisor of Midwives (SoM) rota but this was not supported by local Trusts. The Trust continues to have a low number of SoM’s however did recently have a very good Local Supervisor of Midwives annual audit.

3. **Recommendations for Board of Directors approval**

3.1 There are no recommendations for approval.

4. **Next steps**

4.1 The visual story board is now being developed.

4.2 The development of a Quality Improvement Plan is being discussed by the executive team.

4.3 A round of mock inspections and other activities associated with being ready for re-inspection will take place in the next few weeks.

Tracey L McErlain-Burns, Chief Nurse – April 2016
Appendix 1 Progress to date – end of February 2016

<table>
<thead>
<tr>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action complete and evidence available</td>
</tr>
<tr>
<td>Action complete; evidence being compiled</td>
</tr>
<tr>
<td>Action on track; will progress to timescale</td>
</tr>
<tr>
<td>Action off track and subject to executive escalation</td>
</tr>
<tr>
<td>Not scheduled to have started yet.</td>
</tr>
</tbody>
</table>

Must Do Actions as at 31 March 2016

Should Do Actions at 31 March 2016
## CQC Improvement Action Plan Overview for Board of Directors

<table>
<thead>
<tr>
<th>Action No.</th>
<th>CQC Requirement and Action to Be Taken</th>
<th>Exec Lead</th>
<th>Delivery Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEW</strong> 1.1</td>
<td>A training needs analysis of each service in relation to the numbers of staff who require safeguarding, resuscitation, dementia awareness and Mental Capacity Act training / awareness will be carried out.</td>
<td>DoHR</td>
<td>A S O N D J F M 2015 2016</td>
</tr>
<tr>
<td>1.2</td>
<td>Once the level of training during 2015/16 is understood, a capacity analysis of the availability of Trust trainers will be carried out.</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td>1.3</td>
<td>The Corporate Workforce Committee will advise the Trust Management Committee on whether training needs can be met from additional training needs or not, and if not, solutions will be produced.</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td>1.4</td>
<td>Each division will lead a piece of work to plan staff release for training consistent with the needs analysis and capacity plans described above.</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td>1.5</td>
<td>The Executive Director of HR will lead a risk assessment of any other gaps in training from which a priority training plan for the remainder of 15/16 and 16/17 will be devised.</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td>1.6</td>
<td>The training plans will be monitored by the Corporate Workforce Committee monthly leading to suitable intervention if the plans de-rail.</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td>1.7</td>
<td>In relation to 3.18 the Trust will develop further training plans for colleagues caring for children and young people with mental illness.</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td><strong>NEW</strong> 1.8</td>
<td>Realign competencies in ESR(OLM) to ensure accurate reporting for both Safeguarding data and Resuscitation data</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td><strong>NEW</strong> 1.9</td>
<td>Action removed at Board of Directors meeting on 29 March 2016</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td><strong>NEW</strong> 1.10</td>
<td>Create training needs analysis of each service</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td><strong>NEW</strong> 1.11</td>
<td>Ensure Dementia / Safeguarding / Resuscitation are main focus areas</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td><strong>NEW</strong> 1.12</td>
<td>Carry out capacity analysis of trainers</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td><strong>NEW</strong> 1.13</td>
<td>If capacity of trainers is not sufficient, agenda at Corporate Workforce Committee</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
<tr>
<td><strong>NEW</strong> 1.14</td>
<td>Divisional Directors (General Managers) will plan how to release staff onto training</td>
<td>DoHR</td>
<td>J F M 2015</td>
</tr>
</tbody>
</table>

---

The Trust must ensure there are suitable arrangements in place to ensure all relevant staff receive appropriate training. This must include safeguarding adults and children, resuscitation, mental capacity awareness and living with dementia awareness.
<table>
<thead>
<tr>
<th>Action No.</th>
<th>CQC Requirement and Action to be Taken</th>
<th>Exec Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEW</strong> 1.15</td>
<td>Director of HR to carry out risk assessment on other gaps in MAST</td>
<td>DoHR</td>
</tr>
<tr>
<td><strong>NEW</strong> 1.16</td>
<td>Corporate Workforce Committee monitor training plans monthly at meeting</td>
<td>DoHR</td>
</tr>
</tbody>
</table>

**Key:**
- Action complete and evidence available
- Action complete; evidence being compiled
- Action on track; will progress to timescale
- Action off track and subject to executive escalation
- Not scheduled to have started yet.
- Indicates timescale within which action will be completed.
- No update received this month
<table>
<thead>
<tr>
<th>Action No.</th>
<th>CQC Requirement and Action to be Taken</th>
<th>Exec Lead</th>
<th>Delivery Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M2</strong></td>
<td>The Trust must ensure there are suitable arrangements in place for establishing and acting in accordance with the best interest of patients without the capacity to give consent and treatment in line with the requirements of the Mental Capacity Act (2005) and its associated Deprivation of Liberty Safeguards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>The Trust will recruit to a Band 4 MCA / Deprivation of Liberty Safeguards administrator by 31 July 2015.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>The Trust will provide each clinical area / community team with an MCA resource file.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>The Trust will undertake an MCA audit (involving the SAS doctors in conducting the audit) in October 2015.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>The Trust will hold two focus groups in September 2015; one of clinicians assessing capacity to consent and one of families. This will provide an opportunity to hear the voice of families and colleagues, and inform the planned audit.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>The Trust will publish the improvement journey in the 2015/16 annual safeguarding report.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>2.6</td>
<td>The Trust will develop a second level action plan based on audit findings.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong></td>
<td><strong>2.7</strong> Daily adult safeguarding support to the acute medical unit.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong></td>
<td><strong>2.8</strong> Inclusion of a question regarding any concerns with the patient’s capacity to consent in the ward round proforma.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong></td>
<td><strong>2.9</strong> Delivery of a dedicated awareness session in each medical ward and the surgical assessment unit by 31 March 2016.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong></td>
<td><strong>2.10</strong> The named nurse for adult safeguarding to be released from other activities (subject to risk assessment) in order to spend 2 days per week leading this requirement.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong></td>
<td><strong>2.11</strong> The named nurse for adult safeguarding to work with the associate medical director to align MCA and DoLs awareness to the plans for DNACPR (M4)</td>
<td>CN</td>
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<tr>
<td>Action No.</td>
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<tr>
<td><strong>M3</strong></td>
<td><strong>The Trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of patients.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A.1</td>
<td>A joint operations, HR and finance team will systematically work through coming to one version of the truth on staffing establishments for all clinical areas. For areas employing nurses / midwives, appropriate tools will be used and the establishments will be signed off by the Chief Nurse and reported to the Board.</td>
<td>DoHR &amp; CN</td>
<td></td>
</tr>
<tr>
<td>3A.2</td>
<td>Vacancies against establishment will be prioritised for recruitment based on a risk assessment and a recruitment plan will be generated. The risk assessment will be formally reviewed at the Trust Management Committee alternate months.</td>
<td>DoHR &amp; CN</td>
<td></td>
</tr>
<tr>
<td>3A.3</td>
<td>Changes in skill mix influenced by whether the Trust is able to recruit experienced staff, or not, will be formally risk assessed and influence the recruitment plan.</td>
<td>DoHR &amp; CN</td>
<td></td>
</tr>
<tr>
<td>3A.4</td>
<td>The Trust will appoint vendors for nursing agency staff and agree key performance measures which will be managed via regular business meetings.</td>
<td>DoHR &amp; CN</td>
<td></td>
</tr>
<tr>
<td>3A.5</td>
<td>The Trust will procure an e-roster system which will enable real time analysis of staffing and provide a valuable tool to achieve staffing management</td>
<td>DoHR &amp; CN</td>
<td></td>
</tr>
<tr>
<td>3A.6</td>
<td>The executive team will agree a set of HR / Workforce KPIs</td>
<td>DoHR &amp; CN</td>
<td></td>
</tr>
<tr>
<td>3A.7</td>
<td>The Trust will hold a Band 7 – sister / charge nurse two day event in September and use the event to provide training on budget management, staffing establishment reviews, the use of flexible staffing, risk assessment techniques, good people management etc. This will assist in addressing exit interview feedback about some people management practices.</td>
<td>DoHR &amp; CN</td>
<td></td>
</tr>
<tr>
<td>3A.8</td>
<td>All staffing establishments will be published at the entrance to wards / departments. These will be clearly dated and refreshed as a minimum, every 6 months.</td>
<td>DoHR &amp; CN</td>
<td></td>
</tr>
<tr>
<td>3A.9</td>
<td>The Trust will offer every person resigning from position the opportunity of an exit interview with a member of the Trust Management Committee (TMC)</td>
<td>DoHR &amp; CN</td>
<td></td>
</tr>
<tr>
<td>3A.10</td>
<td>The Trust will establish minimum and optimal staffing levels for all in-patient ward areas</td>
<td>DoHR &amp; CN</td>
<td></td>
</tr>
<tr>
<td>3A.11</td>
<td>The Trust will review School Nursing and Community Nursing caseloads using recommended tools and / or benchmarks</td>
<td>DoHR &amp; CN</td>
<td></td>
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<tr>
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<tr>
<td>3A.12</td>
<td>The Trust will agree maximum caseload sizes for community practitioners,</td>
<td>DoHR &amp; CN</td>
<td>J A S O N D J F M</td>
</tr>
<tr>
<td>3A.13</td>
<td>The Trust will continue to publish nursing and midwifery staffing data in accordance with ‘hard truths’ on the website monthly</td>
<td>DoHR &amp; CN</td>
<td>J A S O N D J F M</td>
</tr>
<tr>
<td>3A.14</td>
<td>The Trust will strengthen the analysis of planned versus actual nurse / midwife staffing levels and continue to report to Board monthly</td>
<td>DoHR &amp; CN</td>
<td>J A S O N D J F M</td>
</tr>
<tr>
<td>3A.15</td>
<td>The Trust will continue to pursue a reduction in sickness / absence levels, achieving best in sector performance during 2016/17, and a rate no greater than 4% by March 2016.</td>
<td>DoHR &amp; CN</td>
<td>J A S O N D J F M</td>
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<tr>
<td>3A.16</td>
<td>The Trust will evaluate the success of the overseas recruitment and make a decision by mid-July on the frequency with which an overseas programme might be repeated and the opportunity to partner with an overseas education establishment to become a UK provider of choice for registrants.</td>
<td>DoHR &amp; CN</td>
<td>J A S O N D J F M</td>
</tr>
<tr>
<td>3A.17</td>
<td>The Trust will initiate a dedicated School Nursing recruitment campaign</td>
<td>DoHR &amp; CN</td>
<td>J A S O N D J F M</td>
</tr>
<tr>
<td>3A.18</td>
<td>Whilst not singularly a result of staffing levels the Trust will work with the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) to review all aspects of the Child and Adolescent Mental Health Service provision here in the Rotherham NHS Foundation Trust. The Trust will seek a service which achieves timely specialist CAMHS assessment, a CAMHS care plan and risk assessment and follow up response relevant to the needs of each individual child.</td>
<td>DoHR &amp; CN</td>
<td>J A S O N D J F M</td>
</tr>
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</tr>
<tr>
<td>3B.1</td>
<td>A joint Division, HR and finance team will systematically work through medical staffing data coming to one version of the truth on medical vacancies.</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.2</td>
<td>The medical staffing report will be strengthened in line with the discussion at QAC in June 2015 and continue to be submitted to QAC every other month.</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.3</td>
<td>The Trust will appoint vendors for medical agency staff and agree key performance measures which will be managed via regular business meetings.</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.4</td>
<td>The Divisional Directors and Medical Staffing Manager will influence the forward-looking workforce plan to identify opportunities for the development of Advanced Nurse Practitioner roles and Physician Assistants to replace traditional medical roles not least in those hard to fill vacancies.</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.4.2</td>
<td>The Director of HR and the Medical Director will develop a medical workforce recruitment plan.</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td><strong>REVISED</strong> 3B.5</td>
<td>The Medical Director will ensure that that all 16/17 job plans are agreed by 31 March 2016</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.6</td>
<td>The Divisional Directors will work together to define 'medical red flags' and ensure that all medical staff report against them.</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.7</td>
<td>The executive team will agree a set of HR / Workforce KPIs</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.8</td>
<td>The Trust will offer every person resigning from position the opportunity of an exit interview with a member of the Trust Management Committee (TMC) to all Trust-employed staff.</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.9</td>
<td>Removed from action plan at November 2015 Board meeting</td>
<td></td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.10</td>
<td>The Trust is considering how we input medical vacancy data into the existing quality metrics.</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.11</td>
<td>The Trust will continue to pursue a reduction in sickness / absence levels, achieving best in sector performance during 2016/17, and a rate no greater than 4% by March 2016.</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
<td>3B.12</td>
<td>The Trust will initiate a medical staffing campaign linked to the development of the Emergency Centre.</td>
<td>DoHR &amp; MD</td>
<td>![2015 delivery milestone] ![2016 delivery milestone]</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>NEW</strong> 4.8</td>
<td>DNA CPR screening tools will be identified</td>
<td>MD</td>
<td>J A S O N D J F M</td>
</tr>
<tr>
<td><strong>NEW</strong> 4.9</td>
<td>The DNACPR policy will be adjusted to include the use of the screening tool at the same time MCA tools will be appended to the policy.</td>
<td>MD</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 4.10</td>
<td>DNA CPR status will be added to the ward round proforma</td>
<td>MD</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 4.11</td>
<td>Recent media coverage and case studies will be developed to bring the policy alive for clinicians.</td>
<td>MD</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 4.12</td>
<td>The adjusted policy will be launched at a Grand Round in February 2016</td>
<td>MD</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 4.13</td>
<td>An audit will be undertaken at the beginning of March 2016.</td>
<td>MD</td>
<td></td>
</tr>
</tbody>
</table>

The Trust must ensure all do not attempt cardio-pulmonary resuscitation (DNA CPR) forms are completed in line with the trust's policy and that patients' capacity is assessed in line with the requirements of the Mental Capacity Act (2005).
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>M5</td>
<td>The Trust must ensure patients are not cared for in mixed sex wards / departments apart from those areas which are exempt from meeting the national requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>The Trust will continue to reinforce the requirement to escalate to the director on call before any anticipated breach of the mixed gender sleeping standard thereby affording the director the opportunity to prevent the breach</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>The Trust will continue to report to Board monthly</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>REVISED</strong> 5.3</td>
<td>Standard operating procedures for adult in-patient pass-by-breaches based on floor maps and algorithms agreed with Ward Sisters and Charge Nurses will be implemented by 15 January 2016</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>REVISED</strong> 5.4</td>
<td>All audits of compliance with the national requirements will be complete by 07 January 2016. Endoscopy and day-care are currently outstanding.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td>The Trust will agree and manage a trajectory for achieving compliance with the ITU/HDU 8 hour rule by 01 September 2015 and then develop a plan for achieving compliance with a 4 hour rule by 31 March 2016.</td>
<td>COO</td>
<td></td>
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<tr>
<td>Action No.</td>
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</tr>
<tr>
<td><strong>NEW</strong> 6.5</td>
<td>A list of specialties with backlogs needs to be compiled, including numbers and length of the waits.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 6.6</td>
<td>Lead clinicians need to assess any clinical risks</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 6.7</td>
<td>Actions need to be taken</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 6.1</td>
<td>The Trust will scope out the full patient backlog delays across all specialties.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 6.2</td>
<td>The Medicine Division review showed specific problem in Gastroenterology. Weekly review meetings have been set up with the Chief Operating Officer, Divisional Management Team and Clinical Leads to implement a recovery plan.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 6.3</td>
<td>Establish a training programme for the management of appointments between specialties and the contact centre.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 6.4</td>
<td>Undertake a demand and capacity analysis across Gastroenterology with the support of the NHS Intensive Support Team which will be replicated in other specialties should it be required.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 6.7</td>
<td>The Trust must ensure that children are protected from the risks associated with unsafe or unsuitable premises. The children’s ward environment must be safe and appropriate for children and young people. The Trust must ensure the environmental risks on the children’s ward are assessed and mitigated so that it is safe and secure.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 6.5</td>
<td>A list of specialities with backlogs needs to be compiled, including numbers and length of the waits.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 6.6</td>
<td>Lead clinicians need to assess any clinical risks</td>
<td>COO</td>
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<tr>
<td><strong>NEW</strong> 6.7</td>
<td>Actions need to be taken</td>
<td>COO</td>
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<tr>
<td><strong>NEW</strong> 6.1</td>
<td>The Trust will scope out the full patient backlog delays across all specialties.</td>
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<td><strong>NEW</strong> 6.2</td>
<td>The Medicine Division review showed specific problem in Gastroenterology. Weekly review meetings have been set up with the Chief Operating Officer, Divisional Management Team and Clinical Leads to implement a recovery plan.</td>
<td>COO</td>
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<tr>
<td><strong>NEW</strong> 6.3</td>
<td>Establish a training programme for the management of appointments between specialties and the contact centre.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 6.4</td>
<td>Undertake a demand and capacity analysis across Gastroenterology with the support of the NHS Intensive Support Team which will be replicated in other specialties should it be required.</td>
<td>COO</td>
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</tbody>
</table>

### M7

**NEW**

7A.1 The Family Health Division will undertake a further environmental risk assessment on the Children’s ward. This will be undertaken by a clinician in conjunction with the Trust’s Health and Safety Advisor, and formally reported to the executive team on 10 June 2015.

7A.2 The outcome of the assessment will lead to plans being devised for safe mitigation in order to be assured that the environment is safe for children.

7B.1 The Family Health Division will undertake an environmental risk assessment on the aforementioned areas and any others that they identify as locations providing regular care to children. This will be undertaken by a clinician in conjunction with the Trust’s Health and Safety Advisor, and formally reported to the executive team by 24 June 2015.
<table>
<thead>
<tr>
<th>Action No.</th>
<th>CQC Requirement and Action to be Taken</th>
<th>Exec Lead</th>
<th>Delivery Milestones</th>
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</thead>
<tbody>
<tr>
<td>7B.2</td>
<td>The Family Health Division will manage the findings of the risk assessment, and oversight of the mitigating actions, in conjunction with the other relevant divisions and the director of estates, reporting through the Performance meetings.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>M8</td>
<td>The Trust must ensure all incidents are reported and investigated in a timely manner and that learning is shared with all relevant staff.</td>
<td></td>
<td></td>
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<tr>
<td>8.1</td>
<td>A baseline performance position will be reported to the Chief Nurse performance meeting in June 2015.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>8.2</td>
<td>An improvement trajectory will be agreed with the Operational Quality, Safety and Experience Group (OQSEG) in July taking account of at least 6 months of actual performance data and resource prioritisation consistent with the other actions in this plan</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>8.3</td>
<td>The Chief Nurse, through the OQSEG will hold the patient safety team and the divisions accountable for delivering the improvement trajectory escalating any concerns to the Trust Management Committee</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>8.4</td>
<td>The Patient Safety Team together with the Patient Safety Group and the Patient Experience Group will agree a learning lessons publication scheme which will be presented to the OQSEG in August 2015. The scheme will build on, but not be confined by, the Trust Governance structures.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>8.5</td>
<td>A number of SAS doctors will audit distribution of publications and knowledge of the lessons shared in January 2016 reporting to the OQSEG</td>
<td>CN</td>
<td></td>
</tr>
<tr>
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<tr>
<td><strong>M9</strong></td>
<td>The Trust must ensure all directorate and corporate risk registers are reviewed so they reflect the current identified risks, contain appropriate mitigating actions and that the risks are monitored and reviewed at appropriate intervals.</td>
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<tr>
<td>9.1</td>
<td>All directorates (now divisions) and corporate teams will prioritise a review of risk registers during July 2015 and provide a statement of assurance to the Trust Management Committee (TMC) in September 2015.</td>
<td>CN</td>
<td>J A S O N D J F M</td>
</tr>
<tr>
<td>9.2</td>
<td>The Chief Nurse will produce a revised risk management strategy for the Board of Directors to approve in July 2015.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td><strong>REVISED</strong> 9.3 (9.4)</td>
<td>The Chief Executive and Head of Governance will undertake spot checks of the assurance provided in action 9.1 for a sample of Divisional / corporate directorate risk registers during November 2015.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> 9.4</td>
<td>The Terms of Reference of the Trust Management Committee (TMC) to be reviewed to ensure that the TMC reviews all risks scoring 16 and above on the corporate risk register on a monthly basis</td>
<td>CN</td>
<td></td>
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</tbody>
</table>
| **NEW** 9.5 | The Trust Management Committee has agreed that its monthly review of the corporate risk register for risks scoring 16 and above will include the following elements:  
• A review of all new risks which score 16 or above in order to moderate the risk score and to ensure that the appropriate mitigating actions have been identified.  
• A review of any risks which have previously been scored at 16 or above and for which it is proposed to downgrade the risk score to ensure it is appropriate to de-escalate the risk.  
• A review of all current risks scoring 16 or above. | CN        |                     |
<p>| <strong>NEW</strong> 9.6 | The Trust Management Committee will commence the review described in 9.5 at its December 2015 meeting.                                                                                                                                   | CN        |                     |
| <strong>NEW</strong> 9.7 | The Assistant Director of Patient Safety and Risk will audit the effectiveness of the Divisional risk register process in January 2016 to ensure that all risks have been identified and appropriate mitigations are in place. An action plan will be developed to address any learning from this review. | CN        |                     |</p>
<table>
<thead>
<tr>
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<tr>
<td><strong>NEW</strong> 9.8</td>
<td>The results of the audit in 9.7 will be provided to the Quality Assurance Committee in February 2016.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>M10</td>
<td>The Trust must ensure that all community health services for adults’ staff are able to attend mandatory training and other essential training as required by the needs of the service.</td>
<td></td>
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</tr>
<tr>
<td>10.1</td>
<td>The Divisional Director of Medicine and the Head of Nursing for Medicine will commission the Matrons and locality leads to engage with community health services for adults staff to validate their mandatory, statutory and essential training records and define the level of need; presenting a paper to the Division of Medicine Governance meeting no later than September 2015.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td>10.2</td>
<td>The Divisional Director of Medicine and Head of Nursing will risk assess the position presented and then agree an in-year plan (based on the risk assessment) from the Matron and locality leads no later than October 2015 (Nb. The Matron must take account of the actions in M1-training).</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td>10.3</td>
<td>Delivery of the plan will be monitored and reported at the Medicine Performance meeting</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td>10.4</td>
<td>By January 2016, the locality leads will present a plan for 2016/17 to the Head of Nursing for sign off.</td>
<td>COO</td>
<td></td>
</tr>
<tr>
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<tr>
<td><strong>NEW</strong> 11.1</td>
<td>The Trust must ensure that patient records are kept securely</td>
<td>CoSec</td>
<td><strong>NEW</strong> 2015 2016</td>
</tr>
<tr>
<td>11.1</td>
<td>The Discharge lounge will be provided with secure record storage by 12 June 2015.</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
<td>11.2</td>
<td>The Trust will communicate reminders and statements of accountability regarding the need to attach patient identifiers to loose forms, and not leaving records unattended during June, July and August.</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
<td>11.3</td>
<td>The SAS doctors will undertake point prevalence audit in August, September and October and report the results to the Operational Quality, Safety and Experience Group (OQSEG)</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
<td>11.4</td>
<td>The Trust will communicate the results of the point prevalence audits using 'league tables'</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
<td>11.5</td>
<td>Confirming the securing of records on each and every quality / safety visit will be built into the visit proforma.</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
<td><strong>NEW</strong> 11.6</td>
<td>Screen savers developed with key messages by 31 January 2016</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
<td><strong>NEW</strong> 11.7</td>
<td>Posters available in all reception areas by 31 January 2016</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
<td><strong>NEW</strong> 11.8</td>
<td>Director of Corporate Affairs will have attended the medical staff committee to speak to clinicians about their responsibilities by 31 January 2016</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
<td><strong>NEW</strong> 11.9</td>
<td>Director of Corporate Affairs will have met with medical secretaries and reception colleagues to discuss what is expected of them by 31 January 2016</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
<td><strong>NEW</strong> 11.10</td>
<td>Regular messages based on 'responsibilities and professional codes of conduct' will be included in weekly communications by 31 January 2016</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
<td><strong>NEW</strong> 11.11</td>
<td>Throughout February the 'stop shift' method of communicating key messages within clinical environments will be implemented and the Director of Corporate Affairs will attend all divisional business meetings to achieve divisional ownership of responsibility for the safe keeping of patient records.</td>
<td>CoSec</td>
<td><strong>NEW</strong></td>
</tr>
<tr>
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<tr>
<td>M12</td>
<td><strong>The Trust must ensure complaints are dealt with in accordance with the trust's policy, national best practice and guidance and people receive a timely and complete response to their complaint that is sensitive to their situation.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.1</td>
<td>The Trust will recruit a long-term, substantive Manager for the Patient Experience team</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>12.2</td>
<td>The current training programme will be extended, with training opportunities provided through the year. Training to include recognition of a complaint, immediate responses, recording of complaints, management of formal complaints and informal concerns, how to manage an investigation, how to prepare a response, how to lead a complaints meeting, how to write an action plan, use of audit and other assurance methodologies, the role of the Patient Experience Group etc.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>12.3</td>
<td>Quarterly newssheets to be produced which include the lessons learnt from complaint investigations and reminders of the dates of future training.</td>
<td>CN</td>
<td></td>
</tr>
<tr>
<td>12.4</td>
<td>The new Patient Experience Manager should be provided with access to supervision and management time one day per month to visit other NHS and Non NHS providers to benchmark and develop practice</td>
<td>CN</td>
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<tr>
<td>M13</td>
<td>The Trust must ensure that children and young people using the short break service, are protected against identifiable risks of acquiring a healthcare associated infection.</td>
<td>DoF</td>
<td>2015</td>
</tr>
<tr>
<td></td>
<td>13.1 PRIORITY – the Assistant DIPC / Lead Nurse will visit the short-break service to undertake an immediate risk assessment, and provide guidance and direction. This will be completed by 11 June 2015.</td>
<td>DoF</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>13.2 The service manager will put arrangements in place for the regular audits to be undertaken and reported.</td>
<td>DoF</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>13.3 Written guidance will be produced by 10.07.15</td>
<td>DoF</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>13.4 Audit of compliance with the guidance will take place by 01.09.15 and again by 01.10.15</td>
<td>DoF</td>
<td>J</td>
</tr>
<tr>
<td>M14</td>
<td>The Trust must ensure that children and young people using the short break service are protected against the risks associated with the unsafe use and management of medicines.</td>
<td>DoF</td>
<td>2015</td>
</tr>
<tr>
<td></td>
<td>14.1 PRIORITY – the Chief Pharmacist will facilitate a detailed risk assessment by a suitably competent person no later than 11 June 2015.</td>
<td>DoF</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>14.2 An action plan will be devised based on the risk assessment. The action plan will cover the specifics of the findings at the time of assessment and those concerns raised by the CQC: • Written guidance or policy on safe storage of medicines • Access to medicines • Written guidance on the recording of administration of medicines • The provision of training to staff in accordance with the guidance / policies to be produced</td>
<td>DoF</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>14.3 With immediate effect the key for the medicines cabinet should be carried by a registered practitioner and not left next to the cabinet containing medicines.</td>
<td>DoF</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>14.4 Once the risk assessment has been undertaken a suitable medicine cabinet will be provided and this will be securely mounted to a wall</td>
<td>DoF</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>14.5 Assuming the pharmacist assesses the need, a medicines fridge will be purchased and instruction will be provided on its use, including secure access</td>
<td>DoF</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>14.6 A point prevalence audit will be undertaken within 4 weeks of the action plan being completed.</td>
<td>DoF</td>
<td>J</td>
</tr>
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<tr>
<td><strong>M15</strong></td>
<td><strong>The Trust must ensure that there is effective liaison between the contraception and sexual health service and the school nursing service about individual young people who may be at risk of abuse.</strong></td>
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<tr>
<td>15.1</td>
<td>A risk assessment will be undertaken on the position as at 01 June 2015.</td>
<td>CN</td>
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<td>15.2</td>
<td>The service leads will liaise with other providers to ascertain evidence of best practice</td>
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<tr>
<td>15.3</td>
<td>The service leads will develop pathways</td>
<td>CN</td>
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</tr>
<tr>
<td>15.4</td>
<td>The service leads will visit the front line contraception, sexual health and school nursing teams to describe the pathways and facilitate understanding of their use in practice</td>
<td>CN</td>
<td></td>
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<tr>
<td>15.5</td>
<td>The service leads will undertake audit 2 months after implementation</td>
<td>CN</td>
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<tr>
<td>15.6</td>
<td>The pathway will be built into the October refresh of the School Nursing Specification</td>
<td>CN</td>
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<tr>
<td>Recommendation 1 - Not Applicable for TRFT</td>
<td>NHS England and Rotherham Clinical Commissioning Group (RCCG): Recommendation 1.1 Work with GPs to ensure that they fully understand the local child protection processes, including their responsibilities around record keeping, information governance and information sharing.</td>
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<tr>
<td>Recommendation 2</td>
<td>NHS England, Rotherham Clinical Commissioning Group (RCCG), Rotherham, Doncaster and South Humberside NHS Foundation Trust (RDaSH) and The Rotherham Foundation NHS Trust (TRFT): Ensure children and young people who have attended the emergency department following an episode of self-harm or other mental health care need and admitted on to the trust’s paediatric ward are looked after by appropriately trained practitioners and that there is a clear, written risk management plan in place for each child.</td>
<td>RCCG/TrFT/RDaSH</td>
<td>2015: J A S O N D 2016: J F M A M</td>
</tr>
<tr>
<td>Recommendation 2.1</td>
<td>A Emergency Centre Children’s Task and Finish Group, with representation from RCCG/TrFT/RDaSH, to lead the development of the Emergency Department Self-Harm Pathway. The development of the pathway will include guidance for the development of personalised risk management plans for individual children.</td>
<td>Emergency Centre Children’s Task and Finish Group: The Chair - RCCG Lead Officer, Senior Manager CAMHS</td>
<td>CAMHS pathways aligned to the TRFT and CAMHS Group Pathway that commenced on 24.8.15.</td>
</tr>
<tr>
<td>2.1 A</td>
<td>CAMHS to provide a programme of mental health training for TRFT paediatric staff to support young people with a mental health issue admitted to paediatric inpatient services.</td>
<td>Service Manager, CAMHS TRFT Clinical Lead</td>
<td></td>
</tr>
<tr>
<td>2.1 B</td>
<td>CAMHS to appoint to a CAMHS Interface Liaison Post, agreed with Rotherham CCG. Post works across CAMHS and TRFT, including a base in TRFT emergency department.</td>
<td>Service Manager, CAMHS, RDaSH</td>
<td></td>
</tr>
<tr>
<td>2.1 C</td>
<td>Undertake an audit of staff awareness and positive influence on practice within 3 months from delivered mental health training.</td>
<td>Named Nurse TRFT/Paediatric Liaison Nurse (CAMHS)</td>
<td></td>
</tr>
<tr>
<td>2.1 D</td>
<td>Undertake an audit 6 months after the implementation of the risk management plans, to measure the impact for children, their families and the staff looking after them.</td>
<td>Named Nurse TRFT/Paediatric Liaison Nurse (CAMHS)</td>
<td></td>
</tr>
</tbody>
</table>

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### Recommendation 2

#### Recommendation 2.2
Develop a perinatal mental health pathway that is compliant with NICE guidance and reflects all services that are available to support women with perinatal mental health needs.

<table>
<thead>
<tr>
<th>Action No.</th>
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<tr>
<td></td>
<td>Recommendations</td>
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<td>J</td>
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<tr>
<td></td>
<td>Recommendation 2.2</td>
<td></td>
<td>J</td>
</tr>
<tr>
<td>RCCG/TRFT/RDaSH</td>
<td>Establish a Task and Finish Group to:</td>
<td>Senior Commissioning Manager Children and Maternity (RCCG)</td>
<td>J</td>
</tr>
<tr>
<td>RCCG/TRFT/RDaSH</td>
<td>- Compare the current pathway against NICE guidance</td>
<td>Head of Contracts &amp; Service Improvement - Mental Health, Learning Disability &amp; End of Life (RCCG) Named Nurse.</td>
<td>J</td>
</tr>
<tr>
<td>RCCG/TRFT/RDaSH</td>
<td>- Building on the work already undertaken by TRFT and look at gaps in the pathway identified in the prospective audits undertaken by TRFT</td>
<td>Obstetrician with Special Interest</td>
<td>J</td>
</tr>
<tr>
<td>RCCG/TRFT/RDaSH</td>
<td>- Look at any necessary changes/additions to the pathway and implementation of the revised pathway including training</td>
<td>Midwife with Special Interest</td>
<td>J</td>
</tr>
<tr>
<td>RCCG/TRFT/RDaSH</td>
<td></td>
<td>Head of Midwifery, Nursing and Professions</td>
<td>J</td>
</tr>
<tr>
<td>RCCG/TRFT/RDaSH</td>
<td></td>
<td>Locality Service Manager, Rotherham Adult Community Mental Health Services</td>
<td>J</td>
</tr>
<tr>
<td>RCCG/TRFT/RDaSH</td>
<td></td>
<td>Nurse Consultant Safeguarding Children RDaSH</td>
<td>J</td>
</tr>
</tbody>
</table>

#### Recommendation 2.3

**A** Providers to hold bespoke MARF training sessions to reiterate the standards and ensure that referrals clearly identify and articulate risks.

<table>
<thead>
<tr>
<th>Action No.</th>
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<tbody>
<tr>
<td></td>
<td>Recommendation 2.3</td>
<td>TRFT Named Nurse Safeguarding</td>
<td>J</td>
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<tr>
<td></td>
<td>Ensure that health practitioners are completing referrals to children's social care that clearly assess and articulate the risk.</td>
<td>TRFT Named Nurse Safeguarding</td>
<td>J</td>
</tr>
</tbody>
</table>

#### Recommendation 2.4

**A** Each organisation to review existing record keeping policy and procedure, to include record keeping standards that clinicians should be working towards.

<table>
<thead>
<tr>
<th>Action No.</th>
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<tbody>
<tr>
<td></td>
<td>Recommendation 2.4</td>
<td>Nurse Consultant, Safeguarding Children RDaSH</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>Ensure effective governance around record keeping, including use of checklists, case note entry, sharing of information and understanding of consent.</td>
<td>Nurse Consultant, Safeguarding Children RDaSH</td>
<td>J</td>
</tr>
</tbody>
</table>

#### Recommendation 3

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### Recommendation 3.1

**A** Ensure that children and young people who are working with CAMHS practitioners have a clearly identified lead professional and that regular communication takes place with the child’s GP where there is concern.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Recommendation 3.1</td>
<td>Nurse Consultant, Safeguarding Children RDaSH</td>
<td>J</td>
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<tr>
<td></td>
<td>Ensure that children and young people engaged with CAMHS practitioners have access to a clear pathway of care that includes arrangements for stepping up and down from Tier 4 services.</td>
<td>Nurse Consultant, Safeguarding Children RDaSH</td>
<td>J</td>
</tr>
</tbody>
</table>

#### Recommendation 3.2

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### Recommendation 3.3

**A** Improve the emergency department documentation and assessment templates to ensure safeguarding processes are robust and support practitioners in the identification and recording of children of adults who are accessing services.

<table>
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<td>Recommendation 3.3</td>
<td>Nurse Consultant, Safeguarding Children RDaSH</td>
<td>J</td>
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<tr>
<td></td>
<td>Ensure that emergency department documentation and assessment templates to ensure safeguarding processes are robust and support practitioners in the identification and recording of children of adults who are accessing services.</td>
<td>Nurse Consultant, Safeguarding Children RDaSH</td>
<td>J</td>
</tr>
</tbody>
</table>

#### Recommendation 3.4

**A** The existing ED and Safeguarding Joint Monthly meeting will be utilised to review an initial model of practice based on ‘Think Family Principle’ documentation ensuring they are fit for purpose.

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<tbody>
<tr>
<td></td>
<td>Recommendation 3.4</td>
<td>TRFT ED Clinical Nurse Specialist and ED Consultant and Paediatric Liaison</td>
<td>J</td>
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<tr>
<td></td>
<td>Ensure that emergency department documentation and assessment templates to ensure safeguarding processes are robust and support practitioners in the identification and recording of children of adults who are accessing services.</td>
<td>TRFT ED Clinical Nurse Specialist and ED Consultant and Paediatric Liaison</td>
<td>J</td>
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<thead>
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<td></td>
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<td>2015</td>
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<td></td>
<td>J</td>
<td>A</td>
</tr>
<tr>
<td><strong>Recommendation 4 -</strong></td>
<td><strong>Not Applicable for TRFT</strong></td>
<td></td>
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<tr>
<td>Recommendation 4</td>
<td>Implement a clear operational performance management system to demonstrate compliance with organisational requirements and effective safeguarding and child protection practice.</td>
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<tr>
<td>TRFT Emergency Department</td>
<td>RCGG and The Rotherham Foundation NHS Trust should:</td>
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</tr>
<tr>
<td>Recommendation 4.1</td>
<td>Ensure that previous attendances at the emergency department by children or young people are routinely considered as part of the safeguarding triage assessment.</td>
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<tr>
<td>TRFT Emergency Department</td>
<td>The ED booking form will be reviewed to ascertain whether it is possible to include questions on dependents.</td>
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<tr>
<td>Recommendation 4.2</td>
<td>The results of the audit will be reported to the ED Governance meeting and the Strategic Safeguarding Group.</td>
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<tr>
<td>TRFT Emergency Department</td>
<td>Audit will be undertaken in November 2015. This will measure the extent to which practitioners are then complying with LSCB policies for referrals to the named doctor and named nurse.</td>
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<td>Recommendation 4.3</td>
<td>Improve the risk assessment for vulnerability in midwifery services, CASH and GUM to ensure that vulnerability is being identified and responded to at the earliest opportunity.</td>
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<tr>
<td>TRFT Midwifery, CASH and GUM, Integrated Sexual Health Services (ISHS)</td>
<td>Head of Midwifery and CSE Specialist Nurse.</td>
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<tr>
<td>Recommendation 4.4</td>
<td>Ensure that best practice is identified and shared with all staff in these identified areas.</td>
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<tr>
<td>TRFT Midwifery, CASH and GUM, Integrated Sexual Health Services (ISHS)</td>
<td>Head of Clinical Director and Matron - Integrated Sexual Health Services.</td>
<td></td>
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<tr>
<td>Recommendation 4.5</td>
<td>Ensure that all relevant staff are up to date with Equality and Diversity Training.</td>
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<tr>
<td>TRFT Midwifery, CASH and GUM, Integrated Sexual Health Services (ISHS)</td>
<td>Head of Midwifery</td>
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<tr>
<td>Recommendation 4.6</td>
<td>Head of Midwifery should:</td>
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</table>

1.6 Systems will be put in place to ensure that the attendance of a child or young person 0-16 years of age, in the previous 6 months are brought to the attention of the named nurse and all practitioners.
2.1 The paediatric liaison nurse will review all previous attendance data when reviewing ED records.
2.2 The ED triage form (new Emergency Centre) will include the requirement for all previous attendances to be included in the GP notification letter.
2.3 The Trust will put in place a mechanism for practitioners to sign the ED record to confirm /affirm that they have taken account of previous attendance data in decision-making.
2.4 The results of the audit will be reported to the ED Governance meeting and the Strategic Safeguarding Group.
3.1 The use of the Pre-Caf will be audited in November 2015.
3.2 The audit will be undertaken in November 2015. This will measure the extent to which practitioners are then complying with LSCB policies for referrals to the named doctor and named nurse.
3.3 The audit will be undertaken in November 2015. This will measure the extent to which practitioners are then complying with LSCB policies for referrals to the named doctor and named nurse.
3.4 The ED Consultant Safeguarding Lead.
3.5 The ED Consultant Safeguarding Lead.
3.6 The ED Consultant Safeguarding Lead.
3.7 The ED Consultant Safeguarding Lead.
3.8 The ED Consultant Safeguarding Lead.
3.9 The ED Consultant Safeguarding Lead.
3.10 The ED Consultant Safeguarding Lead.
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3.36 The ED Consultant Safeguarding Lead.
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3.38 The ED Consultant Safeguarding Lead.
3.39 The ED Consultant Safeguarding Lead.
3.40 The ED Consultant Safeguarding Lead.
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<tbody>
<tr>
<td>TRFT Midwifery and Health Visiting and Public Health as the commissioners of HV/FNP from 01/10/15 and SN</td>
<td>4.4 A The antenatal midwifery pathway will be reviewed to ensure that it leads to the consistent collection and recording of data on Systmone.</td>
<td>Clinical Services Managers, HV Managers and Community Matrons (Midwifery), Head of Health Improvement, RMBC Public Health, RCCG IT Project and Data Quality Team, RMBC Public Health</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.4 B To review the written communication pathway from midwifery to health visitor, ensuring that it is still fit for purpose.</td>
<td>Clinical Services Managers, HV Managers and Community Matrons (Midwifery)</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.4 C The pathways will be audited in November and December with reports to the Strategic Safeguarding Group and the Family Health Governance meeting. Midwifery and Children’s Community Matrons.</td>
<td></td>
<td></td>
<td>Audit has been completed and information requested to be reported into the next safeguarding Strategic Group Meeting planned for 15 April 2016.</td>
</tr>
<tr>
<td>Recommendation 4</td>
<td>Recommendation 4.4</td>
<td>Ensures that midwives are routinely including information from general practice as part of the initial risk assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRFT Midwifery and RCCG</td>
<td>4.5 A An initial baseline audit will be undertaken to ascertain the gaps in information routinely being used to inform initial risk assessments and the extent to which information from GPs is adequate. A point prevalence audit will be undertaken over the course of one week in September 2015.</td>
<td>Head of Midwifery and Primary Care GP Lead</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.5 B The results of the audit will be used to inform a review of current pathways.</td>
<td>Head of Midwifery and Primary Care GP Lead</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.5 C All GPs and midwives will receive the results of the audit and the pathway review in correspondence jointly signed by TRFT and the Primary Care GP lead. This correspondence will outline all any required changes to practice.</td>
<td>Head of Midwifery and Primary Care GP Lead</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.5 D A further audit will be undertaken in January 2016.</td>
<td>Head of Midwifery and Primary Care GP Lead</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td>Recommendation 4</td>
<td>Recommendation 4.6</td>
<td>Work with partners to develop a clear pre-birth protocol for expectant women to include robust plans for timely discharge of mother and baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRFT Midwifery and Health Visiting, FNP, RMBC Children and Young People’s Services</td>
<td>4.6 A Managers of both services to work together to create a joint protocol for pre-birth and safe discharge arrangements.</td>
<td>Head of Midwifery, Director of Safeguarding Children and Young People’s Directorate</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.6 B Implementation and an audit 3 months in of the new joint protocol as above which will include a robust pathway in place so that any breaches in compliance to the protocol can be reported and action taken.</td>
<td>Safeguarding Midwife, LSCB Audit Officer, RMBC Public Health Specialist (Children and Young People), RMBC Early Help Manager</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.6 C All delays to discharge (due to care proceedings) to be escalated to the TRFT Chief Nurse on the day, and copied to the Director of Safeguarding Children and Young People at the same time.</td>
<td>Wharncliffe Ward Manager</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.6 D Monthly review meetings of midwives and social workers to review all vulnerable women to be introduced. Terms of reference to be devised and a first meeting established in November 2015.</td>
<td>Head of Midwifery, Director of Safeguarding Children and Young People’s Directorate</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td>Recommendation 4</td>
<td>Recommendation 4.7</td>
<td>Ensure that practitioners working CASH and GUM service are clear about their contribution to local arrangements for child sexual exploitation and child protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRFT Integrated Sexual Health Service TRFT CSE Nurse CSE Multi-Agency Team Local Authority (LA)</td>
<td>4.7 A A Senior Manager to visit the service and lead awareness sessions in October and November 2015.</td>
<td>Integrated Sexual Health Service Manager</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.7 B All clinicians to evidence completion of CSE awareness training.</td>
<td>Clinical Director</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.7 C An agreed multi-agency risk assessment tool to be identified and implemented.</td>
<td>Clinical Director and Matron for Integrated Sexual Health Service and CSE Specialist Nurse</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.7 D All staff to be trained in the use of the identified risk assessment tool and clarity provided regarding the contribution required by all agencies.</td>
<td>Clinical Director and Matron for Integrated Sexual Health Service and CSE Specialist Nurse</td>
<td>J A S O N D J F M A M</td>
<td></td>
</tr>
</tbody>
</table>
Recommendation 4.9

Ensure that health plans developed from initial health assessments and health reviews are SMART*.

- **Action 4.9.1**: Health Plans will be formulated by a registered medical practitioner for initial health assessments ensuring that they are SMART with measurable health objectives and with timescales and effective follow-up to ensure actions had been taken – meeting the individual needs of the child.
- **Action 4.9.2**: Health plans will be audited using the clinical audit tool. Health audit of looked after children’s services to include the voice of the child commences October 2015.
- **Action 4.9.3**: RCCG and TRFT LAC Team will provide an excel database to ensure that the tracking of LAC health needs are tracked in real time. Looking After Children’s Team
- **Action 4.9.4**: An audit to ensure that the looked after child’s health needs are tracked in real time. Looking After Children’s Team
- **Action 4.9.5**: An audit to ensure that the voice of the child will be included within all health assessments by the practitioner undertaking the assessment. (e.g. Not written in the 3rd person but reflective of the individuality of the child)
- **Action 4.9.6**: GP and CAMHS services will be approached for health information prior to health reviews. Integrating Health visitor and SN service
- **Action 4.9.7**: A review health assessment will be undertaken by a registered nurse within the statutory timescales (usually 1 month for under 5s and 3 months for over 5s). Looked After Children’s Team

**Comments and if Action off Track**

- By the end of May 2016, all looked after children should have received an initial health assessment and the voice of the child included in the assessment.

*SMART: Specific, Measurable, Achievable, Relevant, Time-bound goals*
<table>
<thead>
<tr>
<th>Action No.</th>
<th>CQC Requirement and Action to Be Taken</th>
<th>Lead Officer</th>
<th>Delivery Milestones</th>
<th>Comments and If Action off Track</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation 4</strong></td>
<td></td>
<td></td>
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<tr>
<td>4.10 A</td>
<td>Health staff undertaking LAC health reviews will be reminded of the need to seek consent and record the response of all young people (age appropriate) for their health review to be undertaken.</td>
<td>Looked After Children’s Team, School Nursing Services and Clinical Service Managers</td>
<td></td>
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<td><strong>Looked After Children’s Team / Children and Young People’s Services</strong></td>
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<tr>
<td>4.10 B</td>
<td>Outcome scores from Strengths and Difficulties Questionnaires (SDQs) will be routinely commented on as part of the individuals health review, allowing the young person the opportunity to track their own emotional growth and journey through their time in care and engaging the young person in their own health and wellbeing. This is to be audited in 3 months’ time.</td>
<td>Looked After Children’s Team, School Nursing Service and Clinical Service Managers</td>
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<tr>
<td>4.10 C</td>
<td>Health recommendations from the assessment will be shared with the young person (age appropriate) by their health professional. LAC Council to be kept informed of decisions and present any breaches to RMBC and/or LAC Health Team.</td>
<td>Looked After Children’s Team, School Nursing Service and Clinical Service Managers</td>
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<tr>
<td><strong>Recommendation 4</strong></td>
<td></td>
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<tr>
<td>4.11 A</td>
<td>Health Passports will be updated by the health professional at each health assessment.</td>
<td>Looked After Children’s Team, School Nursing Team</td>
<td></td>
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</tr>
<tr>
<td>4.11 B</td>
<td>Outcome scores from Strengths and Difficulties Questionnaires (SDQs) will be routinely commented on as part of the individuals health review, allowing the young person the opportunity to track their own emotional growth and journey through their time in care and engaging the young person in their own health and wellbeing. This is to be audited in 3 months’ time.</td>
<td>Looked After Children’s Team, School Nursing Service and Clinical Service Managers</td>
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<td></td>
</tr>
<tr>
<td><strong>Looked After Children’s Team / Children and Young People’s Services</strong></td>
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</tr>
<tr>
<td>4.11 C</td>
<td>Health Passports will be updated by the health professional at each health assessment.</td>
<td>Looked After Children’s Team, School Nursing Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recommendation 4</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4.12 A</td>
<td>To review the current paediatric liaison process ensuring that it is fit for purpose.</td>
<td>Senior Practitioner/Matron in ED, Paediatric Liaison</td>
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<tr>
<td><strong>TRFT ED and Paediatric Liaison</strong></td>
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<tr>
<td>4.12 B</td>
<td>To provide assurance that all the staff are trained in safeguarding children and in the use of the safeguarding assessment tool.</td>
<td>Senior Practitioner/ED Audit Team</td>
<td></td>
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</tbody>
</table>

**Key:**
- The task has been completed
- Task is on target
- Task is off target with remedial action
- Task work has yet to be implemented/planned/progressed
- Task schedule to have started yet
- Indicates timescale within which action will be completed. 

Audit delayed due to issue with the passports not being distributed previously. Audit to be undertaken in April 2016 (week commencing 25 April 2016).

Presented by: Derek Thomas, Head of Medical Workforce
Author(s): Derek Thomas, Head of Medical Workforce

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

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

Risk Reference:
- BAF: ID
- Corporate Risk Register: ID

Purpose of this paper:
To present to the Trust Board details of the new Junior Doctor Contract 2016 to be effective from 3 Aug 16.

Summary of Key Points:
The key points arising from the report are:
- Safe Working
- Work Scheduling
- Guardian of Safe Working Hours
- Pay
- Scope
- Implementation

Board action required: For noting.
1. Introduction

1.1 On 31 Mar 16 the Secretary of State for Health announced his decision to impose a new 2016 Doctors in Training Contract\(^1\) following failed negotiations between NHS Employers and the BMA. It is acknowledged, by NHS Employers, the decision to implement this contract without agreement from the BMA is a source of concern for Trust Boards and are giving an assurance the new contract:

- Is a safe and fair one, designed to safeguard hours of work and ensure doctors are paid for all the work they do.
- Honours agreements reached by the BMA during discussions from November 2015 to February 2016.
- Includes the offer made regarding payment for frequent Saturday working and availability for non-resident on-call.

1.2 Conversely, the BMA argues the new contract will spread an already stretched workforce thinner and allows Trusts to roster doctors at weekends more frequently with less OOH enhanced pay.

1.3 Industrial action continues with the next strike taking place on 26 & 27 Apr 16 where an unprecedented full withdrawal of labour by junior doctors will occur between the hours of 0800 and 1700. Regular planning meetings are being held with necessary assurance submissions completed for NHS England. Should there be no change in the Government’s stance then further action can be expected. Note that any doctor employed under the current national TCS is entitled to take action whether employed in a training post or not.

2. Safe Working

2.1 The new national contract places a mutual obligation on employers and doctors to respect the new limits on work hours and consecutive shifts. As an employer, we have a contractual and regulatory responsibility for ensuring a doctor is not contracted, or otherwise required, to work outside the limits set out in the TCS. Further, we must ensure existing rotas are revised to meet the new limits on hours and safeguards on rest; these must be incorporated into new rotas before sending out the offer of employment and work schedule documentation.

2.2 Skills for Health have already released an updated version of Doctors Rostering System (DRS) and rotas have been mapped across to the new rules. Work is underway to ensure rotas are either fit for purpose, require amendment or a complete redesign.

3. Work Scheduling

3.1 This is a new feature of the contract, and employers will be required to complete work schedules for doctors in training. This will begin as a generic schedule setting out the hours of work, the working pattern, the service commitments and the training opportunities available during the post or placement. This must be done prior to any offer of employment to the post being made.

3.2 Once a doctor commences in post, the work schedule will be personalised to include appropriate and identified personal objectives that have been agreed between the doctor and his or her educational supervisor, and will set out the relationship between these personal objectives and local service objectives. The objectives will set out a mutual understanding of what the doctor will be seeking to achieve over the placement period and how this will contribute to the objectives of the employing organisation.

3.3 Work scheduling can be used to drive improvements and quality of patient care and bring together activities to achieve learning and service objectives within contracted hours. A work schedule expressly links work carried out to the training needs identified in the relevant curriculum. This ensures that, alongside commitments for the delivery of patient and other services, the doctor is able to train effectively toward the achievement of the competencies necessary to progress through training.

3.4 Exception reporting is also a new feature of the new contract, enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose. This is beneficial to employers as it will give real-time information and be able to identify key issues as they arise. It also benefits doctors, as issues over safe working or missed educational opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

3.5 It is the Trust’s responsibility to ensure that there is a locally agreed process in place to administer and manage work schedule reviews. All educational supervisors need to be trained in and understand the process. This process should be in place by the time doctors commence in August 2016. A work schedule review should be undertaken wherever there are regular or persistent breaches in safe working hours that have not been addressed, or wherever educational opportunities cannot be accessed due to pressures of workload.

4. Guardian of Safe Working Hours

4.1 All employers have been mandated to establish a locally agreed recruitment process for the appointment of a guardian of safe working hours, with doctors in training being involved in the appointment of the guardian. Schedule 6 of the TCS sets out the principles for the appointment for the guardian and a sample job description and person specification for the role have been provided by NHS Employers.

4.2 The guardian is a new role, which will oversee the safeguards outlined in the contract and will ensure that issues of compliance with safe working hours are addressed by the doctor and / or the employer / host organisation. If concerns have not been resolved through the exception reporting and work schedule review processes, then doctors can escalate their concerns to the guardian. The guardian can formally raise concerns regarding safe working hours with management and can insist that steps are taken to resolve matters of concern. The guardian will be empowered to require departments to take necessary steps to improve the working conditions of doctors.

4.3 The guardian is authorised to levy a financial penalty on the department where the three key safe working hour limits are breached (weekly average of 48 hours; absolute total of 72 hours in seven days; 11 rest between shifts reduced to eight hours or fewer). This fine will go into a budget administered by the guardian, to be spent on improvements to the working and training environment of doctors.
4.4 The guardian will present regular reports on working hours to the board and will undertake regular consultation with doctors employed by the organisation for which the guardian has responsibility. The guardian will be directly accountable to a board-level executive and will report to the board, either directly or through a sub-committee of the board. The board must receive a report from the guardian no less than annually. Reports will also be submitted to Health Education England (via the local office) and will be available to other inspectors and regulators (CQC, NHS Improvement, GMC etc.) on request. The local negotiating committee (LNC) or equivalent should also receive copies of the reports.

5. Pay

5.1 The current system of basic pay and broad banding supplements is being replaced with a new pay structure that rewards doctors for actual work done and directly links pay to the level of responsibility a doctor is required to discharge while employed in a particular post. The current pay spine, with 9 incremental points, will be replaced by a 5-nodal point structure, each of which has a value as per the relevant pay circular. Pay progression will only take place as doctors move through training to take up positions at higher levels of responsibility (i.e. in line with career progression). Each nodal point will be pegged to a step change in responsibility and when the doctor takes on additional responsibility. This system provides for increases in rates of basic pay at nodal points through the career pathway where there are distinct and significant increases in responsibility.

6. Scope

6.1 The new TCS applies to doctors in recognised training posts only, appointed under the auspices of HEE, and is available from 3 Aug 16.

6.2 These contractual arrangements will not apply to any doctors who are not in a training post, i.e. locums appointed for service, trust doctors, clinical fellows, research fellows etc. It is for the Trust to decide locally how to set contractual TCS for doctors who are not employed as doctors in training but are filling vacant recognised training posts. Even where we seek to replicate pay and other terms of the new TCS into any local terms, we are not to replicate the totality of these TCS but to tailor them to meet the different needs of service requirements placed upon trust doctors. We are free to determine what terms and conditions we offer to new staff in such posts, or to those wishing to remain in employment in such posts when existing contracts expire.

7. Implementation

7.1 The suggested implementation timeline is incredibly tight and summarised below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>End Apr 16</td>
<td>Rotas remapped against new shift rules and amended where required</td>
</tr>
<tr>
<td>End May 16</td>
<td>Work schedules for all posts agreed and signed off</td>
</tr>
<tr>
<td>8 Jun 16</td>
<td>Deadline for employers to offer jobs to doctors in August, with work schedules, details of pay and rotas <em>(provided we are aware of details of trainees)</em></td>
</tr>
<tr>
<td>26 Jul 16</td>
<td>Guardian should be appointed by this time</td>
</tr>
<tr>
<td>31 Jul 16</td>
<td>Induction to be set up for August, including different HR aspects for doctors on different contracts</td>
</tr>
<tr>
<td>3 Aug 16</td>
<td>New placements / contracts commence</td>
</tr>
<tr>
<td>Late Aug 16</td>
<td>First payroll run under new system</td>
</tr>
</tbody>
</table>
7.2 The new contract will be implemented in phases from Aug 16 when there is a break in contract of employment and a new contract is taken up. The table below shows details of the full implementation timetable for doctors to transfer to the new TCS:

<table>
<thead>
<tr>
<th>Date</th>
<th>Grade</th>
<th>Rotation(s) / Training Programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug 16</td>
<td>F1</td>
<td>All</td>
</tr>
<tr>
<td>Feb to Apr 17</td>
<td>ST 1/2/3</td>
<td>GP trainees in practice placement only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All psychiatry, Public Health, all Pathologies</td>
</tr>
<tr>
<td></td>
<td>ST1+</td>
<td>Paediatrics, Dentists</td>
</tr>
<tr>
<td>Apr to Aug 17</td>
<td>CT1-3, ST3+</td>
<td>All surgical specialties</td>
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<tr>
<td></td>
<td>ST3+</td>
<td>Anaesthetics, ITU, EM, O&amp;G, Radiology</td>
</tr>
<tr>
<td></td>
<td>ST1-2 / CT1-2</td>
<td>CMT, remaining Core Surgical Training, ACCS, Anaesthetics, Radiology, O&amp;G, any remaining ST1-2</td>
</tr>
<tr>
<td>Aug to Dec 17</td>
<td>All</td>
<td>Any remaining trainees</td>
</tr>
</tbody>
</table>

7.3 Whilst the indicative timeline above gives the timeline of when various grades are to be transferred to the new TCS, this can be done in advance of these dates where practicable. F2 doctors will transfer to the new TCS when they take up a rota that includes practitioners on the new contract.

7.4 A local JD Contract Implementation Group has been introduced, having held its first meeting on 14 Apr 16, and a project plan developed to meet the deadlines at 7.1. The group will meet fortnightly, to be chaired by the Head of Medical Workforce, and consists of representatives from:

- Medical Staffing & Workforce (Project Lead)
- PGME (DME, MEM)
- Payroll
- Finance
- Operations
- ESR
- Communications
- LNC

Further, junior doctor engagement events will be arranged along with briefings for other clinical and operational staff. The local financial impact of the contract is unknown at this stage but it has been clear, nationally, it is to be cost neutral.

7.5 As part of the implementation process NHS Improvement has requested weekly Unify submissions each Wednesday detailing progress with:

- Engagement with Doctors in Training
- Rota Redesign
- Appointment to the Guardian of Safe Working
- Job offers on the new contract

8. Conclusion

8.1 We need to prepare for these new arrangements and ensure effective implementation of the new contract. All require necessary assurances of progress, which will be provided by monthly updates to Board / TMC.
Derek Thomas
Head of Medical Workforce
April 2016
1. Purpose of this paper:
1.1 This report provides the Q4 position (as at end March 2016) with regard to strategic risk and risk scores appearing on the Board Assurance Framework.

2. Summary of Key Points:
2.1 In updating the BAF for Q4 the following changes have been made:
   - All changes to the BAF made in Q4 have been highlighted in red text
   - For B2 it is proposed that the residual risk score is increased from 9 to 12 (increase in consequence score from 3 to 4). This is due to:
     - The addition of ANP gaps in the Emergency department
     - Safeguarding concerns re: ED practice.
   - For B7 it is proposed that the residual risk score is increased from 12 to 16 (increase in likelihood score from 3 to 4). This is due to:
     - Failure to achieve strategic objectives in relation to finance and operational delivery
   - For B22 it is proposed that the residual risk score is increased from 12 to 16 (increase in likelihood score from 3 to 4). This is due to:
     - Poor safeguarding compliance in the Emergency Department (for both adults and children).
     - Retirement of interim named doctor
     - Safeguarding adults level 3 training compliance at ‘average’ across the Trust

Board action required: For decision and approval
To decide whether the residual risk scores provided by the lead executives are appropriate against the information provided for Q4.

3. Board Assurance Framework
3.1 The BAF is presented as one document, all BAF items, with the exception of item B23, have been seen at Board Committees during April 2016.

Lisa Reid
Head of Governance
April 2016
<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>BAF ID</th>
<th>Risk Identity</th>
<th>Risk Register Cross Ref</th>
<th>Risk Owner</th>
<th>Committee Owner</th>
<th>Inherent risk score</th>
<th>2015/16 Q1 residual score</th>
<th>2015/16 Q2 residual score</th>
<th>2015/16 Q3 residual risk score</th>
<th>2015/16 Q4 residual risk score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients: Excellence in Healthcare</strong></td>
<td><strong>B1</strong></td>
<td>Failure to deliver appropriate standards of care and quality</td>
<td>4187</td>
<td>Chief Nurse</td>
<td>QAC</td>
<td>3 x 4 = 12</td>
<td>3 x 3 = 9</td>
<td>2 x 3 = 6</td>
<td>4 x 4 = 16</td>
<td>4 x 4 = 16</td>
</tr>
<tr>
<td>LEAD: Chief Nurse (Medical Director)</td>
<td></td>
<td></td>
<td>3874</td>
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<td></td>
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<tr>
<td><strong>B2</strong></td>
<td>Unable to implement learning and required improvements arising from CQC inspections</td>
<td>3293</td>
<td>Chief Nurse</td>
<td>QAC</td>
<td>3 x 3 = 9</td>
<td>2 x 3 = 6</td>
<td>2 x 3 = 6</td>
<td>3 x 3 = 9</td>
<td>3 x 4 = 12</td>
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<td>4628</td>
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<th><strong>2015/16 Q1 residual score</strong></th>
<th><strong>2015/16 Q2 residual score</strong></th>
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<th><strong>2015/16 Q4 residual risk score</strong></th>
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<td><strong>Colleagues: Engaged, accountable colleagues</strong></td>
<td><strong>B6</strong></td>
<td>Insufficient workforce capability and/ or capacity to deliver the Trust’s objectives and plan</td>
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<td>Failure to reduce workforce costs to planned 2015/16 levels</td>
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<td><strong>Governance:</strong> Trusted, open governance</td>
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<td>Failure to improve financial governance processes leading to poor financial performance</td>
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<td>Failure to achieve compliance with Licence</td>
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<td>Failure protect confidential Trust data - patients, colleagues and other</td>
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<td>Failure to implement a robust performance framework and governance structure at a service line level through to Trust Board.</td>
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<td>Failure to comply with Trust's Standing Financial Instructions</td>
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<td>B14</td>
<td>Inability to fully embed risk management processes</td>
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<th>2015/16 Q1 residual score</th>
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<th>2015/16 Q3 residual risk score</th>
<th>2015/16 Q4 residual risk score</th>
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<td><strong>Finance:</strong> Strong financial foundations</td>
<td>B15</td>
<td>Unable to deliver £12.9m CIPs and reduce the underlying deficit</td>
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<td>F&amp;PC</td>
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<td>B16a</td>
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<td>B16b</td>
<td>Failure to comply with loan requirements through lack of cash management and &quot;Going Concern&quot;</td>
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<td>Failure to deliver capital programme</td>
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<td>F&amp;PC</td>
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<td>Failure to deliver contractual obligations including financial penalties, performance indicators and activity levels.</td>
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<td>F&amp;PC</td>
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<td>Partners: Securing the future together</td>
<td>B20</td>
<td>Failure to deliver transformation in the community</td>
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<td>Chief Operating Officer</td>
<td>QAC</td>
<td>$4 \times 4 = 16$</td>
<td>$4 \times 2 = 8$</td>
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<td>LEAD: Chief Executive (Chief Operating Officer, Chief Nurse)</td>
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<td>Failure to deliver year one of the Emergency Centre programme</td>
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<td>B22</td>
<td>Failure to improve safeguarding arrangements in Rotherham</td>
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<td>Our ability to build effective partnership and collaboration arrangements to support the sustainability of services in the long term</td>
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### Likelihood (L)

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<th>Unlikely (2)</th>
<th>Possible (3)</th>
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**Manage at ward / dept meetings**

**Manage by DCS/Matron/Senior Managers**

**Escalate to corporate committees**

**TMC to escalate to Board where appropriate**
<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Description</th>
<th>Executive Lead</th>
<th>Actual risk now, before assurance and controls</th>
<th>Inherent Risk Score</th>
<th>Controls in place</th>
<th>Assurance on controls</th>
<th>Gaps in Control or Assurance</th>
<th>Residual Risk Score</th>
<th>Further planned actions identified to close gaps</th>
<th>Planned actions to be completed by when and by whom</th>
<th>Risk Appetite</th>
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<tbody>
<tr>
<td>B1</td>
<td>Failure to deliver appropriate standards of care and quality (Chief Nurse)</td>
<td>Chief Nurse</td>
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<td>16</td>
<td>Agreed Quality Account goals in place.</td>
<td>Ongoing monitoring against quality account goals – reported through QAC now.</td>
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<td>4</td>
<td>16</td>
<td>Agree implementation plans for the 2015/16 Quality Account indicators:</td>
<td>By end of Q1 – not complete. QA ambitions: complete. Reviewing implementation plans for QA improvements. End Oct 2015. Q3 update: for some of quality improvements the status quo is being kept due to reprioritisation. Q4 improvements in all except complaints.</td>
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<td>External audit of Quality Accounts provides assurance on some data used in monitoring.</td>
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<td>Progress report to OQSEG in December 2015 &amp; OAC.</td>
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<td>Trust Board minutes.</td>
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<td>Notes from contractual / quality meetings.</td>
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<td>Notes from harm care meetings.</td>
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<td>Notes from monthly directorate performance meetings.</td>
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<td>Divisional clinical governance needs strengthening</td>
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### Patients: Excellence in Healthcare

**Executive Lead:** Chief Nurse, Medical Director

**Committee Responsible:** Quality Assurance Committee

<table>
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<th>ID</th>
<th>Risk Description</th>
<th>Executive Lead</th>
<th>Actual risk score</th>
<th>Inherent Risk Score</th>
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<th>Assurance on controls</th>
<th>Gaps in Control or Assurance</th>
<th>Residual Risk Score</th>
<th>Further planned actions identified to close gaps</th>
<th>Planned actions to be completed by whom and by when</th>
<th>Risk Appetite</th>
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<tbody>
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<td>Failure to deliver appropriate standards of care and quality (Chief Nurse)</td>
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<td>3</td>
<td>5</td>
<td>10</td>
<td>Robust CQC action plan</td>
<td>Weekly meeting with paediatric team to support a series of actions</td>
<td>Monthly divisional performance meetings Trust Board minutes – monitoring progress against CQC action plan</td>
<td>Outcomes of TIAA CQC Audit (Q2) update</td>
<td>Recruitment active. Full nurse staffing review in ED, March 2016</td>
<td>Mar-16</td>
</tr>
<tr>
<td>B2</td>
<td>Unable to implement learning and required improvements arising from CQC inspections (Chief Nurse)</td>
<td>Chief Nurse</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>Unable to deliver CQC action plan</td>
<td>Weekly meetings with CQC action plan leads.</td>
<td>One to one meetings between Chief Nurse and operational leads.</td>
<td>Confirm and challenge process in place across health &amp; social care re: Children Looked After &amp; Safeguarding (CLAS) report.</td>
<td>Two further mock inspections over the next 6 weeks – one of the areas rated inadequate and the second a large scale mock across the Trust.</td>
<td>Q1 2016/17</td>
</tr>
</tbody>
</table>

**Risk Description:**

- High level risk that prevents us achieving our agreed deliverables

**Executive Lead:** Chief Nurse

**Actual risk score:** 3

**Inherent Risk Score:** 5

**Controls in place:**

- Friends and Family Test, survey outcomes
- Assurance Dip Sample undertaken on 6 November 2015.
- CCG clinically-led visit programme (recent visits to Paediatrics, Maternity & Endoscopy)
- SAS doctor audits (e.g. DNACPR & MCA)
- Night visits
- Outcomes of TIAA Infection control – hand hygiene Audit (2015/16 Q2).

**Assurance on controls:**

- Gap in control: Insufficient RN - child to achieve one per shift in ED.

**Gaps in Control or Assurance:**

- Lack of ownership at operational level.
- Lack of evidence, or lack of evidence that controls are working.

**Residual Risk Score:**

- 3

**Further planned actions identified to close gaps:**

- Implement refreshed action plan
- Internal validation of paediatric model: Still awaiting feedback from strategic network.
- Roadshows for colleagues to take place after CQC reports have been issued.

**Planned actions to be completed by whom and by when:**

- Begin - complete by end of Q4
- Jan-16

**Risk Appetite:**

- Mar-16

**Inherent Risk Score:**

- 10

**Controls in place:**

- Self-Assure' regular assessment against standards.
- Monthly monitoring of actions to both Board of Directors, Corporate Committees and Contract Quality Committee.
- SAC minutes – monitoring progress against CQC action plan.
- Trust Board minutes – escalations arising concerns or lack of progress against CQC action plan.
- Outcomes of TIAA CQC Audit (Q2) update.
- Mock inspection report 212/15 (positive & negative assurance).
- Assurance audit 5/11/15 (positive & negative assurance).
- Inaccurate ESR data.
- No medical workforce plan. We now have a strategy.

**Assurance on controls:**

- Lack of ownership at operational level.

**Gaps in Control or Assurance:**

- Doctor gap in ED & ANP gap in ED. Also experiencing some safeguarding concerns re practice.

**Residual Risk Score:**

- 4

**Further planned actions identified to close gaps:**

- External validation of paediatric model.
- Still awaiting feedback from strategic network.

**Planned actions to be completed by whom and by when:**

- By end of Q2 - complete
- During Q3 - Q4 ‘Deep dive’ arranged for 5/11/15 - complete
- September 2015 – complete
- In place since August 2015 - ongoing. Monthly reports to QAC and Board. Presented to Children’s & Young People’s Board.

**Risk Appetite:**

- 2

**Inherent Risk Score:**

- 6

**Controls in place:**

- Story board being developed. Resubmission CQC reports to all service leads for them to refresh their memory of report and actions required.
- 18 April mock inspection re EoLC
- Two further mock inspections over the next 6 weeks – one of the areas rated inadequate and the second a large scale mock across the Trust.
- Design monthly process of auditing records in every in-patient setting with a view to driving the compliance agenda specifically around the ward round, DNACPR, MCA.
- Reports have been released for all managers and clinical leads to review

**Assurance on controls:**

- No medical workforce plan. We now have a strategy.

**Gaps in Control or Assurance:**

- Doctor gap in ED & ANP gap in ED. Also experiencing some safeguarding concerns re practice.

**Residual Risk Score:**

- 4

**Further planned actions identified to close gaps:**

- External validation of paediatric model.
- Still awaiting feedback from strategic network.

**Planned actions to be completed by whom and by when:**

- Jan-16
- To be commenced 2nd week of April 2016: 18 April mock inspection re EoLC
- Apr-16
- Two further mock inspections over the next 6 weeks – one of the areas rated inadequate and the second a large scale mock across the Trust.
- Design monthly process of auditing records in every in-patient setting with a view to driving the compliance agenda specifically around the ward round, DNACPR, MCA.
- Reports have been released for all managers and clinical leads to review

**Risk Appetite:**

- 3
<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Description</th>
<th>Executive Lead</th>
<th>Actual risk now</th>
<th>Assurance on controls</th>
<th>Gaps in control or assurance</th>
<th>Residual Risk Score</th>
<th>Planned actions to be completed by whom and by</th>
<th>Risk Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Stop the Pressure Campaign (from Sept 2014)</td>
<td>Chief Nurse</td>
<td>SDP requires On Call consultant to bring in Agency Locum during out of hours to cover unplanned absence overnight or weekends.</td>
<td>Monthly PU audits of each area.</td>
<td>Q1 2016/17.</td>
<td>2</td>
<td>Human factors training and continued embedding into culture.</td>
<td>Continuous process</td>
</tr>
<tr>
<td>4</td>
<td>WHO surgical checklists.</td>
<td>Medical Director</td>
<td>SDP requires On Call consultant to bring in Agency Locum during out of hours to cover unplanned absence overnight or weekends.</td>
<td>WHO surgical checklist audits. Q2 update: Report to Board in October 2015</td>
<td>Gap in assurance relating to the depth of WHO surgical checklist in operating theatre environments.</td>
<td>4</td>
<td>Work to ensure that checklist is applicable to the specific environments.</td>
<td>Q4</td>
</tr>
<tr>
<td>12</td>
<td>Compliance with NICE guidelines</td>
<td>Medical Director</td>
<td>Emergency OOH Service provided with full cross cover.</td>
<td>Compliance with NICE guidelines. Quarterly report to OQSEG.</td>
<td>Gap in control relating to non operating department environments e.g. Dermatology out patient department.</td>
<td>4</td>
<td>Work to ensure that checklist is applicable to the specific environments.</td>
<td>Q4</td>
</tr>
<tr>
<td>10</td>
<td>Drugs &amp; Therapeutics Group now meeting monthly.</td>
<td>Medical Director</td>
<td>Draft medication framework in development.</td>
<td>Minutes for D&amp;T Group. Action plan to QAC in December 2015. Friends and Family Test, survey data. National Patient Survey data.</td>
<td>Clinical engagement in Sign up to Safety programme. Q3 update: Improved engagement quantitatively, qualitative improvement still required.</td>
<td>4</td>
<td>Work to ensure that checklist is applicable to the specific environments.</td>
<td>Q4</td>
</tr>
<tr>
<td>24</td>
<td>Master vendor in place for locums as part of 3 tier process.</td>
<td>Medical Director</td>
<td>Master vendor in place for locums as part of 3 tier process.</td>
<td>Contract with master vendor NHS Choices data MAST compliance data, includes RCA training and awareness of Duty of Candour. Monthly divisional governance meeting minutes</td>
<td>DNA CPG: orders either not being made or orders of poor / variable quality. Defined medical establishment and defined essential on call roles (red flags).</td>
<td>4</td>
<td>Work to ensure that checklist is applicable to the specific environments.</td>
<td>Q4</td>
</tr>
</tbody>
</table>
### Patients: Excellence in Healthcare

**Executive Lead:** Chief Nurse, Medical Director

**Committee Responsible:** Quality Assurance Committee

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Description</th>
<th>Executive Lead</th>
<th>Inherent Risk Score</th>
<th>Controls in place</th>
<th>Assurance on controls</th>
<th>Gaps in Control or Assurance</th>
<th>Residual Risk Score</th>
<th>Further planned actions identified to close gaps</th>
<th>Planned actions to be completed by when and by whom</th>
<th>Risk Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>B3</td>
<td>Causing avoidable harm to patients (Medical Director) + Chief Nurse for Duty of Candour</td>
<td>Medical Director</td>
<td>3 4 12 Estates Strategy</td>
<td>PLACE assessment (was PEAT) surveys. (2016 round due between April &amp; June) Environmental / IPC Ward / departmental audits Finance report re: capital programme spend Level of complaints Unannounced Exec walkarounds</td>
<td>Estates strategy to be agreed Estates strategy to be agreed</td>
<td>3 3 9 Capital investment in the environment throughout 2016-2021:</td>
<td>Completion of capital programme 2015/16</td>
<td>A consultancy has been appointed to undertake a 5 year Estates Strategy</td>
<td>By end of Q2 2016/17</td>
<td>2 2 4</td>
</tr>
<tr>
<td>B4</td>
<td>Failure to maintain and develop an estate fit for the future</td>
<td>Chief Operating Officer</td>
<td>3 4</td>
<td>Estates Strategy</td>
<td>Clinical Strategy Capital Programme Condition surveys regarding backing maintenance Horizon scanning re: changes in legislation / regulation Multi-disciplinary discussions with key clinical and operational teams (infection control, dementia teams, nursing and medical leadership) to ensure all upgrades and refurbishments meet clinical standards. Weekly upgrade meetings during periods of intense capital planning with multi-disciplinary attendance. Relocated HCUP ward to A2 providing improved privacy and dignity as well as dementia friendliness.</td>
<td>Disease identification and reports Identifying documented reviews of results, trends, audit, monitoring, survey results, regulatory assessments etc.</td>
<td>Clinical strategy covering the next 5 years is required to refine the Estates strategy over the same period and the 5 year financial plan</td>
<td>Commission an estates wide review to be undertaken (likely to be externally led).</td>
<td>Medical Director leading this work via the Clinical Transformation Group</td>
<td>Complete</td>
</tr>
</tbody>
</table>

**Risk Description:**
- **B3:** Causing avoidable harm to patients (Medical Director) + Chief Nurse for Duty of Candour
  - **B4:** Failure to maintain and develop an estate fit for the future
**Patients: Excellence in Healthcare**

**Executive Lead: Chief Nurse, Medical Director**

**Committee Responsible: Quality Assurance Committee**

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Description</th>
<th>Executive Lead</th>
<th>Actual risk now, before assurance and controls</th>
<th>Inherent Risk Score</th>
<th>Controls in place</th>
<th>Assurance on controls</th>
<th>Gaps in Control or Assurance</th>
<th>Residual Risk Score</th>
<th>Further planned actions identified to close gaps</th>
<th>Planned actions to be completed by when and by whom</th>
<th>Risk Appetite</th>
<th>The position where the committee would like to see the risk minimised</th>
</tr>
</thead>
<tbody>
<tr>
<td>86</td>
<td>Failure to maintain and develop a (clinically led) IT system fit for the future</td>
<td>Chief Operating Officer</td>
<td></td>
<td>4 4 16</td>
<td>Clinical Health Informatics Development Group (CHID) (monthly)</td>
<td>Minutes or action notes from all committees / groups in Controls column</td>
<td>Updated IT Strategy not yet fully in place. Deadline extended due to changes in national picture.</td>
<td></td>
<td>4 4 16</td>
<td>Agree &amp; finalise strategy</td>
<td>Implementation of current in year plan (2015/16). Finalising 2016/17 plan. Further issues to be addressed by October 2016.</td>
<td>2 3 6</td>
</tr>
<tr>
<td>88</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Information Governance Committee (now reports to TMC) (6 weekly)</td>
<td>Outcomes of TIAA Clinical Administration Systems Audit (2015/16 Q3/Q4)</td>
<td>No assurance rating provided as it was an advisory assessment. Key findings were: - Standardised diagnostic documented procedures do not exist for all tests. - 94% of respondents are unaware of agreed set times for diagnostic results to be produced. - The use of fax machines to communicate abnormal results is questioned. - Use of manual ordering system when electronic ordering is available.</td>
<td></td>
<td></td>
<td>Complete Medtech upgrade</td>
<td>By end of Q3 - complete.</td>
<td></td>
</tr>
<tr>
<td>89</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Regular Exec &amp; Medtech meetings in place (quarterly)</td>
<td>Updates on TRFT strategy presented at Rotherham-wide IT Strategy Meeting</td>
<td></td>
<td></td>
<td>Finalise replacement procurement of System 1 (community IT)</td>
<td>Complete.</td>
<td></td>
<td></td>
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<tr>
<td>90</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Operational Medtech meeting (monthly)</td>
<td>Dashboards containing more information, reports to TMC</td>
<td></td>
<td></td>
<td>Launch of e-prescribing system</td>
<td>During Q4. Q2 2016/17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>91</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tactical Medtech meeting (weekly)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Revised capacity structure to be presented to CIC</td>
<td>By end Q3 - complete.</td>
<td></td>
</tr>
<tr>
<td>93</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rotherham-wide IT Strategy Meeting (TRFT, RCCG, RMBC and RDASH joint meeting)</td>
<td>Updates on TRFT strategy presented at Rotherham-wide IT Strategy Meeting</td>
<td></td>
<td></td>
<td>Place of work to Rotherham IT Strategy Group and the Working Together programme regarding TRFT’s position compared with others. They will then feed into the Sustainability and Transformation Plan.</td>
<td>Q2 2016/17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>94</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PMO within Health Informatics Dept</td>
<td>Gateways and phases of projects reported at CIC regularly</td>
<td></td>
<td></td>
<td>2 actions required from audit: Change Management policy/procedure to be written and undertake benchmarking on the number of changes going through the Change Advisory Board.</td>
<td>Q1 2016/17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>95</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Regular reports to CIC re: operational performance of IT now in place.</td>
<td>Exception report received monthly at CIC</td>
<td></td>
<td></td>
<td>New substantive Associate Director of Information in post</td>
<td>Jul-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Updated and quality assured Informatics programme plan in place</td>
<td>Quarterly reports against Data Quality Assurance plan</td>
<td></td>
<td></td>
<td>Reorganisation Information Services</td>
<td>Q2 2016/17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Assurance of Integrated Performance Report to Board of Directors</td>
<td>Completion of national digital maturity assessment during Q4. Results will be reported to Corporate Informatics Committee and the Working Together programme in April 2016.</td>
<td></td>
<td></td>
<td>Reorganisation complete</td>
<td>Nov-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>98</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>At least 2 Consultants have time in their job plans to contribute to health informatics strategy and development.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>99</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Chief Clinical Information Officer in post.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 Consultants have been trained in clinical safety as per ISBI129 and DSCN 14/2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>101</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Deputy Chief Nurse recruited with IT responsibilities for nursing within job role.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
## Patients: Excellence in Healthcare

**Executive Lead:** Chief Nurse, Medical Director  
**Committee Responsible:** Quality Assurance Committee

| ID | Risk Description | Inherent Risk Score | Controls in place | Assurance on controls | Gaps in Control or Assurance | Residual Risk Score | Further planned actions identified to close gaps | Planned actions to be completed by when and by whom | Risk Appetite |
|----|------------------|---------------------|------------------|-----------------------|-----------------------------|--------------------|---------------------------------|---------------------------------
|    | High level risk that prevents us achieving our agreed deliverables |                      |                  | Evidence that controls are working e.g. audits, KPIs, meeting minutes, survey results, regulator assessments etc. | Lack of structures, policies etc., or lack of evidence that controls are working |                  |                  |                  |                                                        |

### B19 Medical Director

|          | 4 | 5 | 20 | Clinical Service Reviews completed and documented. |                      |                  |                  |                  |                                                        |
|----------|---|---|-----|-------------------------------------------------|----------------------|--------------------|------------------|---------------------|---------------------------------
|          |   |   |     | Report to June 2015 (item 234/15) & Trust Board. | Clinical reference group has reviewed Clinical Speciality Review status for all relevant services and added Stroke and Acute Medicine to the areas for priority attention. **Q3 update:** These will be incorporated into the Clinical Transformation Reference Group. |                  |                  |                  |                                                        |
|          |   |   |     | Implementation of plan by end of Q4. | Develop clinical services options appraisal |                  |                  |                  |                                                        |
|          |   |   |     | By end of Q4 - complete. SLM complete, re-evaluation to establish if model is optimal. Complete: Phase 2 in plan. | |                  |                  |                  |                  |                                                        |
|          |   |   |     | Development of Clinical Transformation Reference Group. | |                  |                  |                  |                  |                                                        |
|          |   |   |     | **Q3 update:** on track. First meeting planned for beginning of January 2016. Meetings underway. Priorities identified: CDR reviewed. First output end Q1 2016/17. | |                  |                  |                  |                  |                                                        |

### Patient Safety

- **Executive Lead:** Chief Nurse, Medical Director  
- **Committee Responsible:** Quality Assurance Committee

|          | 4 | 5 | 20 | Lack of proactive approach to assuring clinical sustainability |                      |                  |                  |                  |                                                        |
|----------|---|---|-----|-------------------------------------------------------------|----------------------|--------------------|------------------|---------------------|---------------------------------
|          |   |   |     |                  |                  |                  |                  |                  |                                                        |
|          |   |   |     |                  |                  |                  |                  |                  |                                                        |
|          |   |   |     |                  |                  |                  |                  |                  |                                                        |
|          |   |   |     |                  |                  |                  |                  |                  |                                                        |
|          |   |   |     |                  |                  |                  |                  |                  |                                                        |
|          |   |   |     |                  |                  |                  |                  |                  |                                                        |
### Risk Description

- High level risk that prevents us achieving our objectives and capacity to deliver the agreed deliverables.

### Executive Lead

- Executive Director of HR

### Inherent Risk Score

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Description</th>
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<th>Planned actions to be completed by when and by whom</th>
<th>Risk Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Workforce plans submitted to national database annually</td>
<td>20</td>
<td>Clear view of vacancies tracked weekly.</td>
<td>Planning to recruit to critical positions (especially medical)</td>
<td>Training needs analysis against 5 year plan</td>
<td>Oct 2015 - complete</td>
<td></td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Workforce plans in place and reviewed monthly by CWG, quarterly by SWC and annually by TMC</td>
<td>20</td>
<td>Monthly Integrated Performance Report at Trust Board supported by highlight report on workforce outcomes</td>
<td>Monthly nurse staffing report at Trust Board</td>
<td>Undertake PDR inc. development plan for all key post holders</td>
<td>G3, on track - complete for MAST</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Managed locum and nurse agency bank arrangements in place</td>
<td>20</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>Zero vacancies for healthcare assistants</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>On track</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>National and international recruitment campaigns</td>
<td>20</td>
<td>PDR completion and follow up development plans for key post holders</td>
<td>Succession planning and talent management process</td>
<td>Programme complete, evaluation sub-optimal</td>
<td>Complete in terms of international recruitment at this point for nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Development programme for divisions (including corporate)</td>
<td>20</td>
<td>Attendance records and evaluations of each session by participants</td>
<td>Job planning / capacity project still incomplete</td>
<td>Job planning for 2016/17 still incomplete but now 75% complete as at end March 2016</td>
<td>Business case to be completed by Q2 - Complete. E-rostering launch planned for April 2016.</td>
<td></td>
<td>2016/17: Q1 2016/17</td>
<td>2016/17: Q1 2016/17</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Senior leadership programme in place which was completed in December 2015</td>
<td>20</td>
<td>Medical staffing report (alternate months) to GAC and monthly workforce report to SWC</td>
<td>Lack of e-rostering system to provide real time staffing information</td>
<td>Medical workforce plan developed including centralisation of workforce coordinators and the medical staffing HR advisors (HR)</td>
<td>2016/17: Q1 2016/17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Monthly medical recruitment programme report to SWC and to GAC</td>
<td>20</td>
<td>Medical staffing report (alternate months) to GAC and monthly workforce report to SWC</td>
<td>Medical staffing report (alternate months) to GAC</td>
<td>Medical staffing report (alternate months) to GAC and monthly workforce report to SWC</td>
<td>2016/17: Q1 2016/17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Reference action (M1 Training), M3A (Nurse Staffing) and M48 (Medical Staffing) in CQC Improvement Action Plan</td>
<td>20</td>
<td>Medical staffing report (alternate months) to GAC and monthly workforce report to SWC</td>
<td>Medical staffing report (alternate months) to GAC</td>
<td>Medical staffing report (alternate months) to GAC and monthly workforce report to SWC</td>
<td>2016/17: Q1 2016/17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Medical Workforce Plan developed (including centralisation of workforce coordinators and the medical staffing HR advisors (HR))</td>
<td>20</td>
<td>Medical staffing report (alternate months) to GAC and monthly workforce report to SWC</td>
<td>Medical staffing report (alternate months) to GAC</td>
<td>Medical staffing report (alternate months) to GAC and monthly workforce report to SWC</td>
<td>2016/17: Q1 2016/17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Launched new Recruitment &amp; Retention meeting December 2015: fortnightly meeting designed to review the nursing workforces strategy including redesign of roles, training programmes, overseas recruitment and role redesign e.g. ANP and RCN.</td>
<td>20</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>On track</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Allocate Bank module upgrade allows more efficient booking of shifts by bank staff members and agencies.</td>
<td>20</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>On track</td>
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<td>15</td>
<td>Revised establishments using the Safer Nursing Care tool</td>
<td>20</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>New appointments arising from recruitment campaigns.</td>
<td>On track</td>
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### Notes of R&R meeting.

Executive Director of HR noted actions to be completed in December 2015: included in December 2015 Review Meeting.

**Summary:**

- **Risk Appetite:** The position where the committee would like to be by the end of the financial year to ensure that the risk is mitigated.
- **Planned actions:** Identifies the actions to be taken to mitigate the risk.
- **Further planned actions identified to close gaps:** Provides additional actions to address any remaining gaps.

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161
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<thead>
<tr>
<th>ID</th>
<th>Risk Description</th>
<th>Executive Lead</th>
<th>Inherent Risk Score</th>
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</thead>
<tbody>
<tr>
<td>B7</td>
<td>Failure to engage the workforce regarding delivery of the Trust's objectives and strategic plan 2015/16</td>
<td>Executive Director of HR</td>
<td>4 4 16</td>
<td>Various mechanisms in place via meetings / email / Director of HR (DAO) / various channels / monthly directorate performance meetings attended by Execs and directorate leads.</td>
<td>LA staff surveys.</td>
<td>4 4 16</td>
<td>PDR to lead NHS staff survey action plan 2015/16</td>
<td>Improve retention rates aspire to 90% by 2017 – expect an improvement in 2015/16</td>
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<td>Monthly directorate performance meetings evidenced through PDR.</td>
<td>NHS annual staff survey.</td>
<td></td>
<td>New ESR 2 goes live in October 2016, ESR work plan being developed (to SWC in April 2016) to detail the Trust’s readiness and actions required to prepare for the roll out.</td>
<td>Deliver engagement plan as outlined by end Q4. In complete.</td>
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<td>Raising Concerns (Whistleblowing) policy and toolkit in place.</td>
<td>Monthly directorate performance meetings.</td>
<td></td>
<td>Report to SWC Q1 2016/17.</td>
<td>By Q4 - complete, retention rates have improved during 2015/16 but still more work to be done. Nursing &amp; Midwifery staffing turnover remains high.</td>
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<td>ESOPs and process maps developed to support the interface between Subject Matter Experts who deliver MAST and L&amp;D teams and ESR team.</td>
<td>Notes from monthly directorate performance meetings.</td>
<td></td>
<td>Regular reviews by SWC and CWG thereafter.</td>
<td>Deliver engagement plan as outlined by end Q4. In complete.</td>
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<td></td>
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<td></td>
<td>Confidential hotline for ‘whistleblowers’ in place and confidential email address.</td>
<td>Monthly directorate performance meetings.</td>
<td></td>
<td>ESOP roll out for 2016/17.</td>
<td>By Q4 - complete, retention rates have improved during 2015/16 but still more work to be done. Nursing &amp; Midwifery staffing turnover remains high.</td>
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<td></td>
<td>Speak up Guardians in place.</td>
<td>Confidential hotline for ‘whistleblowers’ in place and confidential email address.</td>
<td></td>
<td>ESOP roll out for 2016/17.</td>
<td>Report to SWC Q1 2016/17.</td>
<td>Deliver engagement plan as outlined by end Q4. In complete.</td>
<td>2</td>
</tr>
</tbody>
</table>
Colleagues: Engaged, accountable colleagues

Executive Lead: Executive Director of HR
Committee Responsible: Strategic Workforce Committee

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Failure to reduce workforce costs to planned 2015/16 levels</td>
<td>4 4 16</td>
<td>4 5 20</td>
<td>Monthly review by F&amp;PC and SWC.</td>
<td>Lack of e-rostering system to provide real time staffing information.</td>
<td>Continue review of interim spend, and recruitment to substantive posts.</td>
<td></td>
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<tr>
<td>5</td>
<td>Inherent Risk Score</td>
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<td>Further planned actions identified to close gaps</td>
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<tr>
<td>6</td>
<td>Ongoing Board oversight.</td>
<td>3 3 5</td>
<td>3 3 5</td>
<td>Board minutes</td>
<td></td>
<td>E-rostering system implementation.</td>
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<tr>
<td>7</td>
<td>Robust attendance management policy and delivery in place</td>
<td>3 3 5</td>
<td>3 3 5</td>
<td>Monthly directorate performance meetings attended by Exec and directorate leads with clear visibility on labour costs.</td>
<td></td>
<td>Business case to be completed by Q2.</td>
<td></td>
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<tr>
<td>8</td>
<td>Managed locum and nurse agency bank arrangements in place</td>
<td>3 3 5</td>
<td>3 3 5</td>
<td>Monthly directorate performance meetings attended by Exec and directorate leads with clear visibility on labour costs.</td>
<td></td>
<td>Business case to be completed by Q2.</td>
<td></td>
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<tr>
<td>9</td>
<td>Incentive development and implementation</td>
<td>3 3 5</td>
<td>3 3 5</td>
<td>Monthly directorate performance meetings attended by Exec and directorate leads with clear visibility on labour costs.</td>
<td></td>
<td>Business case to be completed by Q2.</td>
<td></td>
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<tr>
<td>10</td>
<td>Weekly meetings between Exec Directors and Divisional Leads to discuss agency spend, and weekly reporting to Monitor.</td>
<td>3 3 5</td>
<td>3 3 5</td>
<td>Weekly meetings between Exec Directors and Divisional Leads to discuss agency spend, and weekly reporting to Monitor.</td>
<td></td>
<td>Business case to be completed by Q2.</td>
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<tr>
<td>11</td>
<td>Refresh of IR35 process relating to people engaged off payroll.</td>
<td>3 3 5</td>
<td>3 3 5</td>
<td>Regular SWC reports.</td>
<td></td>
<td>Business case to be completed by Q2.</td>
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<tr>
<td>12</td>
<td>Better oversight of all interim.</td>
<td>3 3 5</td>
<td>3 3 5</td>
<td>Regular SWC reports.</td>
<td></td>
<td>Business case to be completed by Q2.</td>
<td></td>
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<tr>
<td>13</td>
<td>Increase in bank rate (25% pay increase) from 1 December 2015 for certain staff groups.</td>
<td>3 3 5</td>
<td>3 3 5</td>
<td>Regular SWC reports.</td>
<td></td>
<td>Business case to be completed by Q2.</td>
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Corporate Committee would like to see the end of the financial year, to ensure that the set target is met.
### Governance: Trusted, open governance

**Executive Lead:** Chief Executive (Director of Finance, Director of Corporate Affairs)

**Committee Responsible:** Audit Committee

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<tbody>
<tr>
<td>B9</td>
<td>Failure to improve financial governance processes leading to poor financial performance</td>
<td>Director of Finance</td>
<td>3 4 12</td>
<td>2 3 6</td>
<td>Establish and implement financial awareness sessions to budget holders and others (DoF)</td>
<td>By end of Q2 – complete, now on a rolling programme.</td>
<td>Q1 2016/17</td>
</tr>
<tr>
<td>B10</td>
<td>Failure to achieve compliance with the Provider Licence</td>
<td>Chief Executive</td>
<td>4 4 16</td>
<td>5 3 15</td>
<td>Compile evidence to support completion of application to remove (some) undertakings (DoF)</td>
<td>Evidence complied. Further evidence likely to be required before submission.</td>
<td>Q3 2016/17</td>
</tr>
</tbody>
</table>

**Inherent Risk Score**
- Audit risk now; before assurance and controls
- Structures, policies, working groups / committees, SLAs / agreements / contracts in place etc
- Evidence that controls are working e.g. audits, KPIs, meeting minutes, survey results, regulator assessments etc
- Lack of structures, policies etc, or lack of evidence that controls are working

**Residual Risk Score**
- Perceived score after mitigating actions

**Controls in place**
- Audit Committee, Business Investment Group, Finance & Performance Committee in place
- Finance Directorate financial governance action plan 2014/15
- 2015/16 Finance directorate action plan
- Revised Standing Financial Instructions (SFIs)
- Implementation of recommendations from 2014/15 audit programme and signing off of actions as complete

**Assurance on controls**
- Minutes from committees/groups
- Trust Board minutes, including escalations
- Progress against the action plans
- Review of both action plans on a weekly basis at Senior Finance team meeting
- Continuous monitoring of adherence to SFIs; any staff member who breaches SFIs is written to every month
- TIAA audit tracker highlights audit recommendations which are not yet complete
- Audit tracker reviewed quarterly at Audit Committee and reviewed monthly by the DoF and Head of Internal Audit.
- 2015/16 Internal Audit programme

**Gaps in Control or Assurance**
- Lack of compliance against actions

**Board of Directors monitor the finance governance action plan on a 6 monthly basis (Sept 2015)**

**Monitor Action Tracker document (lists actions agreed at Monitor PRM meetings to ensure that each action is monitored and delivered in relation to areas of non-compliance)**

**Production and delivery of Annual Plan 2015/16 and 2016/17 that erodes and controls underlying deficit.**

**Finance & Performance Committee via monitoring of achievement of Annual Plan 2015/16.**

**Finance governance action plan**
- Outcomes of TIAA Board Committee Effectiveness Audit (2014/15 Q3) - POSTPONED
- Minutes of Finance & Performance Committee detailing PFC’s monitoring of finance governance action plan on a monthly basis
- TRFT’s 5 year and 1 year plans submitted to Monitor
- Finance governance action plan demonstrates that the Trust has taken action and the progress made

**Risk Appetite**
- The position where the committee would like to be by the end of the financial year, to ensure that the risk is mitigated
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<td>High level risk that prevents us achieving our agreed deliverables</td>
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<td></td>
<td>Evidence that controls are working e.g. audits, KPIs, meeting minutes, survey results, regulator assessments etc</td>
<td>Lack of structures, policies or lack of evidence that controls are working</td>
<td>4</td>
<td>16</td>
<td>July 2015 - complete</td>
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<tr>
<td>811</td>
<td>Failure to protect confidential Trust data - patients, colleagues and other</td>
<td>SIRO</td>
<td>4 5 20</td>
<td>Caldwell Group, Clinical Records Group, in place and meets quarterly.</td>
<td>Minutes from the Groups</td>
<td>IG awareness culture within the Trust appears to be minimal – evidence of lack of awareness / accountability for breaches, lack of ongoing training programmes for colleagues, Except for IT systems, no trained Information Asset Owners in place - as required by Toolkit.</td>
<td>4 4 16</td>
<td>IG Toolkit action plan to be presented to Trust Board which incorporates internal audit recommendations. Additional actions to be developed to assist Standard Owners to comply with standards.</td>
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<td>2016/17</td>
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<td>Policies in place:</td>
<td>Evidence lodged with IG Toolkit</td>
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<td>IAO training to take place on 6 January 2016. Not yet as IAOs require more training. Q2 2016/17</td>
<td>Complete</td>
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<td>Health Records Policy</td>
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<td>Corporate (non-clinical) Records Management Policy</td>
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<td>Risk assessment of IAA's and implementation of business continuity plans where none, start in Q2 ongoing</td>
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<td>Collected at end of Q4.</td>
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<tr>
<td>B12</td>
<td>Failure to implement a robust performance framework and governance structure at a service line level through to Trust Board.</td>
<td>Chief Operating Officer</td>
<td>4</td>
<td>Updated organograms for each clinical directorate has created greater clarity of structures in those areas.</td>
<td>Review of KPI’s with appropriate escalation to Board Committee's.</td>
<td>Not all Divisions are holding CSU performance meetings.</td>
<td>4 3 12</td>
<td>Develop and implement standardised performance management framework (COO)</td>
<td>By end of Q1 – complete for CSU performance meetings. During Q2: reinstated Divisional Performance meetings and updating and revising Divisional performance dashboards. Q4</td>
<td>2 3 6</td>
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</tbody>
</table>
## Governance: Trusted, open governance

**Executive Lead:** Chief Executive (Director of Finance, Director of Corporate Affairs)

**Committee Responsible: Audit Committee**

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<th>Expected Completion</th>
<th>Risk Appetite</th>
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<tr>
<td></td>
<td>High level risk that prevents us achieving our agreed deliverables</td>
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<td>Actual risk now, before assurance and controls</td>
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<td></td>
<td>Lack of structures, policies etc, or lack of evidence that controls are working</td>
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### Inherent Risk Score

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<tbody>
<tr>
<td>B13</td>
<td>Failure to comply with Trust's Policies</td>
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### Residual Risk Score

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### Further planned actions identified to close gaps

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</tr>
<tr>
<td>B14</td>
<td>Inability to fully embed risk management processes</td>
<td>Chief Nurse</td>
</tr>
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Governance: Trusted, open governance

Executive Lead: Chief Executive (Director of Finance, Director of Corporate Affairs)

Committee Responsible: Audit Committee

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- Structures, policies, working groups / committees, SLAs / agreements / contracts in place etc
- Evidence that controls are working e.g. audits, KPIs, meeting minutes, survey results, regulator assessments etc
- Lack of structures, policies etc, or lack of evidence that controls are working

Evidence: Structures, policies, working groups / committees, SLAs / agreements / contracts in place etc

- Lack of structures, policies etc, or lack of evidence that controls are working

Governance: Trusted, open governance

Executive Lead: Chief Executive (Director of Finance, Director of Corporate Affairs)

Committee Responsible: Audit Committee

<table>
<thead>
<tr>
<th>Different Risk Score</th>
<th>Controls in place</th>
<th>Assurance on controls</th>
<th>Gaps in Control or Assurance</th>
<th>Residual Risk Score</th>
<th>Further planned actions identified to close gaps</th>
<th>Planned actions to be completed by when and by whom</th>
<th>Risk Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 4 12</td>
<td>Risk Management Strategy in place (interim strategy). Strategy approved at Board in November 2015.</td>
<td>Evidence that controls are working e.g. audits, KPIs, meeting minutes, survey results, regulator assessments etc</td>
<td>Lack of structures, policies etc, or lack of evidence that controls are working</td>
<td>3 4 12</td>
<td>Board approval of updated Risk Management Strategy</td>
<td>July 2015 board meeting – revised version produced but not accepted. Will be presented to Sept 2015 BoD meeting therefore deadline extended.</td>
<td>2 3 6</td>
</tr>
</tbody>
</table>

Chief Nurse

- Risk register now reviewed at TMC monthly.
- Corporate risk register reviewed at Board of Directors quarterly.
- Presentation on risk appetite to TMC in December 2015.
- Plan to improve risk management agreed with TMC in March 2016.


- More consistent use of Datix for risk management audits by divisions being seen at TMC meetings.
- Received 10 statements of assurance from Divisions / corporate areas about the robustness of their risk management practices.
- Assurance audit by Head of Governance in November 2015 (negative assurance).

Board minutes

TMC minutes.

Corporate risk register reviewed at Board of Directors quarterly.

Presentation on risk appetite to TMC in December 2015.

Plan to improve risk management agreed with TMC in March 2016.

Gap in control and assurance: Risk Management Committee not yet set up.

Advert for Compliance & Risk Manager to be progressed to appointment in Q1 2016/17.

Reported to Board in July 2016.

Assistant Director of Patient Safety & Risk to meet each Division to review risk register.

Risk management training to be programmed.

OQSEG approved the requirement for all clinical environment moves to be risk assessed and signed off by Chief Operating Officer, Medical Director and Chief Nurse.

The risk assessment built into CIP QIA is to be reviewed.

Risk Management Committee to be established

Advert for Compliance & Risk Manager to be progressed to appointment in Q1 2016/17.

Reported to Board in July 2016.
## Finance: Strong financial foundations

**Executive Lead:** Director of Finance  
**Committee Responsible:** Finance & Investment Committee

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Description</th>
<th>Executive Lead</th>
<th>Inherent Risk Score</th>
<th>Controls in place</th>
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</thead>
</table>
| B15 | Unable to deliver £12.9m CIPs and reduce the underlying deficit | Director of Finance | 4 5 20 | Audit Committee, Business Investment Committee, Finance & Performance Committee, TMC-T in place.  
CIP meetings with Divisions and work streams / PMO  
Finance Directorate financial governance action plan  
Monthly report to TMC, F&P and BoD  
Weekly Executive Director-led reviews with senior manager leads against the action plan for the 5 key CIP themes i.e. theatres; outpatients; coding; procurement & medicines management. | Minutes of these meetings  
Annual internal audit programme  
Annual external audit of financial statement  
Monthly Monitor PRM  
Monthly returns to Monitor re: CIPs  
Updated action plan for the 5 CIP themes appended to the CIP report received at the Finance & Performance Committee. | Lack of attendance at fortnightly meetings (Division with PMO and Finance teams)  
Impact of competing priorities on divisional management team re: focus on delivering CIPs.  
Capacity & capability to deliver against the agreed timescales. | 3 5 15 | Deliver programme: Reiterating importance of focus on CIP in monthly divisional performance meetings  
Commence 2016/17 CIP programme  
Confirm indicative 2017 – 2020 values  
Focus on delivering 2016/17 CIPs  
Embed 'Lord Carter' work programme | By end of Q2 - complete.  
By end Q2 - complete.  
By end of Q4 - on track.  
Ongoing  
Q1 2016/17 | 2 4 8 |
| B15a | Failure to achieve planned liquidity | Director of Finance | 4 5 20 | Audit Committee, Business Investment Committee, Finance & Performance Committee in place.  
Weekly Senior Finance staff meeting  
Weekly, 13 weekly and annual cash flow produced | Minutes from committees/groups  
Trust Board minutes, including escalations  
Monthly Monitor PRM  
Annual internal audit programme  
Annual external audit of financial statement | Lack of compliance against actions | 2 2 4 | Submit loan application to the ITFF  
Agree and implement working capital strategy  
Produce 5 year cash flow forecast  
Complete and submit one year operational plan  
Produce high level analysis of the 5 year financial plan  
Produce detailed 5 year financial plan (monthly for 15/16 and 16/17)  
Update working capital strategy | Complete  
Oct-15  
Complete  
Complete  
Complete, though without detailed sector assumptions  
Complete, though without detailed sector assumptions | 2 2 4 |
## Finance: Strong financial foundations

**Executive Lead:** Director of Finance  
**Committee Responsible:** Finance & Investment Committee

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Description</th>
<th>Actual Risk Now</th>
<th>Inherent Risk Score</th>
<th>Controls in Place</th>
<th>Assurance on Controls</th>
<th>Gaps in Control or Assurance</th>
<th>Residual Risk Score</th>
<th>Further planned actions identified to close gaps</th>
<th>Planned actions to be completed by whom and by when</th>
<th>Gap Risk Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>B16b</td>
<td>Failure to comply with loan requirements through lack of cash management and 'Going Concern'</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Audit Committee, Business Investment Committee, Finance &amp; Performance Committee in place. Weekly Senior Finance staff meeting Weekly, 13 weekly and annual cash flow produced 2016/17 annual plan to be submitted to the B&amp;O in March to include cash flow implications and required actions Detailed cash action plan Minutes from committees/groups Trust Board minutes, including escalations Monthly Monitor PRM</td>
<td>Delivery against the agreed actions Non delivery against the I&amp;E trajectory particularly cash releasing schemes</td>
<td>3 5 15</td>
<td>Confirmation of phase 2 of the loan application with the DH Additional actions to ensure delivery of the loan conditions Submission of draft 16/17 in early February to Monitor to clearly identify any cash requirements for the 16/17 financial year Re-negotiate the terms of the 2015/16 loan to include usage for operational costs as well as capital (Awaiting ITFF financial guidance)</td>
<td>Ongoing</td>
<td>3 3 9</td>
</tr>
<tr>
<td>B17</td>
<td>Failure to deliver capital programme</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Audit Committee, Business Investment Committee, Finance &amp; Performance Committee in place. Project Managers for the key capital programmes e.g. Emergency Centre Standing agenda item relating to Capital Programme at Finance &amp; Performance Committee with key officers attending as appropriate to ensure escalation of key issues for detailed review Minutes and actions from the Committees Regular reports and escalations from the capital programmes Minutes of F&amp;P meeting Monthly Monitor PRM meetings</td>
<td>Lack of delivery against key actions e.g. monthly forecasts</td>
<td>3 4 12</td>
<td>Develop, prioritise and sign off the draft 5 year capital programme Alignment with IT and Clinical Estates Strategy (2016/17)</td>
<td>Complete</td>
<td>2 2 4</td>
</tr>
</tbody>
</table>

**Finance:** Strong financial foundations  
**Executive Lead:** Director of Finance  
**Committee Responsible:** Finance & Investment Committee  
**ID:** B16b | B17  
**Residual Risk Score:** 4 4 16  
**Gap Risk Appetite:** 3 3 9  

**Risk Description:** High level risk that prevents us achieving our agreed deliverables  
**Controls in Place:** Structures, policies, working groups / committees, SLAs / agreements / contracts in place etc.  
**Assurance on Controls:** Evidence that controls are working e.g. audits, KPIs, meeting minutes, survey results, regulator assessments etc.  
**Gaps in Control or Assurance:** Lack of structures, policies etc, or lack of evidence that controls are working  
**Further planned actions identified to close gaps:**  
- Confirmation of phase 2 of the loan application with the DH Additional actions to ensure delivery of the loan conditions Submission of draft 16/17 in early February to Monitor to clearly identify any cash requirements for the 16/17 financial year Re-negotiate the terms of the 2015/16 loan to include usage for operational costs as well as capital (Awaiting ITFF financial guidance)  
- Develop, prioritise and sign off the draft 5 year capital programme Alignment with IT and Clinical Estates Strategy (2016/17)  

**Planned actions to be completed by whom and by when:**  
- Ongoing  
- Feb 16  
- May 2016 (Awaiting ITFF financial guidance)  
- Complete  
- Q1 / Q2 2016/17  
- 18-Apr-16  

**ID:** B16b | B17  
**Residual Risk Score:** 4 4 16  
**Gap Risk Appetite:** 3 3 9  

**Risk Description:** High level risk that prevents us achieving our agreed deliverables  
**Controls in Place:** Structures, policies, working groups / committees, SLAs / agreements / contracts in place etc.  
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**ID:** B16b | B17  
**Residual Risk Score:** 4 4 16  
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- Ongoing  
- Feb 16  
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- Complete  
- Q1 / Q2 2016/17  
- 18-Apr-16
## Finance: Strong financial foundations

**Executive Lead:** Director of Finance  
**Committee Responsible:** Finance & Investment Committee

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<tbody>
<tr>
<td></td>
<td>High level risk that prevents us achieving our agreed deliverables</td>
<td>Director of Finance</td>
<td>3 4 12</td>
<td>3 5 15</td>
<td>Agree contract performance arrangements and leads</td>
<td>Complete</td>
<td>2 3 6</td>
</tr>
<tr>
<td>B18</td>
<td>Failure to deliver contractual obligations including financial penalties, performance indicators and activity levels</td>
<td>Audit Committee, Business Investment Committee, Finance &amp; Performance Committee</td>
<td>Minutes and actions from the meetings</td>
<td>Weekly Senior Finance staff meeting</td>
<td>KCIs of penalties reported within the contract report</td>
<td>Commerce 2016/17 contracting round</td>
<td>Begins Q2 – not complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Finance &amp; Performance Committee scrutiny</td>
<td>Monthly contract report</td>
<td>Uncoded episodes at contractual freeze dates</td>
<td>Coding action plan, weekly meetings between Director of Health Informatics, Clinical Information Development Manager and Director of Finance.</td>
<td>In place &amp; ongoing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Compliance with agreed actions</td>
<td>Monthly meeting between TRFT and RCCG</td>
<td></td>
<td>Escalation by exception for non-compliance with actions or timescales.</td>
<td>Q1 – in place &amp; ongoing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Monthly divisional performance meetings</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Quarterly Exec to Exec Meeting with RCCG</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>CQUINS &amp; LoFI are reviewed every month at TMC-T. All indicators are risk assessed with an action plan for any assessed as Red or Amber. Each indicator has an Executive Lead and a responsible officer. CQUINS &amp; LoFI performance is also monitored at the monthly Divisional Performance meetings.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lead Executive Directors are in regular contact with NHS Improvement.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Action log and minutes from TMC-T and F&amp;P Committee minutes.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Changing national guidance impacting locally (C)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Monthly update to Trust Board

#### Recruitment to General Manager post in Integrated Medicine
- Q3
- Launch ‘perfect locality’
- Full review of Intermediate Care provision
- Planned actions to be completed by Q1 2016/17 onwards
- Creation of Frailty Unit / Team
  - Q3 Complete.
- Clear communications plan
  - Q1 2016/17
- Redefine role of the Divisions and the Central Operations Team
  - Q1 2016/17 onwards
- Q3. Complete.
- Q1 2016/17 commence

#### Phase 2 ward re-configuration of bed base
- By end of Q4. 2016/17 programme.
- Year 1
- Implement hospital at night (and day)
- Implement year 1 of the plan
- By end of Q4. 4 Q4 Update: Year plan implemented as far as possible within the year.
- By end of Q2. Model in place. Interviewing for additional posts 22/9/15. Job planning will be completed by end Oct 2015. Q3 update: Job planning process for 2015/16 still underway. All job plans for 2015/16 to be signed off ASAP.

#### Risk Appetite
- Recruitment of PMO support Q1 2016/17
- Appointment to and development of community physician role

### Risk Description

<table>
<thead>
<tr>
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</thead>
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<tr>
<td>B20</td>
<td>Failure to deliver transformation in the acute and community settings</td>
<td>Medical Director</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Transformation Project Board (TPB) - external, monthly</td>
<td>4</td>
<td>4</td>
<td>12</td>
<td>Implement year 1 of the plan</td>
</tr>
<tr>
<td>B20</td>
<td>Failure to deliver transformation in the acute and community settings (continued)</td>
<td>Medical Director</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>Trust Management Committee - Transformation (TMC- Transformation) monthly</td>
<td>Minutes of TMC, TPB, CTPB</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>B20</td>
<td>Failure to deliver transformation in the acute and community settings (continued)</td>
<td>Chief Operating Officer</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Community Transformation Project Board (CTPB), External with CCG. Acute 7/7 and Community 7/7 contract schedules</td>
<td>Contract Review meetings</td>
<td>4</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>B20</td>
<td>Failure to deliver transformation in the acute and community settings (continued)</td>
<td>Chief Operating Officer</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>Monthly update to Trust Board</td>
<td></td>
<td></td>
<td></td>
<td>Deliver quarterly contractual indicators in Community Transformation &amp; 7/7 programme</td>
</tr>
</tbody>
</table>

### Notes
- The position where the committee would like to see the financial year, to ensure that the risk is mitigated.
### Risk Description

High level risk that prevents us achieving our agreed deliverables

- **Executive Director Controls in place**
- **Assurance on controls**
- **Gaps in Control or Assurance**

### Executive Lead

Chief Operating Officer

### Committee Responsible

Quality Assurance Committee / Finance & Investment Committee / Board of Directors

### Inherent Risk Score

Actual risk now, before assurance and controls

- **Risk Appetite**
  - The position where the committee would like to be by the end of the financial year, to ensure that the risk is mitigated

### Residual Risk Score

Evidence that controls are working e.g. audits, KPIs, meeting minutes, survey results, regulator assessments etc

- **Perceived score after mitigating actions**

### Further planned actions identified to close gaps

- **Planned actions to be completed by when and by whom**

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<tr>
<td>B21</td>
<td>Failure to deliver year one of the Emergency Centre programme</td>
<td>Chief Operating Officer</td>
<td>4 5 20</td>
<td>Emergency Centre project governance structure includes regular meetings of:</td>
<td>Minutes of all meetings in controls column.</td>
<td>Project plan is not yet complete for entire EC project. Needs to be built up from Task &amp; finish group project plans</td>
<td>3 5 15</td>
<td>Final version of EC overarching project plan</td>
<td>Q4 Q1 2016/17</td>
<td></td>
</tr>
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<td>Inherent Risk Score</td>
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<td>Residual Risk Score</td>
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<td>Risk Appetite</td>
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</tr>
<tr>
<td>B22</td>
<td>Failure to improve safeguarding arrangements in Rotherham</td>
<td>Chief Nurse</td>
<td>4 4 16</td>
<td>In-house and external multi agency training.</td>
<td>Children Looked After and Safeguarding Report makes a number of recommendations.</td>
<td>4 4 16</td>
<td>Existing CSE Nurse brought into corporate division for more direct oversight by Chief Nurse.</td>
<td>2 3 6</td>
<td>Complete</td>
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<tr>
<td></td>
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<td></td>
<td>Management of women whose children are subject to care proceedings to agreed timescales</td>
<td>Minutes from Strategic Safeguarding Group led by TRFT Chief Nurse which RMBC and CCG attend.</td>
<td>As at 19 September 2015 3. Improvement of safeguarding arrangements. 1 new named doctor and 1 named nurse in place.</td>
<td>Additional safeguarding supervision capacity commissioned.</td>
<td>Complete</td>
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<td></td>
<td>Colocation of adult and child safeguarding teams including Dementia and Learning Disability Nurses.</td>
<td>Bi-monthly reports to TRFT board (confidential) Initial LAC health assessments. Poor compliance.</td>
<td>Planning a LiA event to address LAC initial health assessments</td>
<td>Agency staff booked for 3 months to fill long term sickness gaps.</td>
<td>End December 2015</td>
<td>Complete</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td>LSCB CLAS action plan</td>
<td>LSCB multi agency audits</td>
<td></td>
<td>Undertaking full refresh of ESR training data</td>
<td>End October 2015</td>
<td></td>
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<td></td>
<td></td>
<td>Strategic Safeguarding Group now quarterly aligned to CQUIN &amp; KPI</td>
<td>Safeguarding CQUINS</td>
<td>Now improved.</td>
<td>MCA / DoLS input to AMU daily (Monday to Friday)</td>
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<td></td>
<td></td>
<td>Section 11 audit</td>
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<td>Paediatric Liaison now part of corporate safeguarding resource.</td>
<td>Gap in assurance: Poor safeguarding compliance in the ED (both adult and children).</td>
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<td>New named midwife recruited.</td>
<td>Review of all Datix</td>
<td>Gap in control: Interim named doctor now retired. Agreement to be reached with Miss Patel re: interim named doctor SEND - doctor and designated doctor all here gaps.</td>
<td>Q1 2016/17</td>
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<td></td>
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<td></td>
<td>Review of safeguarding referrals at weekly harm free care meetings.</td>
<td></td>
<td>Gap in control: Safeguarding adult L3 compliance at best average across the Trust.</td>
<td>Need to achieve 80% compliance in Q1.</td>
<td>Q1 2016/17</td>
<td></td>
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<td></td>
<td></td>
<td>S11 audit approved at LSCB.</td>
<td></td>
<td></td>
<td>Meeting with ED on 19 April and recovery plan (as compliance with safeguarding policies) to be with the Chief Nurse by 21 April; thereafter reviewed weekly.</td>
<td>Q1 2016/17</td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
<td>All positions now filled.</td>
<td></td>
<td></td>
<td>Daily input to the ED by the paediatric liaison nurses. Review at the end of Q1.</td>
<td>Q1 2016/17</td>
<td></td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>All safeguarding adult L3 training to be completed by August 2016.</td>
<td>Q2 2016/17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Partners: Securing the future together

**Executive Lead:** Chief Operating Officer  
**Committee Responsible:** Quality Assurance Committee / Finance & Investment Committee / Board of Directors

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<th>ID</th>
<th>Risk Description</th>
<th>Executive Director</th>
<th>Inherent Risk Score</th>
<th>Controls in place</th>
<th>Assurance on controls</th>
<th>Gaps in Control or Assurance</th>
<th>Residual Risk Score</th>
<th>Further planned actions identified to close gaps</th>
<th>Planned actions to be completed by when and by whom</th>
<th>Risk Appetite</th>
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<tbody>
<tr>
<td>B23</td>
<td>High level risk that prevents us achieving our agreed deliverables</td>
<td>Chief Executive</td>
<td>4 5 20</td>
<td>Development of Sustainability and Transformation Plan (STP) across the agreed South Yorkshire and Bassetlaw with associate organisations footprint.</td>
<td>Submission review response from Monitor. Minutes of Working Together Programme (commissioner and provider executive), Progress on STP Vanguard and the Working Together Programme.</td>
<td>Extent to which the Trust’s assessment of sustainability is improving. Need for further clarity on Vanguard strategic priorities and timescales across the STP footprint.</td>
<td>3 5 15</td>
<td>Actions to support development and agreement of the STP</td>
<td>End June 2016</td>
<td>3 3 9</td>
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<td>Trust’s 1 year and 5 year plans set context.</td>
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<td></td>
<td>Proactive relationship building with key stakeholders</td>
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<td>Commenced and ongoing</td>
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<td>Working Together Partnership &amp; Vanguard structure and programme arrangements</td>
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<td></td>
<td>Medical Director’s report on clinical sustainability to Board of Directors and regular reports to TMC-T</td>
<td>Q1 2016/17</td>
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<td>Rotherham Partnership, development of Rotherham Vision and Health &amp; Wellbeing Strategy</td>
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<td>Outstanding enforcement undertakings re: financial and strategic planning</td>
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<td>Agreed plan in place</td>
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<td>Stakeholder engagement led by the Trust and delivery of the Vanguard model for local Health &amp; Social Care economy</td>
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<td>Social care transformation plan led by RMBC</td>
<td>2016/17</td>
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<td>Clinical Transformation Group</td>
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Our ability to build effective partnership and collaboration arrangements to support the sustainability of services in the long term

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<tr>
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<th>Risk Description</th>
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<td>Clinical Transformation Group</td>
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Report: Corporate Risk Register (with risks scoring 16 and above)

Presented by: Tracey McErlain-Burns, Chief Nurse

Author(s): Tracey McErlain-Burns, Chief Nurse and, Fiona Middleton, Assistant Director of Patient Safety and Risk,

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

Regulatory relevance:
Monitor:
CQC Domain: safe / effective / responsive / well-led

Risk Reference:
BAF: B3, B6, B14
Corporate Risk Register: N/A

Purpose of this paper:
To present the risks, scoring 16 and above, from the current corporate risk register to the Board of Directors.

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

- There are currently 24 risks on the corporate risk register with a score of 16 or above
- In the past month no new risks were added to this high scoring category but four risks were removed and these were discussed at the Trust Management Committee
- 9 risks scoring 16 or above are overdue for review.
- The Board should note the new format of this section of the corporate risk register.

Committee action required: For noting
<table>
<thead>
<tr>
<th>Risk No. &amp; Score</th>
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<tbody>
<tr>
<td>Owner</td>
<td>Director of Finance</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Increased cost of bank and agency resulting in over spend against budgets.</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>The Trust is facing increased flexible workforce costs as a result of vacancies and the prolonged recruitment time periods arising from posts which are hard to fill due to national shortages.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Active recruitment; management of the impact of agency price caps; break glass policies in place with strengthened governance arrangements; all positions are subject to review in the content of potentially recruiting to different roles, e.g. advanced nurse practitioners; development of the internal flexible staffing bank; performance management of divisions.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>OVERDUE. Review was due 31.01.16</td>
<td></td>
</tr>
<tr>
<td>Targeted risk score</td>
<td>12</td>
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<tr>
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<tbody>
<tr>
<td>Owner</td>
<td>Director of Finance</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Failure to achieve new to follow up ratios resulting in the Trust not being paid for activity.</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>The Commissioning contract requires the Trust to reduce the rates of follow up appointments. The out-patient review has so far not achieved delivery of those reductions.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>The controls need to be reviewed and the objectives for the out-patient review group need to be made specific</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>OVERDUE. Review was due 31.01.16</td>
<td></td>
</tr>
<tr>
<td>Targeted risk score</td>
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<td>Assurance Committee</td>
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<tr>
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</thead>
<tbody>
<tr>
<td>Owner</td>
<td>Director of Corporate Affairs / Company Secretary / SIRO</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>The Trust has breached the regulatory requirements associated with the NHS Information Governance toolkit.</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Over the course of the past 12 months there have been examples of information governance breaches. These have been reported to the relevant regulators including the Information Commissioner. The impact of those breaches is such that the Trust has failed to attain an IG toolkit score of 2.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Information Asset Owners have been identified and recently trained. The content of the information governance training package has been updated. The obligatory requirements of all colleagues have been included in team brief. Formal disciplinary procedures are in place for use as required. Systems and processes of work are being reviewed in relevant areas of the Trust.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>30.04.16</td>
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</tr>
<tr>
<td>Targeted risk score</td>
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<td>Risk No. &amp; Score</td>
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<tr>
<td>-----------------</td>
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<td>----</td>
</tr>
<tr>
<td>Owner</td>
<td>Divisional Director of Integrated Medicine</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Clinic letter backlogs</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Due to administrative reasons there is a delay in the typing of dictated clinic letters. This could result in GPs making decisions without all the necessary information following consultation at the hospital. The impact is therefore one of reputation and potential risk to patients. There is also a potential impact on income associated with the CQUIN objectives.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Flexible overtime arrangements have been put in place and the division has a performance trajectory against which it is monitored and performance managed by the Chief Operating Officer.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>OVERDUE. Review was due 29.03.16</td>
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<tr>
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<tr>
<td>Owner</td>
<td>Chief Nurse</td>
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</tr>
<tr>
<td>Title</td>
<td>Failure to progress all the elements of the CQC action plan posing a risk of sanctions</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>The CQC visited the Trust in February 2015. Their reports were published in July 2015 and the Trust launched an improvement / action plan. There is a risk of under delivery on some of the actions. The consequence will be adverse media and reputational damage, a loss of confidence in the organisation by the local community, a risk of enforcement action by the CQC and failure to deliver one of the three corporate priorities the other two being the four-hour emergency care target and the financial plan(including the CIP).</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Clear accountability for the delivery of the plan. That accountability sits with the Chief Nurse. Weekly meetings to review performance against the plan. A mock inspection regime. All divisions have been reissued with the CQC reports to review the content and their delivery of improvement. Review of the action plan by the Quality Assurance Committee and the Board of Directors monthly. External validation of the plans and an internal audit review of the assurance processes.</td>
<td></td>
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<td>Review Date</td>
<td>06.05.16</td>
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<tr>
<td>Owner</td>
<td>Director of Corporate Affairs / Company Secretary / SIRO</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Mis-sent mail. Information Governance Breach</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>In 2014 and 2015 there were examples of letters being sent to the wrong address. Those letters contained clinical, therefore confidential information. This constitutes a breach of Information Governance.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Following investigation colleagues involved in the chain of responsibility have been retrained and mechanisms have been put in place such that individuals can be identified if there are any further instances. The relevant policies have been refreshed and the Trusts communication systems have been used to communicate the existence and requirements of those policies. Periodic audits are being undertaken by the Information Governance and Security Manager. At the next review date this risk will be reviewed and amended and removed as a high level risk, and will be replaced by a risk that will reflect the outcome of the SIRO board report, and the internal audit report regarding the IG toolkit, which will be presented to the Audit Committee.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>30.04.16</td>
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<tr>
<td>Targeted risk score</td>
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<td>Owner</td>
<td>Divisional Director of Integrated Medicine</td>
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</tr>
<tr>
<td>Title</td>
<td>The arrival of patients more appropriate for a major trauma centre at the Emergency department of The Rotherham NHS Foundation Trust.</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Patients suffering major trauma should be transferred to the designated major trauma centres and not The Rotherham NHS Foundation Trust. The Trust receives a small number of patients each year. These patients may receive sub-optimal care on the basis that the Trust does not have on-site ED consultants after 10pm, does not have access to CT scan within 30 minutes, does not have interventional radiology etc.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Prevention requires appropriate triage by on site paramedics. The Trust is in liaison with the Yorkshire Ambulance and whenever such an occasion arises the event is reviewed at the Regional Trauma meeting. In the meantime the Trust is putting in place simulation events for junior doctors and nurses working in the ED and revising induction arrangements.</td>
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<tr>
<td>Owner</td>
<td>Divisional Director for Family Health</td>
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</tr>
<tr>
<td>Title</td>
<td>Vacancy of Lead Nurse: Integrated Sexual Health</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Lack of nurse lead within Integrated Sexual Health Services. Loss of current leadership due to notice period having been worked and delays in recruitment process.</td>
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</tr>
<tr>
<td>Controls</td>
<td>Active vacancy management and review of other roles. Short-term interim arrangements.</td>
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<td>Review Date</td>
<td>01.06.16</td>
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<td>Owner</td>
<td>Divisional Director for Family Health</td>
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<tr>
<td>Title</td>
<td>Capacity Risks within Paediatric Services</td>
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<tr>
<td>Description</td>
<td>Lack of capacity within the Paediatric Consultant team</td>
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</tr>
<tr>
<td>Controls</td>
<td>Specialist nurse roles utilised to deliver care closer to home and support admission avoidance. Nurse led clinics developed with physician overview. Job plans reviewed; cancellation of some SPA activity. Appointment of additional consultant hours to increase capacity within the team to allow the rota to be covered and caseloads to be in line with national standards.</td>
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<td>Review Date</td>
<td>01.09.16</td>
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<td>Targeted risk score</td>
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<tr>
<td>Owner</td>
<td>Chief Nurse</td>
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</tr>
<tr>
<td>Title</td>
<td>Insufficient Registered Sick Children’s Nurses in the Emergency Department.</td>
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</tr>
<tr>
<td>Description</td>
<td>Potential lack of identification of children at risk of harm due to vacancies.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Recruitment to Band five posts. Involvement of the Deputy Chief Nurse with E/D colleagues regarding further mitigations until staff in post. Some progress in recruitment however it is likely that a number will not be available before September 2016. Therefore for monthly review and the Deputy Chief Nurse to remain responsible for progressing vacancies through the recruitment and retention meeting.</td>
<td></td>
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<tr>
<td>Review Date</td>
<td>05.05.16</td>
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<tr>
<td>Owner</td>
<td>Director of Finance</td>
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</tr>
<tr>
<td>Title</td>
<td>Premium Spend - Medical and Nursing</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>The Division of Emergency Medicine currently has an high level of spend on agency medics and nursing staff.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Continuous recruitment campaign to attract new, substantive staff. Overseas recruitment for nursing staff. Active management of agency booking by the Head of Nursing.</td>
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<tr>
<td>Owner</td>
<td>Director of Human Resources</td>
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</tr>
<tr>
<td>Title</td>
<td>Substantive Gastro Consultant Gaps</td>
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</tr>
<tr>
<td>Description</td>
<td>There are no substantive consultants in the gastroenterology service unit.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Appointment of Trust locums to provide continuity of care and interim arrangements with The Doncaster and Bassetlaw NHS Foundation Trust. Active recruitment to vacancies. Monthly review of service performance, and the appointment of a new clinical lead for the GI bleed service.</td>
<td></td>
</tr>
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<tr>
<td>Owner</td>
<td>Clinical Director for Emergency Medicine</td>
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<tr>
<td>Title</td>
<td>Cardiac Catheter Lab equipment exceeded lifespan</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Potential for equipment to fail so that the service cannot be maintained.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Weekly management review of any equipment failures. Discussion with procurement about replacement options.</td>
<td></td>
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<tr>
<td>Review Date</td>
<td>29.04.16</td>
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<tr>
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<tbody>
<tr>
<td>Owner</td>
<td>Chief Nurse</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Clinicians do not always recognise the deteriorating patient</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>There is a risk that clinicians will not recognise the deteriorating patient. If this happens the patient may come to significant harm</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>The Trust has signed up to the Sign up to Safety Campaign and all incidents have been subject to root cause analysis and actions have been taken to ensure that learning is transferred into practice. The legal affairs manager has delivered presentations to the clinical teams and human factors training is being provided. ‘Connect Rounds’ have been introduced. A practice Development team has been recruited to develop competence in recognising and managing the deteriorating patient. On 19 April the Trust Management Committee will review the plans for implementing Hospital at Night. A lead ANP has been recruited to lead service improvement at night.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>06.05.16</td>
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<td>Risk No. &amp; Score</td>
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<td>-----------------</td>
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<td>----</td>
</tr>
<tr>
<td>Owner</td>
<td>Clinical Director for Family health</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Fitting of emergency IUD’s on CASH</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Doctor cover may affect the provision of this service.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Extra clinical sessions agreed and locum arrangements being explored.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>OVERDUE Review was due 31.03.16</td>
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<tr>
<td>Owner</td>
<td>Clinical Director for Integrated Medicine</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Gestational follow on care</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Patients with gestational diabetes contacting DSN Service for advice when not known to the service.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Meeting taking place to review pathways. Once reviewed these will be subject to clinical audit.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>20.05.16</td>
<td></td>
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<tr>
<td>Targeted risk score</td>
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<tbody>
<tr>
<td>Owner</td>
<td>Clinical Director for Surgery</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Humphrey Visual field test Machine</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>There is a risk of inappropriate patient management and failure to diagnose glaucoma. If the machine was to fail, patients would require additional appointments</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Alternative equipment being trialled.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>OVERDUE Review was due 25.03.16</td>
<td></td>
</tr>
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<td>Targeted risk score</td>
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<td></td>
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<tr>
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<th>4507</th>
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</thead>
<tbody>
<tr>
<td>Owner</td>
<td>Chief Nurse</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>If Trust-wide clinical staffing is not maintained at appropriate levels, then patient care may be compromised</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>There is a risk that patient care could be compromised if Trust-wide clinical staffing levels are not maintained</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Nursing and medical workforce recruitment plans are in place. Staffing levels are reviewed at least daily. Flexible vendor arrangements are in place albeit the availability of nurses and doctors has reduced since the introduction of agency caps. The site management team maintain a daily overview of acuity. Short-term redeployment across teams.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>07.07.16</td>
<td></td>
</tr>
<tr>
<td>Targeted risk score</td>
<td>12</td>
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</tr>
<tr>
<td>Risk No. &amp; Score</td>
<td>3953</td>
<td>16</td>
</tr>
<tr>
<td>-----------------</td>
<td>------</td>
<td>----</td>
</tr>
<tr>
<td>Owner</td>
<td>Clinical Director for Family Health</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Poor connectivity at outreach clinics</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Staff may not be able to access systems and the consequence would be that they may not be aware of risks. Safeguarding flags may not be visible to colleagues.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Standard operating procedures have been (or are being) put in place. The Director of Health Informatics has reviewed the concerns and presented an improvement plan to the Quality Assurance Committee. Several dozen laptops have been replaced and 4G sims have been provided.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>03.09.16</td>
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<tr>
<td>Targeted risk score</td>
<td>2</td>
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<tbody>
<tr>
<td>Owner</td>
<td>Clinical Director for Medicine.</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Risk to patient safety caused by the delayed or missed diagnosis.</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Patient harm due to possible delays in the identification of abnormal investigation results leading to untimely intervention</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Task and Finish Group established by the Medical Directors Office to undertake a review of the current policy. A baseline audit of clinical administration across the Trust has been undertaken. Standard operating policies are being developed for each administration system.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>OVERDUE Review was due 13.02.16</td>
<td></td>
</tr>
<tr>
<td>Targeted risk score</td>
<td>8</td>
<td></td>
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<tr>
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<th>Risk No. &amp; Score</th>
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</tr>
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<tbody>
<tr>
<td>Owner</td>
<td>Clinical Director for Family Health</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Women’s services: Gynaecology and maternity - Greenoaks</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Co-location of opposing services such as miscarriage with termination of pregnancy and sub-fertility with maternity. Inability to accommodate multidisciplinary team clinics. Inappropriate miscarriage and pregnancy loss facilities</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Patients attending for in-patient miscarriage and pregnancy loss care are accommodated in side rooms with partners able to stay. A clinic review to reduce demand on available space within Greenoaks is being undertaken. Early pregnancy unit and Pregnancy advisory service has separate entrances and each has dedicated staffing, rooms, receptions, waiting areas</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
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<tr>
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<tr>
<td>Risk No. &amp; Score</td>
<td>990</td>
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</tr>
<tr>
<td>----------------</td>
<td>-------</td>
<td>-----</td>
</tr>
<tr>
<td>Owner</td>
<td>Clinical Director for Emergency Medicine</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td><strong>This Risk was opened in 2010</strong>&lt;br&gt;Insufficient staff to run the middle grade doctor rota seven days a week 24 hours a day</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Patient safety and experience being compromised and risk to 4 hour target&lt;br&gt;Unable to recruit to middle grade medical posts in A&amp;E. This is a national problem.</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td><strong>This historic risk needs closing and re-describing. The Trust has an emergency care action plan.</strong></td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>OVERDUE  Review was due 12.02.16</td>
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<tbody>
<tr>
<td>Owner</td>
<td>Clinical Director for Integrated Medicine</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Dermatology Medical Staffing</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Insufficient numbers of Consultant Medical Staff</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Active recruitment being led by the Medical Workforce Manager. Locum contracts are being extended.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>OVERDUE  Review was due 04.04.16</td>
<td></td>
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<tr>
<td>Targeted risk score</td>
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<tbody>
<tr>
<td>Owner</td>
<td>Clinical Director for Family Health</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Simultaneous tendering of Community Children's Services</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Several tenders being released simultaneously. Primary School nursing, health visiting and child health information service. Capacity of Service Manager and Clinical Leads to complete alongside maintaining normal operations</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Approach PMO to see if able to support on another bid, therefore may be able to support when above situation arises. Approach external experts to support identify additional resource internally to support Flag situation with Contracting.</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td>01.02.17</td>
<td></td>
</tr>
<tr>
<td>Targeted risk score</td>
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<td></td>
</tr>
<tr>
<td>Assurance Committee</td>
<td>Quality Assurance Committee</td>
<td></td>
</tr>
</tbody>
</table>

Tracey McErlain-Burns, Chief Nurse and<br>Fiona Middleton, Assistant Director of Patient Safety and Risk<br>April 2016
Purpose of this paper:

Foundation Trust (FT) Boards are required to submit in-year, quarterly, declarations to Monitor to affirm progress against the Trust’s Annual Plan in terms of finance and governance risks and continuing compliance of FTs against the terms and conditions of their Provider Licence.

Summary of Key Points:

Statement details are provided overleaf.

Board action required: For approval
1. **Details**

1.1 FT Boards are required to sign a Governance Statement for governance and finance in terms of both the latest quarterly performance and looking forward. The statement requires two authorised signatures. It is recommended that the Board authorise the Chief Executive and Chairman to sign off the statements:

1.2 For finance that:
The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months:
**Not Confirmed** (Q1, Q2, Q3 = Not Confirmed)

1.3 The Board anticipates that the Trust’s capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.
**Confirmed** (Q1, Q2, Q3 = Confirmed)

1.4 For governance that:
The board is satisfied that plans in place are sufficient to ensure: on-going compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards:
**Confirmed, with caveats** (Q1 and Q2 = Confirmed, Q3 = Confirmed with caveats)

1.5 Otherwise:
The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework table 3) which have not already been reported:
**Confirmed** (Q1, Q2, Q3 = Confirmed)

1.6 Consolidated Subsidiaries:
Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds:
**None.**
Report: Counter Fraud, Bribery and Corruption Policy

Presented by: Simon Sheppard, Director of Finance
Author(s): Robert Purseglove, LCFS

Strategic Objective:
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance

Regulatory relevance:
Monitor: Licence condition number FT4 /
CQC Domain: safe / effective / well-led

Risk Reference:
BAF: B1, B9, B10, B14
Corporate Risk Register: -

Action required: For approval

Overview:
The attached policy has been devised by Robert Purseglove, Local Counter Fraud Specialist, NHS Protect

All fraud, bribery and corruption in the NHS is unacceptable and cannot be tolerated; it affects the ability of the NHS to improve outcomes for patients as resources are wrongfully diverted from their intended purpose.

The attached policy aims to:

- Explain how the Trust intends to tackle Economic Crime
- Provide guidance for colleagues and managers

This policy has been approved at the Trust Management Committee.

Action required:
The Board is asked to approve the policy.
SECTION 1
PROCEDURAL INFORMATION

<table>
<thead>
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<th>Version:</th>
<th>1</th>
</tr>
</thead>
</table>
| Ratified by: | Board of Directors  
              | Audit Committee  
              | Trust Management Committee |
| Date ratified: |               |
| Title of originator/author: | Robert Purseglove, Local Counter  
                            | Fraud Specialist. |
| Title of responsible committee/individual: | Simon Sheppard, Director of  
<pre><code>                                        | Finance. |
</code></pre>
<p>| Date issued: |               |
| Review date: | January 2019 |
| Target audience: | All Staff. |</p>
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<th>Author</th>
<th>Status</th>
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<td>1</td>
<td>November 2015</td>
<td>R Purseglove</td>
<td>Draft</td>
<td>This policy replaces the 2011 Counter Fraud Policy And Response Plan.</td>
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</table>


Section 1 - Contents
1. INTRODUCTION ................................................................................................. 4
2. PURPOSE & SCOPE .......................................................................................... 4
3. ROLES & RESPONSIBILITIES .......................................................................... 5
4. PROCEDURAL INFORMATION ......................................................................... 7
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7. ASSOCIATED DOCUMENTATION ................................................................... 12
8. APPENDIX A - DESKTOP COUNTER FRAUD GUIDE ................................. 13

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<td>9</td>
<td>Consultation and Communication with Stakeholders</td>
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<td>Equality Impact Assessment</td>
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<tr>
<td>13</td>
<td>Review and Revision Arrangements</td>
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</tr>
<tr>
<td>14</td>
<td>Dissemination and Communication Plan</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Implementation and Training Plan</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Plan to monitor the Compliance with, and Effectiveness of, the Trust Document</td>
<td></td>
</tr>
<tr>
<td>16.1</td>
<td>Process for Monitoring Compliance and Effectiveness</td>
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<td>16.2</td>
<td>Standards/Key Performance Indicators</td>
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Section 2 Appendices
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<tr>
<th>Appendix</th>
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<th>Page</th>
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<tr>
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<td>Completed Equality Impact Assessment</td>
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</table>
1. INTRODUCTION

1.1 This policy applies to all employees of The Rotherham NHS Foundation Trust (TRFT) and to contractors who are working for the organisation. It is intended as a guide on countering fraud, bribery and corruption (collectively referred to within this policy as financial crime). It details the Trust’s commitment to the proper use of public funds and outlines roles and responsibilities for the prevention of fraud, bribery and corruption within TRFT, in addition to the approach to be taken regarding matters of suspected financial crime.

2. PURPOSE & SCOPE

2.1 Purpose

TRFT has zero tolerance to fraud, bribery and corruption within the Trust.

The Board of Directors is committed to the elimination of fraud, bribery and corruption by ensuring there is a strong anti-fraud, bribery and corruption culture, proactive prevention, detection and deterrence through widespread awareness and rigorously investigating any such cases, and where proven, to ensure wrong doers are appropriately dealt with, which includes taking steps to recover assets lost as a result of fraud, bribery and corruption.

Any apparent fraud, bribery, corruption or financial irregularity will be investigated and disciplinary action, including reference to any relevant professional body, will be taken. Cases will be referred for formal investigation where there is prima facie evidence of a criminal offence. Where disciplinary action is taken, this will follow the Trust disciplinary policy.

Criminal and civil prosecutions from individuals found to have committed fraud, bribery or corruption will be pursued.

The seeking of financial redress and recovery of losses will always be considered in cases of fraud, bribery or corruption that are investigated by either the Local Counter Fraud Specialist (LCFS) or the NHS Protect National Investigation Team. Recovery of the loss caused by the perpetrator will always be sought.

Redress allows resources that are lost to fraud, bribery and corruption to be returned to the NHS for use as intended for the provision of high quality patient care and services.

All staff have a duty to protect the assets of the Trust and also to cooperate with any investigation and the Board recommends anyone having suspicions of fraud, bribery or corruption to report them. All reasonably held suspicions will be taken seriously.
For concerns which relate to fraud, bribery or corruption these should be reported through the provisions within this policy, rather than through the whistleblowing policy (Policy and Procedure for supporting staff to raise concerns at work (Including whistleblowing)) (ref 194).

2.2 **Scope**

This document states the Trust wide policy in relation to fraud, bribery and corruption and provides some guidance to directors, managers and employees who find themselves having to deal with, or who become aware of suspected fraud, bribery or corruption. Further guidance may be obtained by contacting Robert Purseglove, the Trust’s Local Counter Fraud Specialist (LCFS) on 01709 428701 or by email to robert.purseglove@nhs.net.

3. **ROLES & RESPONSIBILITIES**

This policy applies to all employees and to contractors who are working for the Trust.

<table>
<thead>
<tr>
<th>Roles</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>As the Trust’s Accountable Officer, the Chief Executive has overall responsibility for funds entrusted to TRFT. The Chief Executive must ensure that adequate policies and procedures are in place to protect the Trust and the funds it receives from fraud, bribery and corruption.</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>The Director of Finance has overall responsibility for ensuring that counter fraud, bribery and corruption arrangements are in place. A key element of these responsibilities is to ensure that there is counter fraud, bribery and corruption awareness across the Trust and that all suspected instances of financial crime are appropriately investigated.</td>
</tr>
<tr>
<td>Roles</td>
<td>Responsibilities</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Internal and External Audit</td>
<td>The Trust’s internal and external auditors review and report on the adequacy of the Trust’s controls and systems and ensure compliance with standing financial instructions. They have a duty to report any suspicions of fraud, bribery or corruption identified during the course of their work to the Trust’s LCFS.</td>
</tr>
<tr>
<td>Human Resources Staff</td>
<td>Human Resources staff provide advice, guidance and support to TRFT managers and officers investigating disciplinary matters. All disciplinary matters which involve suspected fraud, bribery or corruption offences will also be subject to parallel criminal investigation by the Trust’s LCFS. A liaison protocol is in place which details arrangements for the conduct of parallel disciplinary and criminal investigations.</td>
</tr>
<tr>
<td>Local Counter Fraud Specialist (LCFS)</td>
<td>The LCFS is responsible for taking forward all counter fraud, bribery and corruption work within the Trust in accordance with NHS Protect Standards for Providers: Fraud, Bribery and Corruption and this policy. The LCFS reports to the Director of Finance and the Trust’s Audit Committee.</td>
</tr>
<tr>
<td></td>
<td>The LCFS is professionally trained and accredited to conduct counter fraud, bribery and corruption work. All criminal investigations undertaken by the LCFS are conducted in accordance with relevant legislation.</td>
</tr>
<tr>
<td>Roles</td>
<td>Responsibilities</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Managers</td>
<td>All TRFT managers are responsible for ensuring compliance with the Trusts policies, procedures and processes applicable to their area of work, for applying controls to prevent financial crime and for identifying and reporting to the LCFS any weaknesses which might allow fraud, bribery or corruption to occur. Managers are also responsible for ensuring that staff are aware of what constitutes fraud, bribery and corruption within the provision of healthcare services to the NHS and that they understand the importance of protecting the Trust from it. Managers must report any instances of actual or suspected fraud, bribery and corruption immediately when concerns are identified or brought to their attention and refrain from undertaking any investigations of financial crimes themselves.</td>
</tr>
<tr>
<td>Employees</td>
<td>It is the responsibility of all individuals to ensure that they comply with this, and all other Trust policies and procedures relevant to their area of work and to ensure that they recognise fraud, bribery and corruption, which might occur within the Trust.</td>
</tr>
</tbody>
</table>

4. PROCEDURAL INFORMATION

Countering fraud, bribery and corruption is the responsibility of all Trust staff. All individuals within the Trust are responsible for reporting any concerns regarding fraud, bribery and corruption immediately as they arise.

We must all work together to be effective in reducing fraud, bribery and corruption to an absolute minimum.

The Trust recognises the potential impact on individuals who have been affected by fraud, bribery or corruption within their working environment, therefore support and advice will be made available.
In accordance with Ministry of Justice guidance, TRFT has undertaken a risk assessment to determine the extent to which bribery and corruption may affect the Trust. Proportionate procedures are in place to mitigate the identified risk include the following requirements:

- All staff are required to act in accordance with the Trust’s Standards of Business Conduct Policy, notably:
  - All staff must disclose their business interests, prior to commencement of employment with TRFT;
  - All staff must declare hospitality (other than modest hospitality) received by or offered to them as TRFT employees;
  - All hospitality (other than extremely minor hospitality) provided by TRFT staff to third parties must be declared; and
  - Staff must not solicit personal gifts and must declare all gifts received (in excess of £25 in value).

Fraud, bribery and corruption training is available to all staff through eLearning, completion of workbooks and face to face presentations. Training can be arranged by contacting the LCFS on 01709 428701 or by email to robert.purseglove@nhs.net.

In compliance with NHS Protect Standards for Providers: Fraud, Bribery and Corruption, TRFT will minimise losses to financial crime through:

**Creating a strong counter fraud, bribery and corruption culture**

We all have a responsibility to protect our Trust and its resources. Everyone, including the public, TRFT staff, professionals, managers and policy makers (the honest majority), must work together to raise awareness of the Trust’s zero tolerance approach to fraud, bribery and corruption, to report concerns and enforce the message to the dishonest minority that such matters are not acceptable within the provision of healthcare services to the NHS and will be dealt with accordingly.

The most effective deterrent will come from those of us within the Trust providing healthcare services to the NHS who value the service provided and disapprove of those who abuse the system through fraud, bribery, corruption and other dishonest acts. In addition, publicity surrounding counter fraud, bribery and corruption work will deter some who perpetrate or consider perpetrating related offences. TRFT will publicise successful investigation outcomes both internally and externally as appropriate in order to aid the deterrent effect.
Proactively preventing and detecting fraud, bribery and corruption

TRFT will ensure (through ‘fraud-proofing’) that its systems, policies and processes are sufficiently robust so that the risk of fraud, bribery and corruption is reduced to a minimum. Checks will be conducted in areas identified to be most at risk to fraud, bribery or corruption in order to proactively detect instances that might otherwise be unreported.

Conducting professional investigations of all instances of suspected fraud, bribery and corruption

Criminal offences of fraud, bribery or corruption will be investigated in a professional, objective and timely manner by an accredited NHS LCFS. Parallel internal investigations may also be carried out by TRFT managers (supported by the Human Resources Team) as part of disciplinary procedures. Such parallel investigations will be conducted in accordance with the agreed HR/LCFS liaison protocol.

Applying effective sanctions

Where fraud, bribery or corruption offences are committed criminal sanctions (including prosecution) will be pursued. TRFT employees found to have committed such offences will also be dealt with in accordance with internal disciplinary procedures and referral to professional bodies where appropriate.

Seeking effective redress

Redress allows resources that are lost to fraud, bribery and corruption to be returned to the NHS for use as intended for the provision of high quality patient care and services. The Trust will consider initiating civil recovery action if this is cost-effective and desirable for deterrence purposes. This could involve a number of options such as applying through the Small Claims Court and/or recovery through debt collection agencies. Each case will be discussed with the Director of Finance to determine the most appropriate action.

Reporting suspected fraud, bribery or corruption.

If fraud, bribery or corruption is discovered or suspected it must immediately be reported directly to the LCFS, the Trust Director of Finance or NHS Protect. Contact details are as follows:

**LCFS - Robert Purseglove**
Tel: 01709 428701
Mobile: 07715 807250
Email: robert.purseglove@nhs.net

**Director of Finance – Simon Sheppard**
Tel: 01709 424668
If there is a concern that the LCFS or the Director of Finance is, themselves, implicated in suspected fraud, bribery or corruption then the concerns should be reported directly to NHS Protect.

NHS Protect
Fraud and Corruption Reporting Line  Tel:  0800 028 40 60 (Freephone).

Secure Website
www.reportnhsfraud.nhs.uk

You do not have to tell us who you are when raising concerns under this policy, however, this may make it more difficult for your concerns to be investigated.

Acting on Your Suspicions – The Dos and Don’ts

If you suspect fraud, bribery or corruption within the provision of healthcare services to the NHS, there are a few simple guidelines that should be followed:

**DO**

- **Note your concerns**
  Make an immediate note of your concerns – note all relevant details, such as the nature of your concerns, names, dates, times and details of conversations and possible witnesses. Time, date and sign your notes.

- **Retain evidence**
  Retain any evidence that could be destroyed, or make a note of available evidence and immediately advise the LCFS.

- **Report your suspicions**
  Deal with the matter promptly – any delay may cause TRFT to suffer further financial loss.

**DON’T**

- **Confront the suspect or convey your concerns to anyone other than the LCFS, Trust’s Director of Finance or NHS Protect.**

- **Try to investigate the matter yourself**
  Never attempt to gather evidence yourself unless it is about to be destroyed or could be tampered with. Gathering evidence must be done in line with legal requirements in order for it to be useful. The
LCFS will conduct any investigation in accordance with relevant legislation.

- **Be afraid of raising your concerns**
  The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer any recrimination from the Trust as a result of voicing a reasonably held suspicion. The Trust will treat any matter raised with sensitivity and confidentiality.

- **Do nothing**

5. **DEFINITIONS AND ABBREVIATIONS**

5.1 **Definitions**

**Fraud**

The Fraud Act 2006 came into force on the 15 January 2007 and introduces the general offence of fraud. Fraud involves dishonestly:

- Making a false representation; or
- Failing to disclose information; or
- Abusing a position held;

With the intention of making a gain for oneself or causing a loss to another.

**Other Fraud-related Offences**

The following offences are not contained in the Fraud Act 2006 but may nevertheless be used to prosecute in cases of fraud against the Trust:

- Conspiracy to defraud
- Forgery & Counterfeiting
- Dishonestly retaining a wrongful credit
- Computer misuse.

**Bribery and Corruption**

Bribery and corruption involves offering, promising or giving a payment or benefit-in-kind in order to influence others to use their position in an improper way to gain an advantage.
The Bribery Act 2010 replaces the fragmented and complex offences at common law and in the Prevention of Corruption Acts 1889-1916. There are two general offences of bribery within the Act:

- Offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly; and

- Requesting or accepting a bribe either in exchange for acting improperly, or where the request or acceptance is itself improper.

The Act also introduced a new corporate offence of negligently failing by a company or limited liability partnership to prevent bribery being given or offered by an employee or agent on behalf of that Trust. TRFT, (in common with other NHS Provider bodies) falls under the definition of a ‘company’ for the purposes of the Act.

5.2 Abbreviations

LCFS – Local Counter Fraud Specialist
TRFT – The Rotherham NHS Foundation Trust

6. REFERENCES

Fraud Act 2006
Bribery Act 2010
NHS Protect Standards for Providers: Fraud, Bribery and Corruption,

7. ASSOCIATED DOCUMENTATION

Security Policy
Policy for the use of Directed Surveillance (Regulation of investigatory Powers Act 2000)
Pre and post-employment checks
Raising Concerns Policy (including Whistleblowing)
Board of Directors’ Code of Conduct
Standards of Business Conduct
Disciplinary Policy
Policy for the Reporting, Investigation, Management and Analysis of Incidents
Policy and Procedure for Managing Attendance at Work in relation to Sickness Absence
Standing Orders, Matters Reserved to the Board
Standing Financial Instructions
Scheme of Delegation
Standards of Business Conduct Policy
Adult Safeguarding – the Role of the Alerter
8. APPENDIX A - DESKTOP COUNTER FRAUD GUIDE

**FRAUD** is the dishonest intent to obtain a financial gain from, or cause a financial loss to a person or party through false representation, failing to disclose information or abuse of position.

**BRIBERY & CORRUPTION** involves offering, promising or giving a payment or benefit-in-kind in order to influence others to use their position in an improper way to gain an advantage.

**Do**
- **Note your concerns**
  Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.
- **Retain evidence**
  Retain any evidence that may be destroyed, or make a note and advise your LCFS.
- **Report your suspicion**
  Delays may lead to further financial loss.

**Do Not**
- **Confront the suspect or convey concerns to anyone other than those authorised, as listed below**
  Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent person.
- **Try to investigate or contact the police directly**
  Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take into account legal procedures in order for it to be useful. Your LCFS can conduct an investigation in accordance with legislation.
- **Be afraid of raising your concerns**
  The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.
- **Do nothing!**

If you suspect that fraud against the NHS has taken place, you must report it immediately, by either:
- contacting the Director of Finance
- directly contacting the Local Counter Fraud Specialist
- contacting the NHS Fraud and Corruption Reporting Line

**Do you have concerns about fraud taking place within the NHS?**
If so, any information can be passed confidentially to the NHS Fraud and Corruption Reporting Line on 0800 028 40 60 or online at [www.reportnhsfraud.nhs.uk](http://www.reportnhsfraud.nhs.uk)

Your Local Counter Fraud Specialist is Robert Purseglove, who can be contacted by telephoning 01709 428701 or by email at robert.purseglove@nhs.net

For more information about the NHS Counter Fraud Service, go to [www.nhsbsa.nhs.uk/fraud](http://www.nhsbsa.nhs.uk/fraud)
COUNTER FRAUD, BRIBERY & CORRUPTION POLICY

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING
9. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS
This document was developed in consultation with:
Trust Management Committee and Audit Committee

10. APPROVAL OF THE DOCUMENT
This document was approved by:
Trust Board, following a recommendation from the Audit Committee

RATIFICATION OF THE DOCUMENT
Trust Board, following a recommendation from the Audit Committee

11. EQUALITY IMPACT ASSESSMENT STATEMENT
An Equality Impact Assessment has been carried out in relation to this document using the approved initial screening tool; the EIA statement is detailed at Appendix 1 to this section of the document.

The manner in which this policy impacts upon equality and diversity will be monitored throughout the life of the policy and re-assessed as appropriate when the policy is reviewed.

NB Once the document has been ratified the author will make arrangements for the Website Summary Form to be published to the Trust’s Internet via the Equality and Engagement Manager.

12. REVIEW AND REVISION ARRANGEMENTS
This document will be reviewed every three years unless such changes occur as to require an earlier review.

The Local Counter Fraud Specialist is responsible for the review of this document.

NB The cover sheet must contain the issue and review dates.

13. DISSEMINATION AND COMMUNICATION PLAN
Identify and insert into the table below any additional arrangements that will be put in place in order to communicate the document’s dissemination. The information in the table below applies to all documents ratified by the Trust Ratification Group. It ratification by this group is not required, amend the table to reflect the local dissemination and communication processes.
<table>
<thead>
<tr>
<th>To be disseminated to</th>
<th>Disseminated by</th>
<th>How</th>
<th>When</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Governance Team via policies email</td>
<td>Author</td>
<td>Email</td>
<td>Within 1 week of ratification</td>
<td>Remove watermark from ratified document and inform Quality Governance Team if a revision and which document it replaces and where it should be located on the intranet. Ensure all documents templates are uploaded as word documents.</td>
</tr>
<tr>
<td>Communication Team (documents ratified by the document ratification group)</td>
<td>Quality Governance Team</td>
<td>Email</td>
<td>Within 1 week of ratification</td>
<td>Communication team to inform all email users of the location of the document.</td>
</tr>
<tr>
<td>All email users</td>
<td>Communication Team</td>
<td>Email</td>
<td>Within 1 week of ratification</td>
<td>Communication team will inform all email users of the policy and provide a link to the policy.</td>
</tr>
<tr>
<td>Key individuals</td>
<td>Author</td>
<td>Meeting / Email as appropriate</td>
<td>When final version completed</td>
<td>The author must inform staff of their duties in relation to the document.</td>
</tr>
<tr>
<td>All staff within area of management</td>
<td>Heads of Departments / Matrons</td>
<td>Meeting / Email as appropriate</td>
<td>As soon as received from the author</td>
<td>Ensure evidence of dissemination to staff is maintained. Request removal of paper copies. Instruct them to inform all staff of the policy including those without access to emails</td>
</tr>
</tbody>
</table>
14. IMPLEMENTATION AND TRAINING PLAN

Identify and insert into the table below what arrangements will be put in place in order to implement the contents of the document and identification and implementation of training and support etc.

If the document has already been implemented/there is no training associated with the document/there are no implementation activities other than that detailed in the communication and dissemination plan, state this here and delete the table.

<table>
<thead>
<tr>
<th>What</th>
<th>How</th>
<th>Associated action</th>
<th>Lead</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

15. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF THE TRUST DOCUMENT

15.1 Process for Monitoring Compliance and Effectiveness

Identify and insert into the table below how compliance with, and the effectiveness of the document will be audited and monitored.

<table>
<thead>
<tr>
<th>Audit/Monitoring Criteria</th>
<th>Process for monitoring e.g. audit, survey</th>
<th>Audit / Monitoring performed by</th>
<th>Audit / Monitoring frequency</th>
<th>Audit / Monitoring reports distributed to</th>
<th>Action plans approved and monitored by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Roles &amp; Responsibilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Example: Local Procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Example: Training attendance</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Example: Staff Awareness</td>
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<td></td>
</tr>
</tbody>
</table>
15.2 Standards/Key Performance Indicators (KPIs)

List relevant standards or KPIs if relevant or appropriate
EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

Document Name: Counter Fraud, Bribery and Corruption Policy
Date/Period of Document: November 2015
Lead Officer: Local Counter Fraud Specialist
Directorate: 
Reviewing Officers: 

Describe the main aim, objectives and intended outcomes of the above:

This policy is intended as a guide on countering fraud, bribery and corruption. It details the Trust’s commitment to the proper use of public funds and outlines roles and responsibilities for the prevention of fraud, bribery and corruption within TRFT, in addition to the approach to be taken regarding matters of suspected financial crime.

You must assess each of the 9 areas separately and consider how your policy may affect people’s human rights.

1. **Assessment of possible adverse impact against any minority group**

<table>
<thead>
<tr>
<th>Area</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Sex (Male and Female?)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Disability (Learning Difficulties/Physical or Sensory Disability)?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Race or Ethnicity?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Religion and Belief?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation (gay, lesbian or heterosexual)?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and Maternity?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Gender Reassignment (The process of transitioning from one gender to another)?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil Partnership?</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

You need to ask yourself:
- Will the policy create any problems or barriers to any community of group? Yes/No
- Will any group be excluded because of the policy? Yes/No
- Will the policy have a negative impact on community relations? Yes/No

If the answer to any of these questions is yes, you must complete a full Equality Impact Assessment.

2. **Positive impact:**

<table>
<thead>
<tr>
<th>Area</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote equal opportunities</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Get rid of discrimination</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Get rid of harassment</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Promote good community relations</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Promote positive attitudes towards disabled people</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Encourage participation by disabled people</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Consider more favourable treatment of disabled people</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Promote and protect human rights</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
3. **Summary**

On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?

<table>
<thead>
<tr>
<th>Positive</th>
<th>Please rate, by circling, the level of impact</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>MEDIUM</td>
<td>LOW</td>
</tr>
</tbody>
</table>

- Date assessment completed: 04/11/2015
- Is a full equality impact assessment required? 🔹 Yes (documentation on the intranet) 🔺 No

Presented by: Anna Milanec, Senior Information Risk Owner
Author(s): As above

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

Regulatory relevance:
- Monitor: Licence Condition FT4/ Monitor’s FT Code of Governance
- CQC Domain: effective / well-led

Risk Reference:
- BAF: ID 11, 12 and 13
- Corporate Risk Register: ID 3509, 3908

Purpose of this paper:

1.1 This report provides an overview on the organisational compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the Data Protection Act (1998) and Freedom of Information Act (2000). It also details the Trust’s level of compliance with the Information Governance Toolkit.

1.2 It presents outline details of Serious Incidents Requiring Investigation (SIRI) within the preceding twelve months, relating to any losses of personal data or breaches of confidentiality.

1.3 It also outlines direction of Information Governance work during 2015/16.

Summary of Key Points:

The key points arising from the report are:
- IG Toolkit Level 1 compliance achieved for 2015/16
- 2 SIRIs submitted during the financial year
- Increasing number of Freedom of Information requests
- Three complaints made to the ICO, found in favour of the Trust
- More IG awareness / training is required across the Trust

Board action required: For noting.
1. **Information Governance background**

1.1 All NHS foundation trusts are mandated to comply with the requirements set out in the Information Governance Toolkit (‘the Toolkit’).

1.2 A minimum of level 2 compliance must be reached by 31 March each year to be Toolkit compliant.

1.3 An internal assessment of the Toolkit was carried out by TIAA in February 2016 which provided an action plan for areas that were still lacking in evidence. That action plan was followed and

2. **Information Governance Assurance Framework**

2.1 The Toolkit is a performance tool produced by the Department of Health (DoH). It draws together legal requirements and central guidance that make up the Information Governance Framework and presents them in one place as a set of information governance standards.

2.2 A report outlining the IG Toolkit v13 assessment for 2015/16 is attached at annex 1 and provides a detailed analysis of the results.

2.3 Last year, this report outlined some initiatives / items that had not been in place, which had affected the IG Toolkit performance at that time. Actions have been taken and these areas of weakness have been addressed throughout 2015/16.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Outcome 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Information Security Assurance Plan</td>
<td>Plan now in place</td>
</tr>
<tr>
<td>Evidence of training for all staff involved in information security not available</td>
<td>Progress has been made in this area with evidence now available</td>
</tr>
<tr>
<td>No identified Information Asset Owners (‘IAOs’) in the directorates</td>
<td>27 IAOs identified – this is in addition to those already acting as IAOs in the IT department (re information systems and security)</td>
</tr>
<tr>
<td>Not all information assets have been identified</td>
<td>IAO’s are now in place and training has started which will mean that IAOs have the knowledge they need to identify IAs.</td>
</tr>
<tr>
<td>No training provided to IAOs that are in place</td>
<td>First training delivered in January 2016. Due to operational pressures, further training dates were not set during the remainder of 2015/16. These will now recommence.</td>
</tr>
</tbody>
</table>
2.4 In order to support the Trust’s IG compliance culture and management, a range of policies and SOPs (standard operating procedures) have been produced where they were absent, or they have been reviewed and updated where they were out of date. Details of some of the IG policies approved in 2015/16 appear below:
- Data Protection Policy
- Data Quality Policy
- Fax Policy
- Forensic Policy
- Health Records Policy
- Information Security Assurance Policy
- IT Business Continuity
- Mobile Working Remote Access Policy
- Pseudonymisation Policy
- Social Networking Policy

3. **Serious Incidents Requiring Investigation (‘SIRI’)**

3.1 All organisations processing health personal data are required to use the IG Toolkit Incident Reporting Tool to report level 2 IG SIRIs.

3.2 There is no exact definition from an information governance aspect of a serious incident although it is likely that one of the following will apply:
- A breach of the Data Protection Act and / the Common Law Duty of Confidentiality has been breached;
- Inappropriate invasion of people’s privacy;
- Personal identity breaches which could lead to identity fraud or similar;
• Data is protected but there is a risk of individuals being identified.

3.3 There are two factors which influence the severity of an IG SIRI – scale (number of individuals whose data has been disclosed) and sensitivity.

3.4 On the basis of the reporting requirements, two SIRI reports were made during the year where information had been disclosed in error (May 2015, and January 2016). Both reports were filed on the basis of having been similar to previous breaches occurring during the previous 12 months. High risk confidential information was not disclosed, and the number of individuals concerned was less than 11 (first baseline on the scoring system).

3.5 The Trust was advised of the breaches via a third party agency to whom the data had been provided. Datix were filed when we were notified, and internal investigations began.

3.6 The ICO, who are automatically advised when the reports were filed through the IG Toolkit, began investigations with the Trust regarding the incidents.

3.7 The Regulator was satisfied that the Trust had taken the correct actions subsequent to the breaches, and that appropriate policies were in place. As a result, the Regulator confirmed that no further action was needed, and no financial penalties or undertakings were required on these occasions.

4. Freedom of Information requests

4.1 The number of Freedom of Information requests has grown year on year across the Public Sector since the Act came into force in 2005.

4.2 The Trust received 554 requests during 2015/16 (compared with 540 during the previous financial year.) The admin process relating to these requests is carried out by one full time member of staff and overseen by the IG Assurance and Security Manager. Complex matters that require review, legal or regulatory interpretation or intervention, are referred to the SIRO. All ICO matters are dealt with by the SIRO.

4.3 The number of questions asked within a single request and the level of detail required to respond to requests, is increasing; it is not unusual to provide information to in excess of a dozen or so elements of a single request for information.

4.4 Repetitive requests and request themes mean that some departments receive more requests per month than other services and so the main burden falls on a smaller group of colleagues to provide the information.

4.5 Once the Trust has responded to an FOI request, the requestor is able to request a review of their case and the information provided, if they are not satisfied with the response received. A perceived unsatisfactory response may be due a decision taken by the Trust to apply exemptions, provided for by statute, to prevent disclosure.

4.6 This occurred on five occasions during the year, one remains pending, with the previous four having been dealt with. On three of those four occasions, the
requestor remained dissatisfied with the response received from the Trust and made a complaint to the Information Commissioners Office.

4.7 All three cases were investigated by the ICO, and found in favour of the Trust.

4.8 In September 2015, the Trust was advised that the requestor from the first case above, had appealed the decision made by the ICO in favour of the Trust, and, as a result, the matter was going to Tribunal.

4.9 The Tribunal was eventually held earlier this month, and the decision reached that the appeal should be refused. Hence, the ICO decision in favour of non-disclosure by the Trust was upheld.

4.10 As part of our commitment to learn from the service we provide, the FOI team ask requestors to respond to a short online survey as to how we might improve the FOI process. Over 60 responses were received during the year. In response to the question, “Do you have any suggestions as to how we can improve our service?” comments received included, “No, absolutely perfect”, “None, the service was excellent”, and “No, you have been amongst the best responding Trusts in the UK”. The only negative comment received was with regard to responses being sent out by the FOI Office, as opposed to being from an individual.

4.10 The positive outcome from the Trust’s high level interaction with the ICO this year is welcome. However, it is not presumed, and the Trust continues to strengthen its relationship with the regulator.

5. **Assurance**

5.1 The following posts within the organisation are confirmed:
Caldicott Guardian = Dr Conrad Wareham (July 2015)
Senior Information Risk Owner = Anna Milanec (December 2014)

5.2 The Caldicott Guardian chairs the Caldicott Group, and the SIRO chairs the Information Governance Committee, both of which meet on a regular basis.

5.3 Both Caldicott Guardian and SIRO have undertaken external training appropriate for their roles. The proposed shift to online training through HSCIC will provide additional online training specifically tailored for the Caldicott Guardian, SIRO and those in positions with IG security and assurance based roles.

6. **Accountability**

6.1 The Information Governance Committee oversees the IG agenda and is attended by governance leads and senior managers.

6.2 The Committee’s effectiveness was reviewed by the SIRO in 2015/16 and its terms of reference, membership and agenda were updated. The Committee now reports directly to the Trust Management Committee. The Committee met on six occasions during the year with quorate attendance. Amongst other items, it reviews IG incidents and risks appearing on Datix, Trust-wide IG policies, IG MAST training
figures, progress against IG Toolkit work on Key Requirements, and recently, progress with M11 of the CQC action plan.

7. Moving forward

7.1 Evidence suggests that Information Governance has not been a priority for the organisation until recently. It also appears that, whilst there is a spirit of complying with the regulations and legislation throughout the organisation, more awareness is required for those who do not specifically work in this governance area.

7.2 Detail of some areas where work is required to bring the organisation up to Level 2 compliant has been provided above, and an action plan will be tracked throughout 2016/17 as part of the strategic objective priorities.

Applicable standards and legislation:

- The Data Protection Act 1998.
- The common law duty of confidence.
- The Confidentiality NHS Code of Practice.
- The NHS Care Record Guarantee for England.
- The Information Security NHS Code of Practice.
- The Records Management NHS Code of Practice.

Anna Milanec
Senior Information Risk Owner
April 2016
Appendix A

The following provides details of some of the work undertaken by the Information Governance department and myself for the period 1 April 2015 – 31 March 2016.

<table>
<thead>
<tr>
<th></th>
<th>From 1 April 2015 to 31 March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOI requests received by the Trust</td>
<td>554</td>
</tr>
<tr>
<td>FOI requests answered by the Trust</td>
<td>531</td>
</tr>
<tr>
<td>FOI reviews (requested by submitter) requested</td>
<td>5</td>
</tr>
<tr>
<td>FOI reviews (requested by submitter) answered</td>
<td>4</td>
</tr>
<tr>
<td>IG breaches reported through Datix</td>
<td>161</td>
</tr>
<tr>
<td>IG breaches reported through Datix requiring investigation</td>
<td>45</td>
</tr>
<tr>
<td>IG Datix investigations completed</td>
<td>40</td>
</tr>
<tr>
<td>IG Datix incidents requiring further action after investigation</td>
<td>5</td>
</tr>
<tr>
<td>IG breaches reported through SIRI</td>
<td>2</td>
</tr>
<tr>
<td>FOI complaint investigations received from ICO</td>
<td>3</td>
</tr>
<tr>
<td>Decision notices received from the ICO in favour of the Trust</td>
<td>3</td>
</tr>
<tr>
<td>Of those above, number that have gone on to Tribunal</td>
<td>1</td>
</tr>
<tr>
<td>Additional, non-statutory IG training sessions taken place</td>
<td>23</td>
</tr>
<tr>
<td>Number of colleagues attending the above</td>
<td>390</td>
</tr>
<tr>
<td>Number of colleagues attending corporate induction and receiving IG training</td>
<td>664</td>
</tr>
</tbody>
</table>
IG Toolkit v13 Assessment 2015/16

1. Introduction

1.1 Whilst acknowledging that the organisation did not achieve Level 2 compliance with the Information Governance Toolkit (‘IG Toolkit’ or ‘the Toolkit’) for 2015/16, this report aims to provide assurance to the Board as to the progress made in the organisation over the last twelve months relating to Information Governance.

2. Information Governance Toolkit background

2.1 The IG Toolkit is a national performance tool produced through the HSCIC (Health and Social Care Information Centre) by the DoH (Department of Health).

2.2 All NHS foundation trusts are mandated to provide a self-assessment against six initiative sets, made up of 45 Key Requirements in total, to comply with the Toolkit. A minimum of level 2 compliance must be reached by 31 March each year to be Toolkit compliant.

2.3 Version 13 of the Toolkit was released on the 1 June 2015, and whilst there were few significant changes from the previous version, there were a number of Key Requirements where the guidance was strengthened or particular wording updated to reflect the HSCIC review of guidance between the v12 to v13 release.

2.4 The toolkit requires that most of the evidence on the online Toolkit is either reviewed, or it forms part of an annual work programme and is therefore developed within the year.

2.5 Each Key Requirement has a senior manager allocated to provide leadership and ownership. Each Key Requirement owner is required to attend the Information Governance Committee when requested, to report on progress. They are also required to meet with the Information Governance and Assurance Manager on a regular basis, until they are able to sign off compliance with the Key Requirement, for which they are responsible.

2.6 As the work programme for the year was followed, the evidence was added to the Toolkit as appropriate for each of the 45 Key Requirements, and therein allocated to level 1, level 2 or level 3 within each Key Requirement (with 3 being the most difficult to achieve).

2.7 The Toolkit scoring works on a cumulative basis; all evidence required to attain level 1 needs to be uploaded in order for successive levels in the same requirement to be declared and count towards the Toolkit score. Therefore, it is possible for a Key Requirement to be scored at a level 0 if a piece of evidence at level 1 was not uploaded, even if all required evidence at level 2 had been uploaded.
2.8 All applicable individual Key Requirements must individually score level 2 compliance to achieve a level 2 compliance overall of the Toolkit.

3. Information Governance Toolkit V13, 2015/16

3.1 Version 13 of the Toolkit required self-assessment against the 45 Key Requirements which are divided into six initiatives.

3.2 Details of the Trust’s scores, divided into the six initiatives, are presented in the table below and provide comparison with the Trust’s 2015 scores (which are automatically calculated on the online tool):

<table>
<thead>
<tr>
<th>Initiative</th>
<th>2015 Score</th>
<th>2015 Compliance Level</th>
<th>2016 Score</th>
<th>2016 Compliance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance Management</td>
<td>60%</td>
<td>Level 1</td>
<td>86%</td>
<td>Level 1</td>
</tr>
<tr>
<td>Confidentiality and Data Protection Assurance</td>
<td>66%</td>
<td>Level 2</td>
<td>75%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Information Security Assurance</td>
<td>60%</td>
<td>Level 1</td>
<td>71%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Clinical Information Assurance</td>
<td>66%</td>
<td>Level 1</td>
<td>66%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Secondary User Assurance</td>
<td>62%</td>
<td>Level 1</td>
<td>66%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Corporate Information Assurance</td>
<td>55%</td>
<td>Level 1</td>
<td>67%</td>
<td>Level 2</td>
</tr>
<tr>
<td><strong>Overall Scores</strong></td>
<td><strong>62%</strong></td>
<td><strong>Level 1</strong></td>
<td><strong>72%</strong></td>
<td><strong>Level 1</strong></td>
</tr>
</tbody>
</table>

3.3 Using the results of the other six Trusts in the WTP as a benchmark, it is clear to see that an overall Toolkit score of 72% (i.e. the same as the Trust scored) or less, enabled three of the six Trusts in the partnership to achieve an overall, level 2 compliance score against the Toolkit.

<table>
<thead>
<tr>
<th>Trust</th>
<th>2016 Overall Scores</th>
<th>2016 Toolkit Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust A</td>
<td>72%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Trust B</td>
<td>67%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Trust C</td>
<td>75%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Trust D</td>
<td>87%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Trust E</td>
<td>67%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Trust F</td>
<td>74%</td>
<td>Level 2</td>
</tr>
<tr>
<td>TRFT</td>
<td>72%</td>
<td>Level 1</td>
</tr>
</tbody>
</table>

3.4 As illustrated above, the Trust failed compliance on the first initiative –
Information Governance Management - with a score of 86%. However, using the WTP partners as the benchmark again, the Trust's result for that one initiative is quite surprising:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Information Governance Management initiative</th>
<th>2016 Toolkit Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust A</td>
<td>73%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Trust B</td>
<td>73%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Trust C</td>
<td>80%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Trust D</td>
<td>100%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Trust E</td>
<td>70%</td>
<td>Level 2</td>
</tr>
<tr>
<td>Trust F</td>
<td>80%</td>
<td>Level 2</td>
</tr>
<tr>
<td>TRFT</td>
<td>86%</td>
<td>Level 1</td>
</tr>
</tbody>
</table>

3.5 The Trust’s score of 86% for this initiative is the second highest in the peer group, but the Trust failed the initiative.

3.6 Detailed analysis, confirms that the Trust failed one Key Requirement of the five in this initiative that was needed in order to pass this section successfully. This was 13-112, “Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained”. (Further details of each initiative score are provided at appendix 1).

3.7 The prerequisite for passing the 13-112 Key Requirement is that at least 95% of all colleagues need to have passed the Trust’s information governance training between 1 April and 13 March annually. IG training is part of the Trust's MAST training. At 31 March 2016, the training figure stood at 86.63% compliance against the 95% target – this was in spite of at least one division showing less than 50% compliance with IG MAST training at that time.

3.8 In addition, the requirement further states that to achieve level 2 compliance, training needs should be reviewed and re-evaluated as necessary, with additional training being provided to key groups where needed.

The action from this latter point is already in place, and additional training has been provided to some of those colleagues who work in areas identified as having high IG incident rates. Further training is planned for the team involved in the latest IG breach, reported to the Board in February.

3.9 All IG training, and production of (non-online) training materials, is provided by the IG Team comprising of 2 WTE.

3.10 It is recognised that taking the training does not provide sufficient assurance that those who have taken it, understand their IG responsibilities. This is evident from the actions arising from M11 of the CQC Action Plan in relation to patient records. By undertaking compliance and audit checks to ensure that
awareness is raised, the IG Team could provide some level 3 compliance with this Key Requirement – if level 2 is achieved with regard to training figures.

4. **Looking forward to 2016/17**

4.1 Some immediate actions to be taken and put in place:

- An improvement action plan relating to the failed requirement 13-112 has already been downloaded from the IG Toolkit.

- A communication will be sent out across the Trust to advise that HSCIC’s online IG training tool should be used to undertake online training, rather than the very simple training already provided through OLM (ESR). The HSCIC version provides a more robust training package which is DOH approved, and also provides specific online training for Caldicott Guardian, SIRO, and similar colleagues. Use of the online training is free.

- Enquiries have already been made with the national suppliers of the HSCIC and ESR IT systems who advise that they do not ‘speak’ to each other. This will mean that all training results from HSCIC will need to be uploaded manually to ESR; additional resource will be required for this. This will also ensure that any training completed online is accounted for on ESR. However, the improved training materials will help to promote a more IG-aware culture within the organisation.

- In the meantime, we are also looking at other providers for an online training tool which is ESR / OLM compliant.

- Further training opportunities provided by the IG Team will be available for everyone, including face-to-face training, role specific training, etc.

- The Datix reporting tool will be looked at with regard to the reporting of IG incidents. At the moment, Datix asks for the severity of harm arising from an incident to be reported (this being either no harm, low, moderate or severe).

Because the level of harm relates to physical or mental harm caused to the patient or colleague, all IG incidents are reported as “no harm”. This is despite the possibility of reputational damage or regulatory fines to the Trust, security issues if information falls into the wrong hands for the individual whose data has been breached, as well as possible mental harm caused by stress or anxiety, etc.

We will look to consider whether a specific IG category can be established, which will help to provide a cultural shift away from ‘no harm’ IG breaches.

- Executive Directors will be asked to review the identity of the 45 Key Requirement owners from their teams to ensure that the most appropriate managers are in place to provide leadership in each of these key areas.
To be assured that the evidence provided on the Toolkit is appropriate and robust, an ongoing audit by the Governance Manager, independent from the IG Team, will be carried out during 2016/17 on each of the Key Requirements.

Further actions to support compliance with the Toolkit are being put into place, some of which can be found in the annual SIRO report.

5. Conclusions

5.1 Whilst the Trust did not achieve level 2 compliance with the Toolkit, I am confident that the Trust has made progress over the last 12 months; compared with the Trust’s scores from the previous year, there is improvement in at least five of the six initiatives, and, compared with its peer group, the Trust appears to be performing on a par.

5.2 Without the 95% training rate, the Trust could not achieve level 2 compliance. According to the Toolkit figures and analysis, this is the single point of failure for the Trust.

5.3 Detailed analysis has shown that the Trust has set its standards high; its baseline assessments at the beginning of the year were often set higher than those reported by the members of its peer group.

5.4 It is not recommend that we lower our own governance standards in order to achieve regulatory compliance. However, it is recognised that there are areas for focus, and whilst challenging, compliance with level 2 for 2016/17 is far from impossible.

6. Finally

6.1 Thanks must be provided to the Key Requirement Owners across the Trust who worked hard to create and upload evidence to the Toolkit.

6.2 Thanks also to the new Information Governance Committee attendees – their attendance and input is very much valued.

6.3 Thanks to everyone who persevered with ESR to complete their online training.

6.4 Finally, thanks must go to the IG Team who have worked hard to provide additional training and support across the organisation for colleagues seeking answers to IG questions and issues.

Anna Milanec
SIRO
April 2016
<table>
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<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Total Req'ts</th>
<th>Overall Score</th>
<th>Self-assessed Grade</th>
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<tr>
<td>IG Toolkit Assessment Summary Report</td>
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<td>THE ROTHERHAM NHS FOUNDATION TRUST</td>
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<tr>
<td>Secondary Use Assurance</td>
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<tr>
<td>Corporate Information Assurance</td>
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<td>34</td>
<td>10</td>
<td>1</td>
<td>45</td>
<td>74%</td>
</tr>
</tbody>
</table>
Report: Responsible Officer Report

Presented by: Conrad Wareham, Medical Director
Author(s): Dr Alison Cooper, Director PGME & AMD Medical Appraisal & Revalidation

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

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

Risk Reference:
BAF:
Corporate Risk Register : 3989 Risk Grade 1

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

Summary of Key Points:
- There have been 60 positive Revalidation Recommendations and 8 Deferrals during the Appraisal year 2015/16 with no non-engagement recorded.
- End of year figures show the Trust overall has achieved an 85% Appraisal rate
- Four out of the five divisions have achieved 90% or above with congratulations to the Division of Clinical Support Services who achieved 100%.
- All Appraisal and Revalidation dates have been logged onto ESR.
- Dr Cooper can now access Complaint and SUI information.

Board action required: For Noting
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total Prescribed Connection of Doctors in Division</th>
<th>Q1 1/4/2015-30/6/2015</th>
<th>Q2 1/7/2015-30/9/2015</th>
<th>Q3 1/10/2015-31/12/2015</th>
<th>Q4 01/01/2016-31/03/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Division of Family Health</td>
<td>27</td>
<td>7</td>
<td>5</td>
<td>8</td>
<td>6</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2 Division of Emergency Care</td>
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<td>6</td>
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<td>0</td>
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<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>3 Division of Integrated Medicine</td>
<td>32</td>
<td>13</td>
<td>5</td>
<td>6</td>
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<td></td>
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<td>4 Division of Surgery</td>
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<td>5 Division of Clinical Support Services</td>
<td>17</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>
## Quarter 4 Medical Appraisal Figures for 2015/16

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 1/4/2015-30/6/2015</th>
<th>Q2 1/7/2015-30/9/2015</th>
<th>Q3 1/10/2015-31/12/2015</th>
<th>Q4 01/01/2016-31/03/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Name of designated body (or NHS England Area Team or Region)</td>
<td>TRFT</td>
<td>TRFT</td>
<td>TRFT</td>
<td>TRFT</td>
</tr>
<tr>
<td>Note: Please ensure your organisation’s name is written exactly as it is recorded on GMC Connect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Number of doctors with whom the designated body has a prescribed connection</td>
<td>206</td>
<td>208</td>
<td>208</td>
<td>210</td>
</tr>
<tr>
<td>3 Number of doctors¹ due to hold an appraisal meeting in the reporting period</td>
<td>55</td>
<td>56</td>
<td>51</td>
<td>90</td>
</tr>
<tr>
<td>Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor’s agreed appraisal month, whichever is the sooner.</td>
<td></td>
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</tr>
<tr>
<td>3.1 Number of those within #3 above who held an appraisal meeting in the reporting period</td>
<td>46</td>
<td>46</td>
<td>28</td>
<td>59</td>
</tr>
<tr>
<td>3.2 Number of those within #3 above who did not hold an appraisal meeting in the reporting period [These to be carried forward to next reporting period]</td>
<td>9</td>
<td>10</td>
<td>23</td>
<td>31</td>
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<tr>
<td>3.2.1 Number of doctors¹ in 3.2 above for whom the reason is both understood and accepted by the RO</td>
<td>9</td>
<td>10</td>
<td>23</td>
<td>31</td>
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<td>3.2.2 Number of doctors¹ in 3.2 above for whom the reason is either not understood or accepted by the RO</td>
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<tr>
<td>2 Maternity Leave</td>
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<td>4 Sabbatical</td>
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<tr>
<td>3 Sick Leave</td>
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<tr>
<td>8 Dates booked for April 2016</td>
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<tr>
<td>6 Started but not yet completed</td>
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<tr>
<td>8 new starters</td>
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Purpose of this paper:

The final version of the new NHS Improvement Agency Rules came into force on 1 April 2016. A copy can be located here.

As a result, and in consideration of additional matters, a new ‘break glass’ procedure has been produced, which is appended.

Summary of Key Points:

- “Trust Boards have primary responsibility for monitoring the local impact of the agency rules and ensuring patient safety.”
  
- The break glass provision must only be used in certain circumstances where patient safety is a risk and other alternatives have been considered.

- Weekly submissions to the regulator must be provided indicating how many shifts have overridden the rules, and must be signed off by a ‘board member’.

- However, the new procedure also considers a wider issue of locum spend in general and will be highlighted at the meeting.

Board action required:

Break Glass Procedure requires board approval

### Part 1 - Justification

<table>
<thead>
<tr>
<th>Division</th>
<th>Grade</th>
<th>Specialty</th>
<th>Reason Cover is Required (choose from dropdown list)</th>
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</table>

<table>
<thead>
<tr>
<th>Justification (to be completed by Division / Department)</th>
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</table>

### Part 2 - Check List

<table>
<thead>
<tr>
<th>Step</th>
<th>Details</th>
<th>Yes / No</th>
<th>Process</th>
<th>Specific Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Confirm staff in work cannot be moved to cross-cover and maintain safe patient care?</td>
<td>No - Step 2</td>
<td>Yes - move staff as required to meet ward / department needs</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is there Internal Bank Staff available to cover?</td>
<td>No - Step 3</td>
<td>Yes - book Internal Bank Staff as per current procedure</td>
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<tr>
<td>3</td>
<td>Confirm requirement for Agency locum / temporary worker is required</td>
<td>Yes - Step 4</td>
<td>No - decision taken not to engage an agency locum / temporary worker</td>
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<tr>
<td>4</td>
<td>Agency locum / temporary worker sourced within price cap</td>
<td>No - Step 5</td>
<td>Yes - book locum / temporary worker and complete details below</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Confirm no other option is available for cover within price cap and failure to book locum will result in patient safety issues</td>
<td>Yes - Step 6</td>
<td>No - continue to attempt to cover within price cap</td>
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</tr>
<tr>
<td>6</td>
<td>Authorise 'break-glass' and report as an override on the weekly submission</td>
<td>Yes</td>
<td>Complete detail below and add shifts to weekly submission</td>
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</table>

### Part 3 - Locum Details & Costings

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<tr>
<th>Locum Booking Details</th>
<th>Financial Details</th>
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<td>Total Hours</td>
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### Part 4 - Details of Requesting Manager

**By requesting this locum I am aware of the cost to my Department (must be budget holder or authorised signatory)**

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<td>Approved By</td>
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<td>Post</td>
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<tr>
<td>Date</td>
<td>Date</td>
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### Part 5 - Authorisation

**To be approved by the General Manager (or deputy) if within price cap or an Executive Director if requesting an override. By approving this locum I am aware of the cost to the Trust and authorise price cap override (where applicable)**
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### Event/Issue

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